REPORT ON SETTLEMENT AGREEMENT IN THE CHRISTENSEN CASE

MILWAUKEE COUNTY JAIL AND THE HOUSE OF CORRECTIONS

May 16-20, 2016

Introduction

Since the November 2015 visit and report there has been instability in the administrative leadership as well as nursing leadership. In fact, since my last visit there have been two Health Service Administrators, including one who started her job within a week of my visit. The Director of Nursing position has also turned over twice since my last visit. In fact, there are new plans to change back to a Director of Nursing at each facility rather than one Director of Nursing with an Assistant Director of Nursing for one of the facilities. The new HSA and new DON bring very good hospital experience; however, neither has experience providing services in corrections. In order to support them, Armour has provided two senior nurses from their eastern region who have been stationed at Milwaukee County for the last several weeks. The current plan is to add a second Director of Nursing for the House of Corrections and a candidate has been identified; however, at the time of my departure there was no agreement with the candidate with regard to employment or a start date. I do believe that despite the turnover and the lack of experience of the new leadership team within a correctional setting, the vendor's plan to provide support should prove effective. Both the HSA as well as the DON appear bright, hard-working and committed to their responsibilities.

Providing stability for the program are the positions of Medical Director and Director of Mental Health Services, each of whom has been in their positions for more than a year. Their contributions were demonstrated during my visit, as I had an opportunity to work closely with each of them. I was also impressed with the efforts of the Quality Improvement Coordinator as well as the Infection Control Nurse. They both have the potential to move the program towards substantial compliance.

On the other hand, I am concerned that 17 of the 31 registered nurse positions were vacant at the time of my visit. In addition, nine of the 26 licensed practical nurse positions were also vacant. I was also informed that seven of the 14 nurse practitioner positions were vacant (two of these vacancies are replaced by one position at the HOC) as well as both health educator positions. With these and other vacancies, at the time of my visit more than 30% of all positions were vacant. Although there are efforts to fill positions on a temporary basis through overtime, use of agency nurses and individual contracts, such a high volume of vacancies means that on a given day it is likely that not all staff understand the requirements of the policies and procedures. There are ongoing efforts, including the utilization of incentives, in order to fill these vacancies. The

concern is that such a high vacancy rate is not only inconsistent with adequate quality of service but also does not portend well for achieving substantial compliance.

The Chief Psychiatrist is available only three days per week and she is currently providing services two days per week at the Jail and one day per week at the House of Corrections. There is another psychiatrist who will begin providing services two days per week in June, but the result therefore is a total of 40 hours of psychiatry, leaving 1.5 psychiatric positions vacant. The Director of Mental Health Services, as I indicated previously, has been in place and continues to do a good job of managing the program. The 12 psychiatric social worker positions include only one vacancy. The three caseworker positions are also currently filled. Thus, the main problem with regard to mental health appears to be a deficiency of prescribers and adequate presence of psychiatric leadership.

The next significant concern revolves around the electronic record, which is fully implemented. During my visit, I had an opportunity to observe the consequences of each of the below listed problems.

1. The clinical staff finds consistently that the electronic record is not “user friendly” and thus reduces their efficiency and productivity when seeing patients. In working with the Medical Director who knows the system well, we reviewed a case in which she concluded that a required assessment had not been performed. Later, the Director of Mental Health Services was able to find the required assessment. The reason the Medical Director was stymied was because there are several places where people can document the same type of information. She looked in a few of those places but had not looked in the place where it was ultimately found. This, of course, greatly reduces user efficiency.
2. We learned that many of the reports that previously were produced cannot be produced with Core EMR. Thus, routine timeliness studies have not been generated in order to look at timeliness of access to both medical and mental health services. When contacting the Armour central office liaison, solutions are not provided. In order to perform some of the quality improvement studies, the Quality Improvement Coordinator was required to collect data manually by sampling several records. One of the features of electronic records is supposed to be the facilitation of self-monitoring. Clearly, this is a problem.
3. Because of the way the electronic record is designed using a multitude of differently labeled forms, the only way to search is to pick a form name and then search for a particular document. When multiple forms can contain identical information you are left guessing which form should be selected for the search.
4. There is no direct lab interface between the laboratory data, which of course is electronic, and the electronic record. The end result is that lab reports come in, have to be scanned into the record and then have to be searched. The way the record should work is the lab reports are sent electronically to the doctor and on the doctor’s desktop a flag is received indicating a new lab report needs to be reviewed and signed off.

