Sixth Monitoring Report
US Department of Justice v. Erie County New York

This report reviews the status of medical program conditions at the time of the Sixth Monitoring visit, which took place from May 13-17, 2014.

B. Medical Care

1. Policies and Procedures

Compliance Status: Substantial compliance drafting of policies; substantial compliance implementation of policies.

Findings

Under the leadership of the Director of Health Care Services and the Director of Nursing, policies remain in compliance and in most areas, implementation improved. There is no question that the absence of a Medical Director has had a negative impact on the program. This is particularly true with regard to professional performance improvement of the advanced level clinicians. We were encouraged to hear that a successor Medical Director has been identified and is able to begin employment in that role in early September 2014. We also learned that this candidate is interested in working on a fee-for-service basis before then by involving himself in the professional performance improvement program with the advanced level clinicians.

Recommendations

1. Please forward the curriculum vitae of the newly selected Medical Director to the medical monitor.
2. Develop a format for systematic and consistent review of professional performance of the advanced level clinicians by the Medical Director. The medical monitor would be happy to assist in the development of this performance review.

2. Medical Autonomy

Compliance Status: Substantial compliance.

Findings

Although there has been a vacuum in the clinical leadership of the medical program, the medical monitor has developed a degree of confidence in the professionalism of the custody leadership such that it is my belief that custody leadership will not exploit this vacuum by intervening in necessary medical decisions. It will be up to the new Medical Director to again establish credibility with custody leadership and it is our belief that this certainly is achievable.

Recommendation: None.

3. Privacy

Compliance Status: Substantial compliance.

Findings

Besides the improved privacy provided by the new intake space, we learned that at the Alden Erie County Correctional Facility the room in the hallway will not be utilized. Rather, an additional exam room has been created in the clinic area. We are also aware that in the pod housing units there is an appropriately equipped examination room which affords the required privacy. Although there is no such room in the linear designed housing units, we are aware that patients are brought instead to the main clinic area where such privacy can be afforded.

Recommendation

1. Continue to provide appropriate privacy for any and all clinical assessments. This precludes any assessments being conducted cell-side.

4. Training of Custody Staff

This area has been in compliance for 18 months.

5. Management of Health Records

Compliance Status: Partial Compliance.

Findings

Although the backlog in inactive records has been eliminated, the effort to integrate all medical and mental health documents into the same record has resulted in increased filing needed to be performed for the active records. At the time of this visit, the loose filing area contained between seven and eight inches of unfiled documents that extended as far back as mid-April. These documents were mostly mental health initiated documents. It is expected that the electronic health record will go live as early as September of this year and certainly before our next visit in November. This should eliminate any of the active record filing as well as inactive record filing within six months of the implementation of the electronic record. The medical monitor is familiar with the particular software chosen and has experience with it, finding it quite user friendly. Another positive aspect of this software is that it is easily customizable with regard to the data entry screens which can be customized by local staff or a consultant to the program. We look forward to this section coming into substantial compliance.

Recommendation

1. Work closely with the IT integration vendor in order to design encounter forms that allow tracking and reporting on important data fields and also to insure that the transition from paper to an electronic record goes as smoothly as possible.

6. Medication Administration

Compliance Status: Substantial compliance.

Findings

Once again, we observed both morning and evening medication administration in both the linear housing units and in the pods. We were pleased to find that the nurses continue to perform both appropriately and professionally. We found that there was helpful participation by the correctional officers. We also found that there had been retraining of nurses such that there was consistency with regard to how they documented inmate refusals of specific medications. We also learned that there has been retraining with regard to the manner of documentation when as needed medications are felt by the patient not to be needed. Finally, we were particularly pleased with the nursing staff compliance with the policy requirement that when a patient refuses a medication for three consecutive medication passes they are referred to the ordering clinician. We observed several medication administration records were there were consecutive refusals and the patients had been referred to the clinicians. This was especially common with regard to the forensic clinicians. We were quite disappointed, however, with the response of the forensic clinicians who neither documented counseling nor made any effort to modify or revise the existing regimen. The purpose of the referral is for any clinician to explain the risks and/or benefits and to work out with the patient a regimen that is much less likely to be refused. There was no documentation that we saw that achieved these goals. We also believe that blank spaces that occur on medication administration records where the medicine is ordered at least daily should be treated as medication errors.

