U.S. Department of Justice

United States Attorney's Office
Eastern District of New York

271 Cadman Plaza East
Brooklyn, New York 11201

December 23, 2013

By Hand and ECF

Honorable Kiyo A. Matsumoto
United States District Judge
Eastern District of New York
225 Cadman Plaza East
Brooklyn, New York 11201

Re: *United States of America v. City of New York (Kings County Hospital Center)*
Civil Action No. CV-10-0060 (KAM)

Dear Judge Matsumoto:

The United States respectfully submits this letter, with the approval of all the parties in this action and the related *Hirschfeld* action, to summarize the report of the expert compliance assessment team from their most recent tour of Kings County Hospital Center's Behavioral Health Service ("KCHC"). The compliance report details the level of KCHC's compliance with the Consent Judgment entered in this action on January 7, 2010. A copy of the experts' report is attached to this letter, which is being hand-delivered to the Court because of its size.

As reflected in the report, KCHC has made enormous progress in the last six months. In a nutshell, although KCHC still has work to do in some areas, it has become a good facility, and has the potential to become a model for other hospitals in New York City and the country. KCHC is now in at least partial compliance with all requirements of the Consent Judgment, and in many areas, in compliance. The following is a summary of the findings of the expert consultants' tour:

A. Protection from Harm

Overall, KCHC has made significant progress in almost all areas related to Protection from Harm. It appropriately assesses patients to determine if they are at risk of harm or causing harm to others. Violence reduction protocols, including early intervention to avoid escalation, are in place, and are being effectively carried out. As a result, overall patient aggression is significantly lower than in the past, and KCHC is using data analysis to recognize and address aggression and reduce it further. KCHC does need to do more work to ensure that it properly integrates risk assessment into treatment planning. Additionally, some work needs to be done to improve the use of psychosocial interventions to address risks for aggression, sexual violence/victimization and suicide.

Serious incident investigations continue to be strong, and documentation and review of patient injury events, including assaults, has improved. KCHC needs to improve coordination and monitoring of the investigatory process. KCHC has substantially improved its quality improvement ("QI") and data collection processes. Data is now collected and analyzed regarding all aspects of care and treatment, and KCHC generates data reports which drive improvements in patient care and which address patient concerns and complaints.

B. Mental Health Care

1. Assessments and Diagnoses

KCHC is now in substantial compliance with several of the Consent Judgment's requirements regarding initial assessment and diagnosis of patients, and is very close to substantial compliance with a number of other provisions. Upon admission, patients are timely assessed through a triage process that commences upon admission to the CPEP, and which is appropriately followed up and updated throughout individuals' time at KCHC. The CPEP performs timely cognitive testing to identify individuals who may have developmental disabilities and ensure that they are treated appropriately. For the most part, the CPEP properly assesses individuals who are determined to be intoxicated, but some additional training is required to ensure that staff uses the assessment tools properly. Minors admitted to the CPEP receive appropriate special attention. However, KCHC needs to take additional steps to increase family participation in the treatment planning process.

On the inpatient units, KCHC is conducting effective interdisciplinary assessments which are individualized and appropriate. Some greater involvement of psychology is needed, however. Psychiatric diagnoses are now justified far more often than in the past, with specific diagnostic criteria. Documentation supporting diagnoses has substantially improved. Treatment and medication regimens are modified over time and the use of inappropriate medications and polypharmacy has dropped significantly. However, diagnoses are not always supported by documented DSM-V criteria. KCHC needs to more judiciously diagnose adults as having schizoaffective disorder and more evidence is required before children are diagnosed as having ADHD. In addition, treatment is not consistently modified based on the patient's response to treatment or changes in the patient's condition or needs.