In summary, all of these problems must either be fixed or the system must be replaced. Without solving these problems, the likelihood of achieving substantial compliance in the future is greatly reduced. It appears that the collaboration between custody at both facilities is being sustained. Also, the Medical Director is able to decide based on patient needs what would be the most appropriate setting to meet those needs. Although there has been improved cooperation, we still see problems at both facilities with regard to access to services, especially dental services. In the dental section we will refer to rates of access that are unsatisfactory. It is particularly important to note that despite the best efforts of the dental staff, no patients designated as maximum security custody were brought to the dental unit in the last month. The dentist has indicated that he would see these patients early in the morning before any other inmates arrived and yet they were never brought over. Maximum security patients must have access to services. This must improve.

I. HEALTH SERVICES PROGRAM STRUCTURE

Compliance Status: Partial compliance.

Findings

A. Program Administrator

At the time of this visit, a new Administrator began her responsibilities; she had worked briefly as an Assistant Administrator. Although she brings significant hospital experience, she has no experience in corrections. I was impressed with her commitment to the job and feel that the vendor is providing adequate support for her functioning in this new position.

During the onsite visit, neither the data for Attachment A, which included mandatory shifts by discipline, day of week and by shift for each facility, nor the data for Attachment B, staffing of required positions vs. filled as well as vacant, was available. I was given verbally information related to Attachment B; however, the data was not provided either prior to my visit or at the time of the visit.

Recommendations:

1. Provide the data for Attachments A and B for the months of July, September and October, 2016 after the completion of each of those months.

B. Medical Director

The Medical Director has continued to perform exceptionally well and has demonstrated very good interpersonal skills in her guidance of the clinicians as well as her work with other disciplines. With regard to professional performance enhancement reviews, I was not provided any documentation of such reviews having occurred and been documented. These need to be performed for new people at least monthly and for people whose performance has been determined to be adequate, at least quarterly.

Recommendations:

1. Continue to document clinical performance enhancement reviews of the clinicians providing chronic care services, sick call services and urgent care services, as well as follow ups for scheduled and unscheduled offsite services.

C. Physician HOC

There currently are two full-time physicians at the House of Corrections. One position is filling vacant nurse practitioner positions.

Recommendations:

1. The Medical Director should perform an initial clinical performance enhancement review of each of the two physicians and this should be documented.

D. Psychiatrist

The Chief Psychiatrist position has been filled, although only partially. The current candidate has been providing services for approximately two months but is only available three days a week. She works two days a week at the Jail and one day a week at the House of Corrections. We are told her services will be supplemented by the addition of another staff psychiatrist who will provide services two days per week. Thus, there will be psychiatric services a total of five days per week. It is not clear to this reviewer that three days a week is sufficient to provide the clinical leadership expected for a Chief Psychiatrist.

Recommendations:

1. The total of five days a week divided between two psychiatrists is likely to yield inconsistency of clinical leadership. An effort should continue to be made to provide at least four days a week of Chief Psychiatrist which can be supplemented additionally by days of staff psychiatrist.

E. Nursing Director

As indicated in the introduction, there has been substantial turnover in the Director of Nursing position, and the current Director of Nursing comes to her position with no correctional experience, although she is receiving support from the vendor's regional nursing leadership team. The current plan is to have two Directors of Nursing, one for each facility, and I have no reason to disagree with that plan. This will mean eliminating or changing the Assistant Director of Nursing position to a Director of Nursing position. In the introduction we indicated that a candidate has been identified but negotiations have not been completed.

Recommendations:

1. The nursing leadership team should develop a calendar for methodically reviewing the services provided by their nurses. Those services include intake screen, sick call, medication administration (by LPNs), urgent/emergent services

and infirmary rounds. I remain available for any consultation on how to accomplish this.

