NCCHC Resources
Solutions From the Most Trusted Name in Correctional Health Care

# GRAND TRAVERSE COUNTY CORRECTIONAL FACILITY

**JULY 2020**

*This report details findings from a site visit occurring July 8-9, 2020.*

NCCHCResources
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# GRAND TRAVERSE COUNTY CORRECTIONAL FACILITY
## SITE VISIT SUMMARY

## Table of Contents






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# Introduction

The NCCHC Resources, Inc. team visited the Grand Traverse County Correctional Facility in Traverse City, Michigan, for the purpose of evaluating the structure, organization, and delivery of health care services provided to inmates.

## Objectives

- Evaluate and provide feedback on the quality of health services based on expert opinion and alignment with the *NCCHC Standards for Health Services in Jails* (2018).
- Assess the health services policies and procedures and recommend changes (as applicable) that can result in improved health care efficiency and effectiveness.
- Conduct a specific review of information (obtained via physical plant walk-through, health record review, staff and patient interviews, etc.) pertaining to provision of quality health services.
- Provide a comprehensive written final report based on the observations made during the assessment.

## Pre-visit videoconference

A Zoom video conference call was held on June 22, 2020 at 2:00 p.m. for the purpose of introductions, reviewing the project objectives, and discussing and planning for the on-site visit that was set for July 8 and 9, 2020.

Those in attendance:

- Sheriff Tom Bensley
- Captain Chris Barsheff – jail administrator
- Amy Booms – HSA/RN
- Jim Voisard, CCHP-A – project lead
- Dr. Randy Stoltz – medical expert
- Dr. Bill Elliott – mental health expert
- Dr. Brent Gibson - NCCHC Chief Health Officer
- Loretta Reed – Director, project management office

# Site Visit

Dr. Randy Stultz and Dr. William Elliott conducted an on-site tour, interviews, and review of the health care services operation on July 8, 2020.

James E. Voisard, CCHP-A conducted an on-site tour, interviews, and review of the health care services operation on July 8 and 9, 2020.

## Interviews conducted

**Grand Traverse County Jail**
Sheriff
Captain
Lieutenant
Officers

**Patients**
Male and female
Short term and long term
Various housing units

**Health Staff - Wellpath**
Health services administrator
Medical director
Psychiatrist
Nurse practitioner
Registered nurse

**Mental Health Staff – Northern Lakes Community Mental Health Authority**
Behavioral health specialist
Peer support specialist

### Abbreviations used in this report

| | |
|---|---|
| CQI | continuous quality improvement |
| ER | emergency room |
| FTE | full-time employee |
| HSA | health services administrator |
| LPN | licensed practical nurse |
| MAR | medication administration record |
| MAT | medication-assisted treatment |
| MH | mental health |
| NLCMHA | Northern Lakes Community Mental Health Authority |
| NP | nurse practitioner |
| RN | registered nurse |
| RTU | residential treatment unit |
| TB | tuberculosis |

# Facility Overview

The Grand Traverse County Correctional Facility is located at 320 Washington Street, Traverse City, Michigan 49686. The central part of the facility was constructed in the mid-1960s and underwent an extensive remodeling project that was completed in the 1980s.

The Grand Traverse County Correctional Facility is a regional training center, hosting corrections academies and other specialized training programs for jail staff throughout Michigan. The facility is reportedly certified with 100% compliance in state-mandated training standards as established by the Michigan Sheriff's Coordinating and Training Council.

The Sheriff's Office has been honored for 5 consecutive years for reaching 100% compliance with the Michigan Department of Corrections' Administrative Rules for Jails.

## Average daily population

January 1, 2019 – December 31, 2019: 132
January 1, 2020 – March 31, 2020: 155

## Book-in statistics

January 1, 2019 – December 31, 2019: 3,795

- 2,684 male (70.72%)
- 1,111 female (29.28%)

January 1, 2020 – March 31, 2020: 852

- 578 male (67.84%)
- 273 female (32.16%)

There were no juveniles booked-in during the above noted time ranges.

Population on July 8, 2020: 76 total (62 adult males and 14 adult females)

Health care services are provided by Wellpath LLC and Northern Lakes Community Mental Health Authority.

## Health care staffing

| **Wellpath** | | |
|---|---|---|
| **Days** | Medical director | 2 to 4 hours per month |
| | Nurse practitioner | 0.15 FTE |
| | HSA/RN | 1.00 FTE |
| | LPN | 1.00 FTE |
| | Psychiatrist | 0.05 FTE (Thursdays via telemedicine) |
| **Evenings** | RN | 1.40 FTE |

After hours on-call is handled by the medical director and nurse practitioner. Wellpath has been providing contract health care service at the jail since 2011.

| Northern Lakes | | |
|---|---|---|
| Days | Behavioral health specialist | 1.00 FTE |
| | Peer support specialist | 1.00 FTE |

- Emergency response team for assessment and monitoring of potentially suicidal patients
  - Initial assessment – whenever a patient is placed on suicide precautions
  - Monitoring assessments – daily when patient on suicide watch

Nursing coverage: 7 days per week
Medication administration rounds:

| | |
|---|---|
| 8:00am – 4:00 pm | 9:00 am |
| | 4:00 pm |
| 3:00pm – 11:00pm | 9:00 pm |

Note: COVID-19 guidelines have had an impact on the average daily population as well as both health care and correctional operations. Access to medical and mental health services has not been adversely affected, whereas dental services were significantly reduced for a period of time in accordance with CDC and White House Coronavirus Task Force guidelines and recommendations.