2. Treatment Planning

KCHC has made substantial progress in treatment planning, an area of significant weakness in the past. It has now achieved at least partial compliance in a significant number of the provisions in this area. KCHC has developed an effective methodology for developing treatment plans (now called Individual Recovery Plans ("IRPs")) and its approach to developing IRPs is appropriately interdisciplinary and integrated. KCHC is increasingly using the "recovery model" for treatment, meaning that the goal is not simply to control behaviors, but to work in a patient centered environment to assist the patient towards quickly recovering and successfully re-integrate into the community. This is still a work in progress, however. KCHC needs to accomplish some greater individualization of treatment plans and treatment teams still vary too much, particularly with respect to ensuring patients' objectives are included in the IRP. Our on site review of charts reflects that changes in symptoms, while better documented, do not consistently lead to appropriate changes in diagnoses. Responses or lack of responses to

medication are not consistently used to help refine diagnoses. Psychosocial rehabilitation is increasingly used in treatment, but it needs to be more individualized and psychologists need to play a greater role in developing treatment plans. The Behavioral Support Team ("BST") has become effective in conducting behavioral assessments and developing individualized behavioral plans, but it needs to give more attention to identifying patients who could benefit from such plans.

3. Medication Management and Monitoring

KCHC has invested significant time and creativity to improve the quality of medication management and monitoring. A full-time, dedicated psychopharmacologist is assigned to the Behavioral Health Service, and this has resulted in substantial improvements, including ensuring that medications are prescribed in only therapeutic amounts and that prescriptions are clinically justified and tailored to each patient's individual symptom. Psychiatrists newly hired by KCHC have been vigorously trained in the new model of treatment planning and prescribing. As a result, polypharmacy is substantially reduced. When it is used, it is carefully monitored and reviewed regularly. KCHC uses STAT medications appropriately, for the most part and medications are no longer being used for their secondary sedative effect. Treatment teams show some inconsistency in adherence to patients' psychopharmacological plans of care, and more training is needed to ensure that treatment team decisions incorporate appropriate standards for prescribing.

C. Behavioral Management

KCHC's BST director continues to be a major institutional strength. The BST has developed excellent policies and its behavioral philosophy is being spread throughout the disciplines at KCHC, particularly nursing. However, the quality of behavioral programming has suffered because of staff turnover in the BST. There has been an increased reliance on unit psychologists, who need to become more consistently effective in helping patients learn adaptive techniques to address behavioral issues. Behavioral plans are more often integrated into IRPs, but some additional work needs to be done in this area

The data that the experts reviewed reflects that overall, KCHC is using mechanical restraints far less frequently in the past, and when it does use restraint, uses only four point restraints, as the Consent Judgment requires. KCHC terminates restraints at the earliest possible time, and without the requirement that a doctor approve. Restraints are almost never used as punishment, but KCHC needs to develop a monitoring or other tool to ensure that restraints are not used as an alternative to active treatment. KCHC continues to reduce use of close observation (e.g., 1:1, observation every 15 minutes). However, KCHC needs to develop better monitoring tools to ensure that it uses these techniques only when necessary.

D. Medical and Nursing Care

KCHC has significantly improved its monitoring of acute medical conditions and has included medical assessment in the initial treatment planning process. This has led to improved coordination, integration of information and enhanced patient care, reducing the potential for medical emergencies and crises. Complete medical assessments are usually conducted on a

timely basis within the first 24 hours of admission. KCHC has developed an effective program to address medical emergencies. Medical documentation has improved, but the electronic medical record system remains confusing and difficult to use.

Medical care on the children's and adolescent units is not at the same level as on the adult services. There is still no consistent pediatric leadership provided relative to youth medical needs. Pediatric leadership is still not involved in monitoring and evaluating the practices of pediatricians in BHS. The expert team expressed serious concerns about whether young patients were receiving care based on clinicians' understanding of patients' comprehensive needs and adequate involvement in developing coordinated recovery plans. The coordination of care and integration of medical issues with behavioral health issues remains compromised in spite of well-considered attempts to improve these areas.

Overall, nursing has improved significantly at KCHC. Nursing is better integrated into all levels of the organization, particularly in treatment planning. Nursing leadership is now very strong, and there is ongoing coaching, training and supervision, creating a new environment in which nurses are more engaged with patients. There are still too many patients in bed during the day, but nursing staff is employing new strategies to address this problem. Further, KCHC's Human Resources Department has presented barriers to improvement in the BHS nursing unit. There are too many sustained nursing vacancies and serious hiring delays. Also, where nursing management has found that nurses have not met job standards, including in situations involving allegations of staff abuse or neglect, the Human Resources department has not supported management by taking timely and appropriate action.