F. Nurse Practitioners

There are 14 ARNP authorized positions, of which 7.0 are filled and 7.0 are vacant. There is an extra physician at the House of Corrections filling in for two of those nurse practitioners. However, the program does need to fill some of the primary care nurse practitioner positions and at least one of the psychiatric nurse practitioner positions. These positions are critical to providing adequate quality services on a timely basis.

Recommendations:

1. Fill at least two primary care ARNP positions as well as one of the psychiatric nurse practitioner positions and the health educator positions and bring the overall vacancy rate down to 20% or less at the time of my next visit.

G. Staffing

Overall, more than 30% of the total required positions are currently vacant. This is clearly not acceptable and the vendor is making efforts through use of incentives and a variety of strategies. However, providing reasonable quality services in a timely fashion is extremely problematic when such a high vacancy rate exists.

II. MEDICAL SERVICES

Compliance Status: Partial compliance.

Findings

A. Intake Screening

1. Triage

We again reviewed records in which we could confirm that performance had been improved; however, we continue to find some records in which additional information should have been elicited. We also identified electronic record problems, in that one of the records we selected was a patient with both acute (detoxification) and chronic problems. However, the computer forces you to choose either acute or chronic and it does not allow you to click both acute and chronic. This is a design flaw which clearly has to be corrected. We also found a record in which there was no order for a withdrawal assessment but the withdrawal assessment had been done. It is not clear how that was done. Although there has been improvement in the performance of the nurse screen, further improvement can and must be accomplished.

2. Referrals

This area also was improved, although we did identify records in which the timeliness of the assessment did not meet the requirements of the policy. Also, there were delays in the initial chronic care visit which could and should have been avoided. Overall, these areas are improving, although we remain concerned about the vacancies of primary care nurse practitioners and the ability to comply with the timeliness requirements. The QI program performed excellent reviews looking at both the appropriateness of the RN assessment as well as the appropriateness of the acuity level assigned. They also looked at the health assessment completed, the percentages of completion within the timeframe and also whether the provider documented a change in the acuity level. These are areas that continue to need work and we made some recommendations to the QI program that hopefully will be utilized.

Recommendations:

1. In looking at the length of time until seen by a PCP, in addition to the average which is currently presented, the range of shortest to longest would also be useful so we can see to what extent the timeliness or the average length of time is effected by a dramatic quantity in terms of the range.
2. The QI program should review the appropriateness of the nursing supervisor reviews and provide feedback to the supervisors with regard to opportunities for improvement. The QI program should also review the timeliness of the nursing supervisor reviews and the timeliness of the corrective action intervention.
3. The QI program should review a sample of 10% of the level 1s, 10% of the level 2s and 20% of the level 3s every other month. This review should occur every other month with feedback and coaching in the alternate months.
4. A method for quantifying the performance scores should be developed for each nurse and displayed so that performance and improvement is measureable.
5. The Medical Director should, as part of the QI program, continue to review the performance of the practitioners with regard to the adequacy of the subjective and objective data collected as well as the appropriateness of the assessment and the appropriateness of the plan. These reviews should entail feedback with the clinicians. To the extent that this can also be quantified, this will help the clinicians perceive performance improvement.

B. TB Screening

Compliance Status: Partial compliance, near substantial.

Findings

The infection control nurse performed an excellent attempt to identify the extent to which patients were receiving their required TB screening within 10 days of their booking. However, she made an assumption that patients not skin tested were invariably released within the 10 days. This, in fact, could be an error and we are recommending that she obtain from the offender tracking system the numbers of people who are released each month within 10 days. Also, she indicated in her study that at the House of Corrections when the 10th day occurs on a weekend there is no TB skin

testing until the following Monday, which could be day 13. This is not acceptable. There is no reason why TB skin testing could not be performed on the weekend; the numbers may not be significant but when you are performing a study looking at a 10-day release sample you have to apply that standard at both facilities. Therefore, we are strongly encouraging that skin testing be performed after day 10 at both facilities. Overall, her study is exactly what we are looking for given the changes we are currently recommending. This study should be performed at least quarterly for both facilities.

Recommendations:

1. Repeat the TB program study utilizing the offender tracking system 10-day release data.
2. Implement weekend skin testing and reading at the HOC and then repeat the TB study.

