HEALTH MANAGEMENT ASSOCIATES

June 8, 2016

Report and Recommendations
Clinical Operations at East Baton Rouge Parish Prison

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East Baton Rouge Context

- EBR Parish Prison census has been increasing since 2005
- Daily census consistently is at capacity >1500 with additional detainees housed at other facilities
  - Increased numbers of misdemeanants reported
- Migration of people relocating after Hurricane Katrina may have contributed to increased census at EBR Parish Prison
- Consultant engaged to assess legal processes
- Previous HMA report proposed set of diversion programs to help reduce number of people with behavioral health issues enter the EBR Parish Prison

Deliverables

- An overview and assessment of current medical operations of clinical services
  - Staffing
  - Pharmacy
  - Medication administration
  - Medical records
  - QI and performance metrics
  - Receiving and Processing
  - Health assessments
  - Infirmary Care**
  - Emergency services

Access to Care
Follow up Care
Best Practices
Offsite Services
Treat/Manage Communicable Diseases
Chronic Care
Mortality Reviews
Grievances

- Evaluation of offsite services and available offsite financials for efficiencies and recommendations
- A review of current standards including the Louisiana guidelines for jails, ACA and NCCHC with benchmarking of above assessment to industry standards, expectations and/or recommendations where applicable

** no true infirmary

National Standards Focus

- Access to Care
  - Screening and Assessment
  - Sick Call
  - Segregation
  - Timeliness of Care
- Quality of Care
- Clinical Care
  - Acute or Emergent Management
  - Chronic Care Management
  - Comprehensive and Continuity of Care
- Medical and Administrative Leadership

Methodology

- Onsite visit February 23 – 25, 2016
- Interviews with
  - William Daniel, Chief Administration Officer, Office of the Mayor-President
  - John Price, Assistant Chief Administrative Officer, Office of the Mayor-President
  - Chad Guillot, Interim Administrator, Emergency Medical Services
  - Dennis Grimes, Warden EBR Parish Prison
  - Rintha Simpson, Interim Responsible Health Administrator, EMS
  - Dr. Bridges, Medical Director
  - Dr. Whitfield, Primary Care Provider
  - Dr. Leggio, Dentist
  - Dr. Blanche, Psychiatrist
  - Kristy Perry, Psych NP
  - B. Stine, RN
  - Lisa Burns, LCSW
  - Capital Area LMSW (Jessica)
  - Tracy Washington, LPN
  - EBR Parish Prison detainees (greater than 30)
  - Correction Officers
  - Nursing staff
  - Clerical/Administrative staff

Methodology

- Documentation Reviewed
  - EMS Prison Medical Overview (dated 2/2016)
    - EBR Parish Prison 2014 actual/2015 budget
    - Contracts (medical director, physicians, CAHSD), job descriptions
    - EMS protocols (dated 1995 – 2005)
  - EBR Parish Prison Inmate Rules and Regulations (rev 10/2015)
  - Disciplinary Procedures (dated 1/2016)
  - Use of Force (dated 1/2016)
  - Classification Procedures (dated 1/2016)
  - Medical Intake and Orientation (dated 7/2012)
  - Medication expenditure reports 2015 (by patient and facility)
- Pharmacy Reports
- CorEMR electronic medical records
  - Reviewed individual patient records (sample based on patient permission and specific diagnoses)
  - Available reports generated by CorEMR

AN OVERVIEW AND ASSESSMENT OF CURRENT MEDICAL OPERATIONS OF CLINICAL SERVICES

EBR Parish Prison Health Services Work Flow

Central Booking Health Screen (Corrections Officer)

- Are you taking prescribed medication?
- Are you under the care of a doctor?
- Do you need to see a doctor?
- Officer may request LPN assessment
- People with obvious medical needs are transported out for medical clearance

Initial Health Screening (LPN)

- Structured screening tool based on detainee response and LPN observation
- Includes Brief Jail Mental Health Screen
- Routine medical screen for chronic health issues and current medications
- TB test placed

Medical and Mental Health Assessment

(If Health Screen identifies need)

