19-454

**MILWAUKEE COUNTY CHCSO PROJECT**

**INFORMATIONAL UPDATE & ACTION REQUEST**

# INTRODUCTORY COMMENTS

During the months of March and April, the CHCSO Project Team explored a wide variety of topics. These topics included, but are not limited to:

- Assignment of a Responsible Health Authority (NCCHC Standard J-A-02);
- Modification of the project's name from "Inmate Medical Services Self-Operation Project" to "Correctional Health Care Self-Operation Project" to reflect person-first language which is humanizing and destigmatizing for our patient population;
- Insurance discovery and challenges, including difficulties faced obtaining insurance, types of claims expected, potential cost of claims, processing methodologies and risk mitigation strategies;
- NRI discovery and site visits, focused on fully understanding all medical services to be provided by the new Department, resulting in NRI's Medical Services Brief (attached);
- Facilities discovery focused on adequacy of clinical space and inventory of County-owned high-cost medical equipment, resulting in NRI's Clinic Space Report (attached);
- Procurement introduction to purchasing and supply concerns unique to a medical operation, and the assignment of a Procurement Project Lead to the CHCSO Project, resulting in NRI's Supplies & Equipment Report (attached);
- HR review of collective bargaining concerns and an assessment regarding the impact of Act 10, if any;
- HR request for additional positions necessary to support the CHCSO Project;
- PSB and Comptroller discovery regarding the potential billing and claims needs, current practices, and possible challenges; and
- Cross-functional review of NRI's first draft of an Organization Chart for the CHCD (Correctional Health Care Department) and comment regarding that Org Chart, which will be further discussed with this body in future reports and correspondence.

This list should be considered as an informational overview of the kinds of subjects the Project Team is tackling. Most, if not all, of the categories above are in the early discovery stages and have not produced any actionable items for the Board at this time. One topic has emerged as a leading area of evaluation and development at this stage in the Project:

**Assignment of a Responsible Health Authority (NCCHC Standard J-A-02).**

This topic is explained in further detail in the body of this report.

At this time, the Project Team welcomes your policy guidance, thoughts, and suggestions as we proceed in discovery, and is providing this data for your information and consideration as our valued partners in this process.

# RESPONSIBLE HEALTH AUTHORITY

The Responsible Health Authority (RHA) is a term defined by the National Commission on Correctional Health Care in essential standard J-A-02 (Responsible Health Authority). According to Standard J-A-02, the RHA:

- Ensures that the facility maintains a coordinated system for health care delivery;
- Arranges for all levels of health care and ensures quality, accessible, and timely health services for patients;
- Is a designated individual or entity that is tasked with ensuring the organization and delivery of all health care in the facility;
- May be an individual, physician, health services administrator, or agency;
  - When the RHA is a state, regional, national, or corporate entity, there is also a designated individual at the local level who is on-site at least weekly to ensure policies are carried out.
- Is supported by the responsible physician who has final clinical judgment;
- Is supported by the designated mental health clinician when there is a separate organizational structure for mental health services; and
- Is supported by the designated dental clinician when there is a separate organizational structure for dental services.

The standard states that the "...RHA functions to ensure that health services are organized, adequate, and efficient. If this designated authority is not a physician, the responsible physician supervises the clinical aspects of health care."

During discovery, the Project Team identified several potential structures for the assignment of the RHA. None of these structures are considered to be "best practice" or "ideal" as many models could be used successfully. Ultimately, success of any model is highly dependent on multiple-stakeholder buy-in and support, both at initiation and as time passes and needs change. The County should adopt a Continuous Quality Improvement (CQI) approach to its provision of correctional health care (and supporting systems and structures), frequently assessing its performance and modifying its approach as needed.

**It is important to note that any model of RHA assignment will provide accountability to the County Board, and a method to ensure Board policies pertaining to the correctional health care mission will be appropriately carried out. Any model will also follow all state statutes and County ordinances pertaining to the approval of annual budget(s) and contract(s) which require the review and approval of the Board. No model will remove or modify the financial oversight and control as it currently exists.**

## Milwaukee County as RHA

If Milwaukee County as a municipal body corporate is assigned as the RHA, the "designated individual" who ensures policies are carried out would be the Director of the Correctional Health Care Department. The responsible physician, mental health professional, and dentist would fill the clinical roles required by the standard if the Director is not a clinician.

### Pros:

The pros of this model include:

- Inclusivity. The County as RHA creates the broadest responsibility for health care, making the County Executive, County Board, Director of the Correctional Health Care Department, DAS Director, Comptroller, Sheriff, and Superintendent of the HOC responsible partners in the provision of quality care.