Recommendation

1. The quality improvement program should select MARs that reflect the work of a variety of nurses, especially for patients who are on multiple medications, multiple times per day. In reviewing these medication administration records, a calculation should be performed of the error rate, meaning the rate of blank spaces versus the total number of expected doses administered. This error rate should not only be used to improve performance, but it also should be reported in the quality improvement minutes at least quarterly.

7. Access to Care

Compliance Status: Partial compliance.

Findings

We were pleased to observe that the logging of medical sick call requests is occurring and these requests have been separated into symptom describing requests and other so-called administrative or informational requests. However, the manner in which they were recorded does not easily allow for a simple observation of the timeframe between request received and face-to-face assessment having occurred. We believe it will be more useful to have a logbook that lists patient identifiers, date received, nature of the complaint, date of assessment and disposition. This would allow to visually determine the average timeframe in which these assessments occur simply by glancing at the two columns, date received and date of assessment,. Finally, with regard to the disposition, we attempted to do a study looking at the records of patients in which the disposition described referral to an advanced level provider. The first five such records we pulled contained zero notes by an advanced level clinician. We learned that a policy had been implemented in which, when the nurses refer the patients to the advanced level clinicians, these advanced level clinicians had a choice of reviewing the record alone or also seeing the patient. In none of the records we reviewed was the patient seen face-to-face for an assessment by an advanced level clinician. Therefore, we are strongly recommending that the policy with regard to referral be changed. The discretion by an advanced level clinician of only reviewing the record should be eliminated. We have never heard of an instance where a patient learned anything when their record had been reviewed by any clinician. The choices the nurses should have is to either discuss the case with the clinician at the time the patient is there or refer the patient to the clinician for a mandatory face-to-face assessment by the clinician. We also discussed with the Director of Health Services that it is very important that no clinicians are allowed to conserve personal energy by manipulating the list of patients they are to see in such a way that their workload is reduced.

Recommendations

1. Set up a logbook that allows visual tracking of symptom complaints for time of receipt, presenting complaint, time of nurse assessment as well as disposition.
2. The QI program should present data from these logbooks with regard to average timeframe between receipt and nurse assessment.
3. Eliminate the advanced level provider review and make all referrals to an advanced level provider mandatory, face-to-face assessments where they can help understand the patient's problems and educate their patient.
4. The QI program should monitor the average timeframe for advanced level clinician face-to-face assessment after nurse referral, with a threshold of no more than five business days.

8. Emergency Care

Compliance Status: Substantial compliance.

Findings

We reviewed seven records of patients who were sent offsite on an emergency basis. In general, these patients were assessed timely prior to send out, an advanced level clinician was notified and recommended the patient be sent out, and when the patient returned the appropriate offsite documents were available and the patients were seen by a nurse upon return and by an advanced level clinician within a few days after return. In most of those follow-up visits, the findings and plan were discussed. However, we did find an occasional record where there was no documentation of contact with an advanced level provider as well as an occasional record where the offsite service document was missing. We also found an occasional record where the nurse note on return was absent and an occasional record where the follow-up visit with the advanced level clinician either did not occur or did not include documentation of a discussion with the patient regarding the findings and plan. Because we did not identify a pattern to any of these individual errors, we still assessed this area as substantial compliance.

Recommendations

1. The QI program should be monitoring a set of emergency offsite visits and insuring that there is documentation of a discussion with an advanced level clinician prior to send out and that there is a nurse note upon return, as well as both the available documents from the offsite service and a timely follow up by an advanced level clinician at which there is documentation of a discussion regarding the findings and plan.

9. Follow-Up Care

Compliance Status: Partial compliance.

Findings

We looked at scheduled offsite services, that is consultations and procedures, both at Alden and at the holding center. In both facilities, we identified multiple records where there was a breakdown in either availability of offsite service documents or in a timely follow up by the clinician in which there was documentation of a discussion with the patient regarding findings and plan. There were records at both sites in which all of the required elements were present. However, between the two sites the rate of records where all of the elements in the offsite service process were successfully completed was less than 50%. Therefore, the assessment of partial compliance.