- Medical assessments completed by physicians
- Mental health assessment completed by EMS LCSW and referred to psychiatric provider if needed
- Dental services requested if required
- Follow-up appointments based on identified need

Medication Passed and Health Service Request Review (LPN)

- LPNs pass medications 3 times a day
- During medication pass LPNs may identify need for medical or MH follow-up and request via CorEMR
- Detainees request sick slips which are reviewed and triaged nightly by LPN if follow-up needed scheduled in CorEMR

EBR Parish Prison Health Services Overview

- Administrative medical authority and health staff provided by Emergency Medical Services (EMS)
  - Responsible administrative leader
  - Nursing
    - 1.0 FTE Director of Nursing (RN)
    - 2.0 FTE Assistant Director of Nursing (vacant)
    - 5.0 FTE LPN Supervisors
    - 20.0 FTE LPN (6 vacant)
  - Mental Health
    - 1.0 FTE LCSW

EBR Parish Prison Health Services Overview

Professional Services Contracts with the City-Parish

- Total 0.7 FTE medical providers
  - 0.3 FTE Medical Director
  - 0.3 FTE Primary Care Physician
  - 0.1 FTE HIV Physician
- Total 0.50 psychiatric providers
  - 0.3 FTE Psychiatrist
  - 0.2 FTE Psychiatric Nurse Practitioner
- 0.20 FTE Dentist
- 2.20 Capital Area mental health staff (1.8 Social Worker and 0.40 Peer Specialist)
- 0.10 X-Ray technician
- Contract Pharmacy Services (CPS) provides medications
- Simple extractions, basic eye exams and ultrasound services as needed

Staffing

- Notable vacancy rate for RN and LPN positions.
- Insufficient number of RNs to supervise LPN dominated nursing staff.
- 3-4 LPNs are fully assigned to non-nursing duties (pharmacy coordinator, provider scheduling, and order entry, etc.)
- Medical provider staffing is insufficient to meet the needs of the EBR patient population.
- Mental health provider staffing is insufficient to meet the needs of the EBR patient population
- MH staff (excluding LCSW) are not addressing in-facility needs of inmates

Pharmacy

- Contract with CPS for medication filling works well
- LPN in pharmacy is well organized and has good systems in place for medication management of floor stock and emergency medications
- Pharmacy provides reports on utilization and offers support
- Process in place to provide a bridge supply of prescribed meds to patient-inmates who are being discharged to the community

Staffing needs for providers

- Based on chart audits, provider staffing and current productivity compared to other jail systems. We estimate:
  - The 0.6 physician position is approximately 36% of actual need
  - The 0.5 psychiatric provider positions are approximately 61% of actual need
- This estimate excludes receiving assessments

Medication Administration

- Documented in the EMR
- Reports available for medication administration
- LPNs do Medication pass
- January Pharmacy data showed:
  - 43.2% of inmates are on medications*
  - 20.28% of inmates were on psychiatric medications*

(data is limited because it is not attached to diagnosis)

Medical Records

- Using EMR but not used by all providers
- Provider notes lack diagnosis, plan of care and consistency
- EMR robust reporting capability limited by not using all features (available reports are not shared with providers)
- LPN documentation is present but limited
- Physical exams are scanned with long delays so not available to clinicians for clinical decision making
- Lab results are scanned into the record and often not available when the patient is seen by the provider. They should be interfaced to allow provider to see trending in labs and old labs for comparison

*These numbers only reflect those inmates screened and started on medications

Medication Administration 2016

Month	% receiving medications as ordered (includes documented refusals)
January 2016	77.1%
February 2016	78.0%
March 2016	81.2%
April 2016	83.4%
May 2016	83.1%
January to May 2016 average	80.5%

Includes all medications ordered

QI and Performance

- Absolute absence of quality improvement committee, meetings, processes, projects
- Data gathered and reported is not used to track, trend, improve efficiencies, access, quality of care.
- There are no clinical process or outcome metrics gathered and assessed
- Peer review of health care providers is not conducted

Best Practices

- Clinical guidelines are not used consistently but rather left to the provide
- Policies, protocols and standards of care are not
  - Accessible to staff or distributed
  - Updated or kept current; some have not been reviewed or updated in 10+ years.
  - Tailored to the EBR Parish Prison facility