- Ease of Application. The County as RHA follows a similar model to a vendor's assignment as RHA. A private vendor named as RHA would likely have all of the following: an advisory or governing Board (analogous to the Board of Supervisors), a CEO (similar to the CEX), and an on-site Director (similar to the CHCD Director). We know that this model has been successful in meeting the NCCHC standard for large for-profit entities such as Armor, Wellpath, NaphCare, and Centurion.

- Leveraging of Existing Structures and Institutional Knowledge. The CEX, County Board, DAS Director, Comptroller, Sheriff, and Superintendent are entities and individuals within the County that are pre-existing. They understand how to operate within the County's culture to get things done and will not have a warm-up period or learning curve to adjust to our unique processes. The cross-functional responsibility for provision of care may improve timeframes.

### Cons:

The cons of this model include:

- Potential Command and Control Confusion. The County as RHA creates diffuse authority across several entities for the provision of quality care. The lack of a single point of authority may slow decision-making processes or open the door to intra-personal or intra-departmental conflicts that could impact care.

## CHCD as RHA

If the new Correctional Health Care Department is assigned as the RHA, the "designated individual" who ensures policies are carried out would be the Director of the Correctional Health Care Department. The responsible physician, mental health professional, and dentist would fill the clinical roles required by the standard if the Director is not a clinician.

### Pros:

The pros of this model include:

- Autonomous Command and Control Structure. The CHCD as RHA means that the authority for provision of health care will rest in a single entity. Administrative decisions will rest with the Director. This model may eliminate concerns of diffuse authority or conflict.

- Ease of Application. The Departmental model of subject-area-specific control with a Director and Managers is presently used in almost all County Departments and is familiar to us. The RHA would then report to the County Executive and County Board both to provide accountability for its

methodologies and to demonstrate alignment with Board policy, and to make financial and budgetary requests as required by State statute and County ordinance. This model is also similar to a model that might be used by subsidiary companies in private industry, in which a regional Director and Managers report to a CEO and Board of Directors.

### Cons:

The cons of this model include:

- Lack of Institutional Knowledge and Support. Because the CHCD will be a new Department, it is likely many of the staff members (Director and Managers) responsible for making decisions will be new employees. These individuals will lack institutional knowledge of County processes and procedures and will demonstrate a learning curve that may reduce efficiency at the beginning of the process.

- Turnover May Impact Efficiency. Because the CHCD will be a separate Department, turnover of key positions (Director and Managers) may result in knowledge loss, reduced speed, and inefficiency in process as new staff are onboarded and trained.

- Departmental Cooperation. As a new Department, the CHCD will require cooperation from existing Departments to function smoothly. Conflict between Departments may cause reduced efficiency. Supporting departments faced with budget cuts, lack of resources, or increased workloads may have an impact on the RHA's function. Because these departments are not directly tasked with healthcare as the RHA, competing workloads may cause conflict of interest.

## CHCD Director as RHA

If the new Correctional Health Care Department's Director is assigned as the RHA, no "designated individual" would be necessary, and the responsible physician, mental health professional, and dentist would fill the clinical roles required by the standard if the Director is not a clinician.

### Pros:

The pros of this model include:

- Single Point of Authority. The Director of CHCD as RHA creates a clear, bright line of authority and responsibility for the success of the health care operation. The Director, appointed by the CEX and approved by the Board, would report to the CEX and provide a direct line of accountability to the Board.

- Ease of Implementation. A single person assigned as the RHA is straightforward to implement and creates clear lines of accountability. Legislative policies enacted by the Board would fall to a single individual to implement.

### Cons:

The cons of this model include:

- Single Point of Authority. Because a clear, bright line of authority and responsibility for the success of the health operation is drawn, the Director role becomes crucial. This can create strain on the employee if there is conflict or refusal to comply by supporting Departments, or can potentially create service quality issues if the employee is unsuccessful in his/her role or a bad match for the position. It may also cause conflict with the Board or CEX if there are interpersonal concerns or if opinions differ strongly between the Director and others.

- Lack of Institutional Knowledge. Because this individual is likely to be a new hire, he or she will not have institutional and cultural knowledge about County processes. If the individual is not familiar with government operations, he or she may also have a steep learning curve in dealing with legislative bodies, statutes, regulations and ordinances which could reduce efficiency early in the Department's history. However, most medical personnel will have exposure to federal and state compliance requirements and will have a frame of reference to use. The Director will need to build relationships within the County to be successful, and this may take time.