Recommendation

1. The QI program should monitor at each site a sample of patients sent offsite for scheduled offsite services. The monitoring should include the timeliness of the appointment, the presence of the offsite service report upon return and the follow-up visit with an advanced level clinician in which they document the findings and plan having been discussed with the patient. When there is breakdown in any of these steps, the QI

program should assess the contributing factors and develop improvement strategies to mitigate the occurrence of these factors.

10. Chronic Disease

Compliance Status: Partial compliance.

Findings

In our last report we voiced concerns regarding the loss of the Medical Director and the ability of the program to therefore improve clinical performance. At this visit, with regard to chronic diseases, our concerns were realized. During this visit, we looked particularly at diabetes care and HIV care in order to determine whether problems we had identified in our prior visit had in fact been mitigated. In general, with some exceptions, we found that many of the prior stated performance issues have not been mitigated. The following is a list of those concerns.

We found patients for whom for the first visit, the initial baseline form was not utilized and as a result there was insufficient disease specific history. We also found records where only one of the chronic diseases was addressed and therefore the other chronic diseases appeared to have been ignored. We also found records where there was no assessment of degree of control, which ultimately determines the management approach. In the case of HIV disease, we found patients seen where at the initial visit there was no order for the viral load, although there was an order for the CD 4 count. The viral load is critical in order to determine viral activity. The CD 4 count may be within normal range, but if the viral load is significantly elevated, this may mean either that if the patient is on medications, resistance is possibly developing or in a patient not on medications, it is likely to indicate the need for initiating medications. With the absence of the viral load at the time the patient is sent to the HIV specialist, this may delay the ability of the HIV specialist to determine when treatment needs to be initiated. These types of problems hopefully will be easily addressed by the new Medical Director. If the program is able to develop a contract with the proposed Medical Director in the interim before he is to start as Medical Director, this could allow improvement in ALP performance over the next few months.

Recommendations

1. Send to the medical monitor the curriculum vitae of the proposed Medical Director,
2. Proceed with the administrative steps necessary to bring the proposed Medical Director on board in the interim to perform professional performance enhancement reviews.
3. The Director of Correctional Health Services should contact the medical monitor about designing a form to be utilized by the proposed Medical Director in performing the professional performance reviews.

11. Dental Care

Compliance Status: Substantial compliance.

Findings

We were not able to interview the dentist during this visit and therefore we were not able to review the program as thoroughly as during our prior visits. However, when we reviewed the data on performance of restorations versus extractions, we observed that the prior problem of one dentist overwhelmingly performing extractions has been eliminated. We were informed that that dentist has been terminated. We believe that it is important for the quality improvement program to track date of receipt of symptomatic requests that reflect tooth pain and date of face-to-face encounter either with a nurse or with dental staff during which analgesia is provided. We also believe that tracking of dental pain in relationship to assessment by a dentist should also be tracked.

Recommendations

1. The QI program should track symptomatic requests that discuss tooth pain and date of initiation of analgesia.
2. The QI program should also track date of request received describing dental pain along with date of assessment by the dentist. These studies should be reported monthly and reviewed at the QI meeting quarterly.

12. Care for Pregnant Prisoners

Compliance Status: Partial compliance.

Findings

During our last monitoring visit, we assessed the compliance status as conditionally substantial compliance. We have downgraded the assessment to partial compliance because two of the five records reviewed lacked the necessary offsite service documents to allow for appropriate continuity of care onsite. We understand that there has been contact with the Women and Children's Hospital administration regarding providing the necessary documents. However, the staff at ECHC and ECCF must persist in obtaining these critical documents. It may be that in addition to another meeting with the leadership of these offsite services that a letter from the Department of Health or Correctional Health Services be brought by an officer to the offsite service provider which indicates the officer must return with the required documentation in an envelope in order to facilitate continuity of care onsite and in order for the service to be completed, thus allowing for timely compensation.

Recommendations

1. Develop an administrative strategy that facilitates timely retrieval of the critical offsite service documents.
2. The QI program should continue to track timeliness of initial ALP assessment after determination of pregnancy as well as timeliness of offsite service obstetric visit from time of diagnosis.

13. Dietary Allowances and Food Service

Compliance Status: Partial compliance.