Pharmaceuticals are provided by Correct Rx with support from a local pharmacy as a back-up resource for urgent or unique medications. Medications can be delivered to the jail after hours by placement of the medications in a locked drop box located in the jail lobby. The individual who drops off the medications is required to complete a form.

There have been two suicides within the past 4 years. One in 2017 and the other in 2018. Both deaths were by hanging.

A community private practice dentist provides dental services upon referral.

# Documentation Reviewed

- 2018 to 2020 officer training topic totals
- 2019 Wellpath consolidated annual compliance courses
- 2020 NLCMHA agreement
- Chronic care log
- Monthly health care statistics April to December 2019
- Monthly health care statistics, January to May 2020
- Wellpath staffing matrix
- Medical policies
- Mental health policies
- Minimum standards of care – State of Michigan
- NLCMHA jail services board presentation
- Wellpath nursing pathways
- Wellpath agreement
- Wellpath CQI report
- Wellpath policy and procedure manual
- Health care pre-screening form
- After-hours medication drop-off inventory form
- Health care records

# Clinical Health Care Findings – Medical and Dental

Our focused assessment of the medical and dental clinical services included a facility tour, interviews with the medical staff, and chart reviews as well as a discussion with the Captain. The facility doesn't have the most ideal layout, but it is functional and can meet the medical needs of the inmates.

We reviewed multiple charts that involved chronic diseases including diabetes, HIV, pregnancy, asthma, lipid disorders, hypertension, and mental health issues. Other record reviews were focused on various aspects of care such as sick call, lab and X-ray studies, oral care, receiving screening, and health assessments.

We also conducted interviews with the HSA, medical director, and nurse practitioner.

The medical director is on site an average of 2 hours per month and essentially sees chronic care patients. Each sick call visit routinely includes assessment of either three new chronic care patients or six follow-up visits. She does not have any assigned administrative duties. She is not involved in the clinical performance review of the nurse practitioner and was unsure if anyone from corporate completes a review of the clinical care that she provides. If clinical reviews have been conducted, the findings were reportedly not shared with the providers. She was unaware of the chronic care guidelines that are available through Wellpath and therefore has not read, approved, or implemented the guidelines.

The medical director stated that she provides care at another jail in the region and that she is also in a private practice. The nurse practitioner and the medical director are scheduled to be on-call for after-hours consultation on alternating weeks. We learned that the number of texts that the on-call provider receives can be up to 60 per day. There is no documentation of the text messages and responses.

The nurse practitioner is on site once per week for an average of 4 hours and her primary duties are to see the sick call patients that the nurses have triaged and scheduled. In addition, she reviews lab and X-ray diagnostic reports. As with the medical director, she reported that she was not familiar with the full complement of chronic care guidelines available through corporate.

The HSA discussed the processes that are in place for conducting receiving screenings, health assessments, and nursing and provider sick call. She advised that the initial health assessments are completed by both LPNs and RNs.

It appears that the general care is adequate and the staff are committed to the performance of their assigned duties and to the provision of care to patients.

## Matters of concern

1. Registered nurses should be the ones responsible for completing the health assessments as this function is most often outside an LPN's scope of practice. An LPN's involvement in the hands-on component of the health assessment would not be within NCCHC accreditation standards compliance.

2. The health records are in a paper format and somewhat disorganized. Allergies are not always listed on the front of the chart.
3. There is no master problem list in most of the records. It is recommended that a master problem list be placed in every patient record along with a current medication list. Every patient who is taking medication for a chronic condition must have a corresponding documented diagnosis in the health record. The records system would be much improved if divider tabs were utilized. The dividers would allow for a more organized record that would provide a system for easier retrieval of patient information by all health staff.
4. There were numerous times that a provider signature was not dated on health record forms. All health record entries must indicate the date and time of entry.
5. It would be wise to document text messages that are sent as well as the recommendations that come back from the provider.
6. Laboratory reports need to have a provider interpretation and plan documented, rather than just signing off the test results page. Also, the test results and X-ray reports need to be consistently shared with the patients and documented. This applies to test results that have abnormal findings as well as those that are within normal ranges. It is appropriate patient care to provide all results regardless of the findings.
7. Refusal of care forms were signed and witnessed for the most part. However, there are cases when an informed refusal is required. The patient should be advised as to the potential negative consequences if they do not accept the clinically indicated care. The more serious cases require additional counseling and understanding that should the patient change their mind and want to accept the care they are to notify staff.
8. Oral exams were not consistently done as part of the initial health assessment and no written oral hygiene instructions are given to the patient. The instructions may be given verbally, however there is no documentation to show this patient education has taken place.
9. It would be prudent to ask about and document how much alcohol or benzodiazepine the individual uses, their time of last use, and whether they experience any serious problems when they stop using and start to withdraw.
10. In the event of a death, the medical director should be involved in the mortality review process, including the clinical evaluation of care for appropriateness. Also, in the event of a suicide, there needs to be a psychological autopsy completed within 30 days.
11. Tylenol #3 should not be used as a medication bridge or for medically supervised opioid withdrawal in pregnant individuals. Methadone or buprenorphine are viable options in order to prevent withdrawal which could result in fetal demise.