- Delay of Position Filling. Hiring a senior executive is a time consuming and often expensive process. The County may need to rely on an individual in an Acting capacity for many months, and this means an Acting RHA for an indefinite period, creating instability and uncertainty. Furthermore, the number of qualified individuals in the field of correctional health care is limited and may require significant financial incentives to successfully fill.

Any one of the models above can be successful with appropriate implementation. The Project Team has expressed a preference for the CHCD (Department) to be the RHA due to the ease of implementation and consolidation of authority. The Project Team's recommendation is that this model captures the best of both worlds from the County as RHA and Director as RHA models, and is most likely to be successful.

More information on this area will be made available at our next meeting and upon request.

## SELF OPERATION

## MEDICAL EQUIPMENT REQUIREMENTS

Upon rolling out the effective date for self-operation, the county will assume responsibility for all constitutionally required patient care within the jails. In order to procure and stock the proper medical equipment while remaining fiscally prudent, the county will require an assessment of equipment needs based upon services provided at each respective facility and a method of purchasing that meets the statutes and policies of the county. Correctional health care spending is inclusive of on-site care, outpatient medical products for long and short-term care, health, residential and personal care and other expenditures funded by the county budget.

Government agencies typically use a purchase order system when ordering and receiving inventory of medical supplies and equipment. This involves submission of orders in accordance with inventory management data in the health services department and supplies are generally ordered through a business entity that specializes in medical equipment and supplies and whose services are approved through the contracting procedures within the county agency.

Best practices in correctional health care dictate that there will be a broad array of supplies that are typically kept on hand, and include items used for various medical and dental use. Wound management supplies are kept in stock for treatment of cuts, abrasions, small fractures and infection control. These items include adhesive bandages, cast and bandage protectors, sterile and non-sterile gauze bandages, dressing retention bandages, gauze sponges and pads, tubular gauze bandages Unna boot and specialty leg wraps. These supplies are used with various tape types that must also be on hand. These include clear, cloth, elastic, foam and paper tape.

Items may be kept in supply for treatment of common chronic illnesses and for post-surgery practices. Items include compression therapy socks and garments, crutches and canes, braces that meet security requirements and aids to impairment items such as wheelchairs.

Medical gloves are imperative for sanitary treatment procedures, infection control and protection from pathogens. Gloves must be available for use in all clinical areas including exam rooms on the units, any infirmary housing and at intake.

Medical units must also keep miscellaneous supplies on hand for the various emergent and non-emergent events that occur regularly in a jail system. These items include allergy masks, bandage scissors, CPR shields, eye patched. Surgical masks and wound cleansers.

Jails that house females should keep an inventory of supplies on hand for treatment of issues related to pregnancy such as maternity slings and back support items that can be purchased from the medical equipment vendor.

There are many supply items that do not need to be maintained on hand, but the health services purchasing agent should have knowledge of how to acquire the items once a provider has prescribed its usage.

In accordance with national standards and best practices, each facility clinical area should have at a minimum, the following equipment supplies and materials: Hand washing facilities and alternate means of hand sanitation, examination tables, a light capable of providing direct illumination, scale, thermometer, blood pressure monitoring equipment, stethoscopes, ophthalmoscope, otoscope, transportation equipment such as wheelchairs and stretchers, containers for biohazardous materials and sharps, sterilizer for non-disposable medical or dental equipment, appropriate space, equipment and supplies for pelvic examinations for facilities housing females, oxygen, AEDs, pulse oximeter, personal protective equipment such as gloves, eye protection, gowns and masks.

According to national standards and best practices, on-site dental areas must contain hand washing facilities, dental examination chair, examination light, instruments, containers for bio hazardous materials and sharps, a dentist's stool and personal protective equipment. The presence of dental operatory requires the addition of at least an x-ray unit with developing capability, blood pressure monitoring equipment and oxygen.

For the purpose of onsite diagnostic services, facilities should have at a minimum, multiple test dipstick urinalysis, finger stick blood glucose tests, peak flow meters (handheld or other), stool-blood testing material and pregnancy tests.

Areas that are considered to belong to the clinic and will need to store an inventory of basic supplies include the main clinic, any exam rooms on housing units, the intake area and any specialty housing such as infirmary and mental health housing.

As we get closer to the date of self-operation, it is suggested that the Health services Director work with the NRI monitor to develop a list of required equipment items and begin purchasing and storing the items in a sterile and appropriate area in order to have the required supplies and equipment on hand.