C. Physical Examinations

Compliance Status: Partial compliance.

Findings

We remain concerned about the primary care nurse practitioner vacancies and whether this significantly compromises the ability to provide timely assessments. Every patient who is identified as a level 1, 2 or 3 must be seen for an assessment within the required timeframe based on level. With significant numbers of vacancies, we are concerned that those timeframes are in fact being effected.

Recommendations:

1. The Medical Director, as part of the quality improvement program, should review a sample of health appraisals performed by each practitioner on a regular basis. This review should include whether all of the relevant positives in the nurse intake screen were addressed and whether an appropriate diagnosis and plan was in fact generated.

D. Sick Call

Compliance Status: Partial compliance.

1. Nurse Sick Call

Findings

The electronic record is unable, we are told, to perform timeliness studies. Thus, only by performing manual studies can this be accomplished. This is again an electronic record flaw that must be corrected or the system replaced. In the records we reviewed, we did identify a few which had significant delays, more than a week, and also an inconsistency between the written request and what was described on the physical findings. One way to measure timeliness would be starting with the date task created and measuring until the date the patient was seen or the form completed. The problem with that strategy is it presumes that the task was created on the date the request was

received, but there may have been delays which may not be identifiable. It is not clear through our discussions whether there will be a single nurse at the Jail performing all of the sick call assessments or multiple nurses. The medical records problems need to be sorted out in order for the program to adequately self-monitor.

Recommendations:

1. The EMR system needs to be able to perform electronic timeliness reports in terms of access to services. This is true with regard to sick call, including dental requests and other types of services. If this is not corrected, then the system may need to be replaced.
2. At each facility each month, 20 symptom kites should be reviewed by the health educator for both timeliness and professional performance. Included in the nursing performance is the utilization of the appropriate nursing protocol forms, completeness of the subjective and objective data collection and appropriateness of the assessment and plan.
3. A method for quantifying the results should be developed and utilized over time so that performance improvement is measurable.

2. Advanced Level Provider Sick Call

Findings

It is not clear that this was reviewed by the Medical Director in an organized way, thus no documentation was provided to us.

Recommendations:

1. The Medical Director should at least quarterly review the performance of the practitioners when providing sick call services. If the performance is reviewed and it is determined that a particular practitioner is performing in a substandard manner, this practitioner's performance must be reviewed monthly with feedback until adequate performance is achieved.

E. Chronic Care

Compliance Status: Partial compliance.

Findings

We reviewed a record of a patient with diabetes for whom the assessment appeared appropriate and the plan also appeared appropriate. However, the patient did not receive the phlebotomy services for almost a month. Therefore, the lab information was unavailable at the time of the initial chronic care visit. This problem has to be fixed and it is partly attributable to the 30-day wait for chronic care visits. Patients who are scheduled for a lab test and need to be rescheduled should not be waiting several weeks to obtain the services. Those tests should be scheduled on the next available lab draw. In addition, chronic care services anticipate follow-up visits that are scheduled and thus the timing of the lab draw should be roughly one week before the scheduled

visit. Thus, the results should be available in the record at the time of the visit and the provider should discuss the current results with the patient.

Recommendations:

1. Continue to review a sample of patients with chronic diseases whose services are provided by each of the practitioners for compliance with policy and guidelines.
2. Perform a review by September and then document feedback provided to the clinicians and re-review in October in order to be able to demonstrate whether improvement has occurred.

F. Urgent/Emergent Care

Compliance Status: Partial compliance.

Findings

We reviewed several records in which critical documents from the offsite service were unavailable. This included either a discharge summary or an emergency room report. The responsibility for obtaining these documents must be assigned. In most programs the nurse who receives the patient on return accepts that responsibility. Also, there was no follow-up visit after the document was returned where the clinician documents a discussion with the patient about the findings and the plan.

Recommendations:

1. The leadership team should work with the hospitals to insure that for every offsite service there is a document that contains the relevant clinical information, either from the ER or, if admitted, a discharge summary. These should be utilized by the clinicians to insure appropriate follow up.
2. A staff member needs to be assigned the responsibility for insuring timely availability of relevant offsite service documents.
3. The QI program should be monitoring the timeliness of the occurrence of clinician follow up in which there is a discussion of the relevant findings and plan as identified by the offsite service.