Receiving and Processing

- **Critical process** that identifies at risk inmates for poor outcomes. Should be 100%
- No identifiable process to identify who missed initial screening
- Approximately 88% of detainees receive Initial Health Screen
  - Validated substance withdrawal screen not included
  - Data collected regarding who has not been screened is not considered reliable
  - Screens may not be completed until 24 – 36+ hours after entering the facility resulting in potential to miss prescribed medications
  - Inconsistent screening practices by LPNs including completing portions of forms without asking questions (need training to standardize practice)

Health Assessments

- Secondary health assessment (PE) performed by physician
  - Documentation is of limited clinical value and not done in EMR
  - Inmates missed or not performed in a timely manner
  - Not best use of MD time, could be performed by RN
- LCSW and psychiatrist practice better model for limited resources

Access to Care

- Sick call volume below expected rate
  - Health service requests (sick call slips) must be requested from Corrections Officer
  - Requests are between 16% and 33% of national rates based on number of detainees
  - Majority of detainees are not offered follow-up medical visits based on health service request
  - In January 2016 approximately 17 nurse sick call visits/day were performed (1.1% of daily census) significantly below expected utilization
  - There is a charge for both physical and mental heath visits
- Segregation for Mental Health inmates until seen by provider

Emergency Services

- 911 to OLOL
- Urgent care or fast track levels of service transported offsite for care
- Frequently inmates sent directly to ED without evaluation or assessment by nursing
- Limited routine health care and access to medical staff results in avoidable emergency transfer to external health services

Emergency Transfers Audit January 2016

- 39 total transfers to OLOL ED
- 9 removed from study*

- Appropriate transfers 16.7%
- Appropriate but avoidable transfers 40%
- Inappropriate transfers 43.3%

*7 illegible names; 3 with no notes to inform decisions; 2 other

Treat/Manage Communicable Diseases

- 0.1 HIV provider dependent on screening to be notified of patients with HIV
- Tuberculosis screening program is in place but there is opportunity for improvement
- No policies on infection control available for review
- No policy on ILI* or AGE**

*ILI = influenza like illness

**AGE=acute gastroenteritis

Chronic Care

- Currently no Chronic Disease clinic
- No scheduled visits or follow up
- MD Callout frequently rescheduled without review by provider
- Chronic Diseases are noted on Health Assessment when performed
- EMR has robust Chronic Disease module which is not being used
- No current metrics on level of control for panels of patients with chronic diseases
- HMA Chart audits found need for improvement

Off Site Services

- HMA Audits limited to ED usage secondary to data availability
- Consider increasing telepsychiatry and telemedicine capacity particularly for specialty care to eliminate transfer costs and CO costs for escort
- Dialysis provider is contracted vendor and seems to have adequate capacity
- Should explore opportunity to contract with local specialists

Follow Up Care

- No standardized post ED or hospital care
- 62% of inmates have nurse's note when sent to ED/hospital but typically notes do not contain vitals or assessment
- 82.8% of inmates have nurse's note upon return from ED/hospital but documentation is minimal and frequently does not contain assessment
- Only 3.4% have an MD note upon ED/hospital return

Mortality Reviews

- No formal mortality review currently performed
- No documented reports or action plans
- No formal sentinel event analysis
- No formal root cause analysis process
- Should be tied to Quality Improvement

Dental Services

- Access to dental provider is inadequate to meet the needs of the patient population
- Dental services provided onsite are limited to simple extractions and inspection. No fillings are done. This constitutes a barrier to basic care

Behavioral Health Services

- No designated medical detox area or standardized processes for managing withdrawal from substances
- Routine staffing is held to review mental health cases once per month attended by the Warden, social workers and administrative staff
- Recently added 1.8 FTE SW .4 Peer Specialist (3 persons) who are not direct report to EMS HSA but rather to outside agency. Their work is primarily assessing previous community linkages when there is a critical internal need for access to mental health services.
- CorEMR data fields and reports not populated or routinely reviewed
- Excessive use of Seroquel for treatment of insomnia
  - Second most prescribed medication (293 unique prescriptions in one month) exceeded only by ibuprofen
  - Literature questions "safety and efficacy" of use of Seroquel for insomnia treatment (Park, 2013)
    - Seroquel has been removed from corrections medication formularies due to risk of abuse and expense with minimal clinical disruption noted (Tamburello et al, 2012)