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## Milwaukee Self Operation

## Services to be Provided

Upon implementation of the self-operation process, procedures will be in place for effective delivery of health services to the inmate population, including specialty and multi-disciplinary care (Medical, dental and mental health). The health services plan will include chronic disease management for inmates that will emphasize identification, early intervention, treatments based on clinical evidence, education and ongoing case management. Comprehensive health care services will be delivered in a manner consistent with National Standards for healthcare in Jails, NCCHC, 2018. The services provided will include at a minimum:

**Access to care.** The responsible health authority will identify and eliminate all unreasonable barriers, intentional and unintentional, to inmates receiving care. Examples of unreasonable barriers are: punishing inmates for seeking health services, assessing excessive fees for service, any deterrence for seeking care such as holding sick call at 2:00 AM, having understaffed or underfunded or a poorly organized system with a result that care is not able to be provided.

**Initial receiving screening** will be performed on all inmates upon arrival at the facility to ensure that emergent and urgent health needs are met. The screening will inquire as to the inmates health status including current and past illnesses, past infectious disease, recent communicative illnesses or symptoms, current or past mental health illness including hospitalizations, current or past suicidal ideations, dental problems, allergies, dietary needs, prescription medications, illegal drug use, past or current possible pregnancy, and any other health problems that require follow up.

**Initial health assessment** will occur within 14 days of admission to the jail. It will include at a minimum, data collection to complete medical, mental health and dental histories and current status and a physical examination by a qualified health professional being an RN, NP or provider. It will also include taking of vital signs and a screening test for latent TB unless completed prior to the health assessment.

**Mental Health Screening and Evaluation** will occur upon admission into the facility by a trained, qualified health care professional. The results of the screening will be documented in the inmate's health record. Inmates displaying acute symptoms of mental illness will be referred immediately for an emergency evaluation by a qualified mental health professional.

**Mental Health Services** will be available for all inmates who require them. Patients needs will be addressed on site or by referral to appropriate alternative facilities. Out patient services will include identification and referral of inmates with mental health needs, crisis intervention services, psychotropic medication management when indicated, individual counseling, group counseling or psychoeducational programs, treatment documentation and follow up.

**Suicide prevention** and intervention services will be implemented and will include identification and immediate response to suicidal ideation, evaluation by qualified health professionals, monitoring of acutely and non-acutely suicidal inmates according to national standards and treatment plans developed that address suicidal ideations.

**Chronic care diagnosis and treatment** will follow established clinical protocols based upon best practices for chronic illness management. Protocols will be consistent with national clinical practice guidelines and will be reviewed and approved annually by the medical director. Patients will have their diagnosis documented on an initial and master problem list in the health charting system. A list of chronic disease patients will be maintained and regular chronic are clinics will be conducted, following the individual treatment plans that have been developed.

**Sick Call** will be conducted daily. Non-emergent health care requests will be available for inmates to submit at least daily. Requests will be picked up and triaged daily and a face to face health care encounter will occur within 24 hours. Patients will be evaluated in a clinical setting as indicated. All aspects of the process from review and prioritization to the subsequent encounter will be documented in the patient's chart.

**Infectious disease control** services will meet national standards as set by NCCHC as well as county and state public health requirements. Oversite will include medical care for patients with HIV/AIDS, hepatitis C and other infectious diseases. Individual treatment plans and case management will be developed.

*A written exposure plan* will be developed and approved by the responsible physician. Medical, dental and laboratory equipment will be appropriately cleaned, decontaminated and sterilized. Sharps and biohazardous materials will be properly disposed of. Surveillance to detect inmates with infectious or communicable disease will be in place in order to treat and prevent further spreading. Inmates with contagious diseases will be identified and isolated if needed.

*An effective ectoparasite program* will be in place for treatment of affected patients and will include disinfecting clothing and bedding.

All health care staff and correctional staff will be trained in appropriate methods for handling and disposing of all biohazardous materials and spills.

**On site diagnostic services** will be provided, including testing for detection of sexually transmitted infections such as chlamydia, gonorrhea, HIV and syphilis. The MCJ and HOC will have at a minimum, multiple test dipstick urinalysis, finger stick blood glucose tests, peak flow meters (handheld or other), stool-blood testing material and pregnancy tests.

**The need for immunizations** will be determined by the provider; orders shall be carried out in conjunction with the health assessment. Clinical priority should be given to chronically ill, immune compromised, frail elderly patients, etc.; Pneumovax vaccination is preferable according to physician order and protocol.