G. Specialty Services

Compliance Status: This area was previously in substantial compliance; however, we found records in which no follow-up visit occurred.

Findings

In both records that we reviewed there was no follow-up visit in which a clinician documented a discussion with the patient regarding findings and plan.

Recommendations:

1. This area should be reviewed by the QI program with data available at my next visit.

H. Infirmary

Compliance Status: This area was previously in substantial compliance.

Findings

This area was not assessed.

Recommendations:

1. This area should be reviewed by the QI program with data available at my next visit.

I. Medication Distribution

Compliance Status: This area was in substantial compliance.

Findings

This area was not assessed.

Recommendations:

1. The Nursing Director should emphasize to the nurses that they must create the impression in the patients that they are interested in inspecting the patient's mouth after ingestion of the pills.
2. This area should be reviewed by the QI program with data available at my next visit.

J. Women's Health

Compliance Status: This area was previously in substantial compliance.

Findings

This area was not assessed.

Recommendations:

1. This area should be reviewed by the Medical Director as part of the QI program.

K. Therapeutic Diets

Compliance Status: This area was previously in substantial compliance.

Findings

This area was not assessed.

Recommendations:

1. This area should be reviewed by the QI program, especially with regard to the elimination of preference diets.

III. Mental Health Services

Compliance Status: Partial compliance.

Findings

As indicated earlier in this report, the Chief Psychiatrist position has been filled for about eight weeks on a part-time basis. The psychiatrist is available two days per week at the Jail and one day a week at the House of Corrections. Thus, there is 60% of Chief Psychiatrist. An additional staff psychiatrist has plans to join the team for two days per week, totaling 40 hours a week of psychiatry. We do not believe this is sufficient nor do we believe that the hours committed to Chief Psychiatrist are sufficient. We continue to be encouraged by the use of non-pharmacologic services such as group counseling and individual counseling, both in the House of Corrections and now also in the Jail. There are also three vacant psychiatric nurse practitioner positions, at least one of which needs to be filled and a second needs to be filled for whom responsibilities will include quality improvement reviews. We have had discussions with the Director of Mental Health Services and she is identifying a job description which will allow approximately half-time for quality improvement activities. The Director of Mental Health Services is actively engaged in working with the outside community and with the patient advocacy groups.

A. Intake and

B. Program

Findings

I have not yet seen any reports from the electronic record that document the timeliness of patients being seen from identification at intake with positive mental health screens to mental health assessment. I have also not seen timeliness studies with regard to the timeframe between referral from social workers to psychiatric prescribers or from primary care practitioners to psychiatric prescribers. I hope that the capability to run these reports can be created. Even under Tier, the prior electronic record, these reports were available. If it proves impossible to create the capability within Core EMR, then it will need to be replaced.

Recommendations:

1. Add at least one additional psych ARNP as well as at least a half-time psych ARNP whose time is committed to quality improvement studies but can also practice clinical activities.
2. Perform a manual study looking at the positive mental health histories and timeliness of social worker evaluation. Review at least 20 records in June and July and forward the data to me.
3. The Director of Mental Health Services should, per our discussion, begin professional performance reviews of the notes documented in the electronic record by the social workers for June and July, 2016, with feedback where improvement is indicated.

C. Staffing

Findings

As indicated previously, there are three vacant psychiatric nurse practitioner positions and at the time of my visit the Chief Psychiatrist was working three days per week. Although we see this as a start, we do not see it as sufficient.

Recommendations:

1. Hire at least one and a half more psychiatric nurse practitioners prior to my next visit.

D. Urgent/Emergent and Emergency Psychiatric Services

Findings

This area is covered by mental health policies. We did not get the opportunity to review this with the Director of Mental Health.

Recommendations:

1. Develop a log to track the emergent mental health cases for both timeliness and appropriateness of services.

IV. Dental Services

Compliance Status: Partial compliance.