HMA Physical Plant Findings

- Physical plant is notably deficient
  - Poor lines of sight in many housing units secondary to linear design
  - Inadequate medical units, dental suites, infirmary space, acute and SPMI housing, medical/ MH screening space
  - Better lines of sight and climate control for areas with suicide watch
  - Need sufficient ADA compliant space for population

Also noted…

- **Lack of Experienced Health Services Administration**
  - Interim administrative leader in place dividing time with other duties
  - Not experienced in clinic management or corrections health
- **Clinical Leadership (medical, mental health, dental, nursing) are not fully engaged in directing, monitoring, improving processes and services.**
- **Need for standardized inspection and management of equipment**
- **Health care provided is episodic and inconsistent**
  - Lacks standardized processes and protocols.
  - Lacks checks and balances
- **For example:** CorEMR report for May 2016 showed 646 inmates were released without any record of medical care and the average number of days they were incarcerated was 80 days.

NCCHC Healthcare Standards

- EBR Prison currently would not pass standards outlined by NCCHC for healthcare within a jail setting

Strengths and Best Practices at EBR Parish Prison

- Adoption of CorEMR
  - Powerful tool with significant health management and data capabilities
- Pharmacy management
  - Internal processes and external vendor
- LCSW screens and triages requests for psychiatric provider assessment and medication management
  - Helps identify priority detainees for follow-up
  - Documentation details needs and plan

HMA Staffing Recommendations

1. Current leadership not capable of taking EBR Prison where they need to go
   a) Hire a full-time administrative leader (RHA)
   b) Consider engaging an interim leader who has external perspective who can view the current health care delivery without historical bias and with skills to change practice
   c) Need Medical Director functioning as Medical Director to lead internal change
2. Fill current vacancies understanding that current staffing levels are not adequate
   a) Consider changing current staffing mix and ratios to better meet needs of the prison
      i. Increase clinical RNs for assessments
      ii. Consider provider mix with NPs or PAs
   b) Remove obstacles to hiring including salary shortfalls, cumbersome hiring and background check processes and testing
3. Dedicated staff person focused on instituting a quality program (no one currently on staff appears to have this skillset)
   a) Create and Develop Quality Plan
   b) Monthly Quality meetings
   c) Implement Quality Dashboard, collection of data and provide reports to providers
   d) Implement formal Mortality Review with root cause analysis and formal sentinel event analysis

HMA Recommendations

1. Draft and Align Policy and Procedures to national standards
   a) Should provide clear expectations for clinical services
   b) Should reflect quality standards, scope of practice for staff and interagency expectations
   c) Train staff on policies and procedures on hire and review annually.
   d) Ensure all staff follow policies
2. Become a Data Driven System
   a) Include data to drive decision making and process improvement
   b) Expect reporting on volume, process and outcome measures
   c) Use data to standardize care and ensure you are providing standard of care
3. Create functional job descriptions for key positions
   a) Medical Director: administrative, quality and clinical services
   b) Health Services Authority: administrative, quality and clinical services
4. All providers and clinicians must document in EMR
   a) Utilize full functionality and reporting capability

HMA Recommendations

1. Need both immediate and long term plan for management of health services
   a) Need an immediate plan for implementation of changes to meet standards of care and minimize risk
   b) Any solution will be more expensive then current system although efficiencies can be found in current model of care
2. Determine who and how health care services will be provided at EBR Parish Prison given current size of the facility. Budget to provide adequate health care services Options may include:
   a) In-house management (will require interim leadership with assertive plan to overhaul the current services)
   b) Contracting with local hospital, health care delivery system or academic medical center
   c) Contracting a private vendor
3. Any options will require
   a) Clarity on expected standards of care to be in place
   b) Proposed budget and allocation of resources
   c) Detailed staffing plan, job descriptions and productivity expectations
   d) Quality and outcome metrics expected and results to be achieved

Questions?