**Health education and instruction** in self-care will be provided to inmates and will be documented in the health chart. The education provided will include information on HIV, smoking, alcohol and substance abuse disorders, sexually transmitted diseases, therapeutic diets, oral hygiene and preventative oral education.

**Medically supervised withdrawal** will be provided for inmates who are intoxicated or undergoing withdrawal from alcohol, sedatives, opioids or other substances. Protocols for intoxication and withdrawal will be approved by the responsible physician and will be consistent with nationally accepted guidelines such as the Clinical Withdrawal assessment (CIWA) and the Clinical Opiate Withdrawal Scale (COWS) assessment tools. However, the facility should possess a policy and a procedure for the implementation of medically assisted treatment for patients who are withdrawing or experiencing detoxification. This would allow the patient to undergo a gradual reduction, or tapering, of medications over time and under the supervision of a provider to properly manage and substantively mitigate symptoms of withdrawal for the purpose of reducing or eliminating physiological symptoms of withdrawal.

**Hospital and specialty care** will be available to all patients who require this type of care. There will be appropriate communication between the facility health care providers and the outside entity. The health record will reflect all results and recommendations from off site visits.

**Counseling and care of pregnant inmates** will be provided by qualified health staff. Prenatal care will include medical examinations by a provider qualified to provide this service, laboratory and diagnostic services in accordance with national guidelines, orders and treatment plans documenting clinically indicated levels of activity, medications, housing and safety precautions.

Pregnant inmates with *active opioid use disorder* will be evaluated upon intake and will receive mediation assisted treatment using methadone or buprenorphine.

*Post-partum care* will be provided and documented for the first six weeks after delivery.

**Oral care** will be provided by a licensed dentist. Oral screening will take place as soon as possible, but no longer than 14 days after the inmates admission into the facility. Instructions in oral hygiene and preventative education will be given to the patients. Treatment not limited to extractions in provided according to the treatment plan based upon established priorities for care. Consultation for referrals to oral health specialists will be available.

**Medical diets** will be provided by the facility, based upon the orders by the provider which will be communicated to the dietary staff. A registered dietician will review the menu provisions no less than annual.

Other health services will be provided based upon the needs of the population, standards set by NCCHC and indication by the responsible physician.

## SELF OPERATION

## CLINIC SPACE

At both the MCJ and HOC, there must be sufficient clinical space and supplies in order to provide the care that is required for the inmate population. This includes examination and treatment rooms for medical, dental and mental health needs. There should be adequate office space with administrative files, secure storage of records, and desks. When laboratory, radiological or other ancillary services are provided, the designated areas are adequate to hold equipment and records.

Assessments of clinical space at the facilities found that **space is being used efficiently for the services provided at both facilities**. Clinical services at the MCJ are mostly conducted on the second floor in the clinic area, where the main facility clinic is located. Here, patients are escorted to appointments with providers and for clinical encounters based upon need. The second floor clinic area has offices for providers, the director(s) of nursing and the HSA, patient waiting room, exam rooms, medication room, dental area, nurses' station with security officer post, and an area for office supplies.

Additionally, the facility infirmary is located near the clinic area. There is an exam room, a prep-room, and 11 beds, three of which are in negative pressure rooms. The infirmary has a nurse station that also has a security officer post.

Sick call is held on all housing units, using a private space for encounters. There are exam rooms next to some housing units that are not used often.

Acute mental health services at the MCJ are conducted on the second floor also. The MHU has three sub pods, two of which have eight cells and one with three cells designated for suicide watch and close observation of patients. Patients are seen on the unit and can also be escorted to the main clinic area.

There is a dialysis room available at the MCJ, however it is currently not in use and does not have the dialysis equipment. If services were to be expanded to include dialysis, the room could potentially be reactivated.

The clinical space at the HOC is adequate for delivery of services.

The main clinic at the HOC is on the second floor. The population at the HOC has less medical and mental health acuity and services are provided mostly in house and consists mostly of sick call encounters and chronic care clinics. There is sufficient office space for the HSA, providers and nurses. There are exam rooms in the main clinic area as well as on the housing units. The medication room is across the hallway from the main clinic. Patients who require specialty care are transported off site. Patients who require a higher level of care than the health staff can

provide at the HOC are currently being transported to the MCJ. Unless the mission changes for the classification of inmates that determines housing either at the MCJ or the HOC, the current plan for clinical care and clinical space is adequate at both facilities.

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