Findings

We were impressed with the dietitian who has been hired on a part-time basis to guide the food services operations. We had an opportunity to talk with her and learned that she has been assessing whether there could be a transition to a heart-healthy diet. We were informed that at the ECCF there was a well-designed and equipped kitchen and therefore they could convert to such a diet. On the other hand, at the holding center, the kitchen, which was built with the building several decades ago, was only designed for potential population of 200 detainees. Therefore, the size of the kitchen does not currently allow for the type of food preparation for a heart-ealthy diet and rather requires the utilization of a significant amount of processed foods. This creates a challenge, particularly with regard to the salt content of the master menu diet at the holding center. It would be problematic to have one master menu at one facility and a significantly different master menu at the other facility. We also found that the number of detainees for whom both a diabetic diet and a cardiac diet were ordered was substantially less than what one would project for the holding center. This suggests that there is continued need to attempt to move to a heart-healthy master menu because accomplishing that goal would eliminate the need for special diets for diabetes and hypertension and thus increase the likelihood that detainees with these problems would receive an appropriate dietary regimen.

Recommendations

1. Bring in an appropriate consultant to determine whether the existing holding center kitchen can be expanded and equipped sufficiently to allow for a heart-healthy diet.
2. Provide the medical monitor with an analysis of the existing food served both at the ECCF and at ECHC so that the dietitian can determine how big a change moving to a heart health diet would cause.

14. Health Screening of Food Service Workers

This area has been in compliance for 18 months.

15. Treatment and Management of Communicable Diseases

Compliance Status: Partial compliance.

Findings

The Director of Nursing, who has excellent prior experience, is currently functioning as the infection control nurse for both facilities. We discussed with her the infection control program in general and discussed in detail the TB surveillance program as well as the MRSA surveillance program. We also discussed data collection with regard to hepatitis A, B and C as well as HIV

disease. We would like to review the TB control policy which we had reviewed several years previously. We also learned that the ability to track skin infections presumptively treated for MRSA has not yet been implemented. The implementation of the electronic medical record should facilitate notification by clinicians to the infection control coordinator when such presumptive treatment occurs. This can be done internally through the EMR flagging system (internal e-mail).

Recommendations

1. Establish a system to monitor both culture proven and presumptively treated MRSA cases on a monthly basis.
2. Report both categories of MRSA cases at the QI meeting on a quarterly basis.

16. Sexual Abuse

Compliance Status: Partial compliance.

Findings

When we reviewed the records of patients who had historically alleged sexual abuse, we found that the documentation from the offsite services did not even mention the performance of a forensic exam nor the provision of rape crisis counseling services. We understood that discussions between the leadership of correctional health services and the leadership of ECMC have occurred and yet line staff from the offsite services are still not always providing the necessary documentation. We strongly urge a letter be drafted coming from the Department of Health to ECMC staff that describes the federal requirement that documentation of such services, including prophylactic treatment for sexually transmitted diseases and counseling regarding pregnancy, be included in the offsite service documentation. This letter should be brought by an officer for each and every patient who is to be assessed at the hospital via a forensic exam.

Recommendation

1. The Department of Health should develop a letter to the ECMC staff that documents the requirement of correctional facilities to be able to demonstrate documentation of the occurrence of both a forensic exam and rape crisis counseling along with the provision of sexually transmitted disease treatment and pregnancy counseling where indicated.
2. The QI program should track the receipt of this documentation for each and every allegation.

17. Quality Management

Compliance Status: Partial compliance.

Findings

In the absence of a Quality Improvement Coordinator, the Director of Nursing services is also attempting to perform these duties. We believe this is hindering the development of this program. Additionally, the Director of Nursing, in the absence of an assistant Director of Nursing for the ECCF, is also providing direct oversight to both facilities. Clearly, an Assistant Director of Nursing for the ECCF is also required. We reviewed the minutes of the quality improvement committee meetings and identified that the minutes read more like staff meeting minutes than QI meeting minutes in which data is presented and analyzed and, where indicated, improvement strategies are developed. We could not find these activities in the quality improvement committee minutes. On the other hand, we were shown some important studies performed.

1. A study of the timeliness of receipt by the patient of critical forensic medications. We found that 40 of 48 forensic medications labeled as critical were received within the forensic mental health definition of timeliness, that is within 24 hours. Eight patients received their medication later than 24 hours.
2. We also found a study of the timeliness of receipt of routine medications utilizing a definition of 48 hours. Thirty-seven of 44 patients received their medical medications within 48 hours. Seven patients had their medications delayed greater than 48 hours. Ten patients refused their medications at the time of receipt and all of these were referred to the advanced level provider.
3. There was also a completeness study of the elements during the intake process, such as the medical screen, patient consent, vital signs and detox referral where indicated along with medical classification, alerts and suicide screen.