Findings

Within the past month we have found access compromised at both facilities, including on most days approximately 50% of the patients had access to the dental clinic. Clearly this is not acceptable. Custody must insure that at least 80-90% of the patients are brought to the clinic. They can certainly refuse in the clinic but they must be brought to the clinic. Additionally, at the Jail, approximately 0 out of 10 scheduled patients with maximum security designation were seen in the past month. This is a level of consistency that would be impressive if 10 out of 10 were seen. However, when 0 out of 10 are seen, this means that custody is an obstacle to providing adequate services. The dentist has offered to see the patients early when no other patients are around and yet patients with maximum security designation are still not brought over. The Supreme Court has made it clear that the punishment is incarceration. The punishment cannot additionally be denial of access to services. This problem must be remedied immediately.

Recommendations:

1. Improve the access to dental services and especially for maximum security patients so designated at the Jail.

V. Support Services

Compliance Status: Substantial compliance.

A. Medical Records

Findings

In the introduction we identified four deficiencies that must be remedied. If they cannot be remedied, then the electronic record should be replaced. I have seen electronic records in correctional settings that don't have the same problems that Core EMR has. This agreement presumes an ability to self-monitor effectively and efficiently. The Core EMR program has not produced in that area. Also, clinicians indicate that the program diminishes their productivity and efficiency. The staffing plan is based on clinicians being able to practice relatively efficiently. It would be absurd to enhance the number of positions in order to work around the electronic record.

Recommendations:

1. Fix the problems identified or replace the record.

B. Pharmacy

Findings

The program has not, in an organized way, been monitoring the quality control and/or timeliness of these services.

Recommendations:

1. The program should begin to monitor the quality control and the timeliness of the availability of medication services.

VI. Miscellaneous

A. Physical Plant

Compliance Status: Substantial compliance.

Findings None.

Recommendations: None.

B. Quality Improvement Council

Compliance Status: Partial compliance.

Findings

Several of the documents I requested either prior to or at the time of my site visit were not available. I did spend time with the QI Coordinator and have reviewed studies

with her, some of which are quite impressive. I will list the areas that need to continue to be reviewed on a regular basis, but at a minimum once a year.

1. Intake Services.
2. Primary Care Services (sick call).
3. Urgent Care Services.
4. Scheduled Offsite Services.
5. Chronic Care Services.
6. Dental Services.
7. Communicable Diseases.
8. Morbidity and Mortality Review.
9. Medication Services.
10. Women's Health.
11. Medical Housing.
12. Grievances.

With regard to #7, Communicable Diseases, the communicable disease nurse appears to be performing and collecting the kind of data critical for a jail health program. In reviewing her data, I noticed that several patients were presumptively treated for MRSA with Cephalexin. Since MRSA is much less likely to be sensitive to Cephalexin, presumptively treated MRSA should be treated with Bactrim. As I was reviewing the data I saw those cases, I think there were five or six. The Medical Director should look at that and address it with the appropriate clinicians.

C. Death Review

I was informed that there had been a death within the last few months but I was not presented with the death review summary. I am awaiting its transmittal to me so that I can comment on it.

Conclusion

Clearly I was disappointed at the turnover of the leadership positions. I am somewhat encouraged by the addition of a part-time Chief Psychiatrist but I believe that more clinical leadership is needed and three days per week is not sufficient. I have been favorably impressed with both the communicable disease nurse and the quality improvement coordinator and expect that their efforts will be supported. It is mandatory that many of these vacancies be filled as quickly as possible, not the least of which are the health educator positions, who should be able to support the quality improvement program. Also, the ARNP positions both the primary care ARNP positions, all of which should be filled, as well as the psych ARNP positions, at least one and a half which should be filled, need to be addressed. A vacancy rate which exceeds 30% clearly is counterproductive and represents a reasonable threat to achieving substantial compliance. I am more than a little chagrined at the absence of documents sent to me prior to the visit. It is only through those activities that I can get a sense between the visits of whether progress is being made.

In conclusion, I would like the following documents:

1. Mortality review
2. The data from April on Attachments A and B
3. Then, as performed, some of the QI studies, particularly by the Medical Director and the Quality Improvement Nurse, along with the TB study by the Infection Control Coordinator and a repeat MRSA study.

Respectfully submitted,

R. Shansky, MD

RS/kh