E. Quality Assurance/ Performance Improvement

BHS has maintained and strengthened the robust Quality Assurance/Performance Improvement ("QA/PI") system that was present during the last tour, and is closer to achieving substantial compliance with this requirement. The QA/PI system is even further integrated throughout the BHS, providing insight into all disciplines' strengths and areas which need improvement. Very few additional refinements in QI are required—KCHC needs only to continue to collect its data and sharpen its analytical tools, such as its inter-rater reliability methodology (inter-rater reliability is a measure of reliability used to assess the degree to which different judges or raters agree in their assessment decisions).

F. Fire And Life Safety

KCHC is in substantial compliance in this area. The one issue from the last review of this area, the need to hire additional fire safety officers, has been resolved. Fire drills are conducted properly and KCHC properly documents all of its fire safety reviews. Emergency keys are properly marked and consistently stored in a quickly accessible location. Overall, the facility is clean and well maintained. Linens and other laundry are kept clean. The food service is well run, and food is maintained and served at proper temperatures.

G. Discharge and Aftercare Planning

KCHC's discharge planning process remains strong. Discharge planning begins at admission and is an integral part of treatment planning from the onset. The facility needs to do a better job of identifying barriers to discharge and skills which will ensure a successful discharge to the community. KCHC needs to develop additional measurable goals to ensure that it is complying with the requirements of the Consent Judgment and, more importantly, effectively conducting discharge planning. Significant gaps in certain community services and supports continue to exist and result in repeat admissions and greater lengths of hospitalization than necessary. The lack of sufficient community resources still significantly restricts KCHC's discharge planning process and causes lengths of stay to be too long, but social work management continues to work hard to develop new contacts and identify appropriate resources. KCHC's Monitoring Referral Linkage Unit ("MRLU"), which is responsible for ensuring that patients who are discharged receive continuity of care and are linked with and follow up with community resources and treatment, is increasingly effective.

H. KCHC Hospital Police Policies, Procedures and Practices

As we have noted in our previous reports, the Hospital Police ("HP") at KCHC has improved dramatically. The department now has only very limited contact with psychiatric patients, and officers are not allowed on BHS units unless they are called by clinical staff to investigate a criminal incident. The HP is efficiently and professionally managed, and has a comprehensive set of policies and procedures. Officers receive appropriate training prior to being released to patrol duty, and supervisors ensure that officers receive substantial guidance. Officers maintain logbooks and other documentation properly, and these are reviewed regularly by supervisory personnel.

However, HP is now only in partial compliance with in the training requirements of the Consent Judgment. HP trains its officers in Crisis Intervention policies only once, upon hiring, and does not provide regular a refresher course to officers, something that should occur at least once every two years. Similarly, KCHC does not provide annual Fire/Safety training for Hospital Police. Fire Safety certification is awarded to HP staff based upon the results of a written test. If an officer passes the test, she is not required to undergo any training. Further HP records reflect that only about half of the HP officers even took the Fire/Safety test in 2012 and 2013. All HP officers should receive fire safety training annually.

I. Training

KCHC has made substantial progress during this reporting period. It now has a Staff Development Director who can build on KCHC's existing foundation for an appropriate training program. Interdisciplinary training has advanced with a special focus on violence reduction protocols and treatment planning. The percentage of staff members who are trained in all competency areas has increased, but needs to improve further.

In sum, conditions of treatment at KCHC are much better than even a year ago. If KCHC continues to improve, and corrects the remaining deficiencies identified in our report, there is

every expectation that KCHC will come into substantial compliance with all the requirements of the Consent Judgment. However, as is evident from the Report and the Compliance Summary Chart, there are areas of the Consent Judgment where KCHC is currently only in partial compliance. KCHC needs to continue to improve and take additional steps into order to achieve compliance with all the requirements of the Consent Judgment.

We will continue to monitor KCHC's implementation of the requirements of the Consent Judgment. As always, the parties are available to the Court to answer any questions or address any concerns it may have.

Respectfully submitted,

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