These studies are important and helpful. However, in the recommendation section of this report we have also listed studies for the quality improvement program to perform dealing with care of the pregnant patients, sexual abuse cases, chronic disease cases, dental services, scheduled offsite services, unscheduled offsite services, and others. We believe it is not possible to perform all of these reviews without the addition of a Quality Management Coordinator.

Recommendations

1. Add both a Quality Management Coordinator and the Assistant Director of Nursing positions as soon as possible.
2. Work with the IT consultant regarding the ability to track critical elements through the EMR by re-customizing encounter forms where indicated.
3. Perform the studies referred to under the recommendations section consistent with the recommendations we have made.
4. Revisit the definitions for timeframe of receipt for critical medications for both medical medications and forensic medications. For medical medications that are critical, such as anticoagulants, anti-seizure meds and HIV medications, the goal is prevent dose discontinuity by insuring that the dose is received in a timeframe that mitigates the

probability of dose discontinuity. That is almost invariably in a timeframe significantly less than 24 hours. For routine medical medications, the goal should be receipt within 24 hours. Forensic medications may have a different timeframe and different targets. This should be worked out with the leadership of forensic medical services.

18. Review of Clinical Care by Responsible Physician

Compliance Status: Non-compliance.

Findings

Since the departure of the Medical Director there has been no review of clinical care by a responsible physician. Thus the assessment of non-compliance. We are hopeful that the Director of Correctional Health Services can work with the medical monitor to design a system for professional review. We are also hopeful that between receipt of this report and the beginning of September this review can be initiated.

Recommendations

1. The Director of Clinical Services should initiated communication with the medical monitor in order to develop a systematic review of professional performance.
2. The Director of Correctional Health Services should contact a physician to perform this service.

III. Protection from Harm

E. Training of Officers with Regard to Sexual Abuse and Policy on Handling Sexual Abuse

Compliance Status: Substantial compliance.

Findings

Both the policy and the training are consistent with an assessment of substantial compliance.

Recommendation None.

I. Training of Medical and Mental Health Staff

Compliance Status: Substantial compliance.

Findings

Both the medical and mental health staff have completed their training with regard to the handling of sexual abuse. The percent trained is well above 90%.

Recommendation None.

J. Suicide Prevention Program

e. Privacy

Compliance Status: Substantial compliance.

Findings

See number 3 under Medical Care section.

Recommendation None.

f. Assessment of Inmates in Detoxification

Compliance Status: Substantial compliance.

Findings

The detoxification unit continues to function as a well-designed program.

Recommendation

1. The QI program should continue to monitor the compliance of the nursing staff in performing the CIWA assessments.

D. Training of Officer Staff with Regard to Suicide Prevention Training

Compliance Status: Substantial compliance.

Findings

This area remains in substantial compliance and has achieved sustained compliance.

3. Detoxification Training Program

Compliance Status: Sustained substantial compliance.

Findings

All of the required medical staff have had this training.

Recommendation None.

Summary of Findings

Although when one reviews the section headings and the compliance status assessed one sees, if anything, in a few categories there have been some setbacks. However, within the partial compliance category we have observed improvement in some sections, particularly scheduled offsite services and chronic diseases as well as access to care and the quality improvement

program among others. The method of assessment, choosing one of three statuses, does not allow for the description of the progress other than in the findings section. We continue to be impressed by the efforts by both the Department of Health and the Department of Corrections to do what is necessary in order to achieve substantial compliance. We are particularly impressed with the work by the Director of Correctional Health Services and the Director of Nursing, without whose work the progress that we observed would not have been observed. This was accomplished despite the loss of the Medical Director. We would hope that with the hiring of a new Medical Director as well as the implementation of an electronic record that we will see significant improvements at the time of our next visit. We continue to encourage the leadership of the medical program to utilize our services whenever they deem appropriate. We look forward to substantial progress at the time of our next visit.

Respectfully submitted,

R. Shansky, MD
Medical Monitor

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