Other issues that came up were that chronic care guidelines need to be updated, signed off by the medical director, and the providers must follow these. The current one states peak flows should be done on asthmatics, but the site doesn't even have a peak flow meter. There are other examples as well and these were discussed with the staff. The Wellpath representative said the chronic care guidelines will soon be updated.

Upon reviewing all the current MARs, we see that providers (medical and psychiatric) prescribe many potentially abused drugs and sedatives, including Remeron, Vistaril, melatonin, Wellbutrin, Trazadone, Buspar, Seroquel, and muscle relaxants. The use of these seemed unusually high compared to other facilities of similar size.

On a positive note, sick call requests through the kiosk system appeared to be answered pretty quickly, TB skin testing was done and documented well, the initial health assessments were usually done within a week, and community-based prescriptions were continued in a timely manner after verification had been completed at book-in. The overall medical care appeared to be good despite all the suggestions above.

# Clinical Health Findings – Behavioral Health Care

The focused assessment of behavioral health care services included a facility tour, review of seven health care records, interviews with three patients, and interviews with the jail commander, Wellpath's health services administrator (HSA) and their part-time psychiatrist, and the clinical supervisor, behavioral health specialist, and peer support specialist employed by the Northern Lakes Community Mental Health Authority (NLCMHA). Several major areas of concern were revealed throughout the assessment including, but not limited to, the following:

1. Significant disconnect between NLCMHA professionals and the Wellpath psychiatric provider and HSA
2. Absence of NLCMHA documentation in the jail health record
3. Pervasive evidence that essential mental health services are not currently provided to jail inmates
4. No evidence of NLCMHA contact with 50% of the inmates assigned to the MH caseload
5. Disproportionate (i.e., up to 40%) amount of the behavioral health specialist's time devoted to only three inmates

## Summary of health record reviews

Two of the records reviewed were those of patients who had completed suicide within the past 4 years. In both cases, no initial mental health assessment had been conducted and contact with mental health professionals (other than the psychiatric provider) was negligible.

In two of the other five records reviewed, there was no evidence that an initial mental health assessment had been completed. In the other three cases, an initial evaluation was completed by the psychiatric provider.

Only two exceedingly brief clinical notes authored by NLCMHA professionals were found in the seven records.

There was no evidence of NLCMHA involvement in the management and treatment of the inmate (81954) who had recently been placed in a restraint chair and then placed on suicide watch.

There is consistent evidence of frequent and timely psychiatric treatment.

## Summary of patient interviews

One of the patients interviewed was housed in the "group cell" (#207) reserved for the inmates participating in the "group program" based on the Harris County, Texas, mental health treatment model. This patient is also receiving psychiatric services. He is scheduled to see the peer support specialist for discharge planning purposes very soon. He is highly satisfied with the quality and quantity of mental health services he has received since his admission to the jail.

A second patient has seen both the NLCMHA behavioral health specialist and peer support specialist and has received various worksheets related to cognitive-behavioral coping skills.

She is also receiving psychiatric services. However, she laments the fact that groups and other specialized mental health services are not available to female inmates.

The third patient, recently placed on suicide watch, claimed that she has had no contact with either the behavioral health specialist or peer support specialist. She is not currently receiving psychiatric services. She reported a history of prior sexual abuse and indicated that she feels vulnerable in the jail and would welcome mental health services.

### Summary of interview with health services administrator

Ms. Boom expressed concern that she has no idea which patients are seen by the NLCMHA behavioral health specialist. However, she does not believe that he sees the full range of patients who populate the mental health caseload. Moreover, Ms. Boom is troubled by the fact that NLCMHA records are not routinely available to Wellpath personnel, and that NLCMHA staff are sometimes unresponsive to her requests.

Ms. Boom acknowledged that health records are currently disorganized and that it is difficult to find information in a timely manner. She voiced a strong desire to shift to an electronic health record system as soon as possible. She also lamented the lack of nursing hours and hopes that a current part-time position can be converted to a full-time position.

### Summary of interview with psychiatrist

Dr. Dennis provides telepsychiatry services to jail patients 2 hours per week. She reported that no system currently exists to create treatment plans and that multidisciplinary treatment team meetings are not currently held. She further stated that her interactions with NLCMHA professionals are limited to patients for whom court orders have been entered. Dr. Dennis did, however, report a good working relationship with the HSA and nurses. She mentioned concern that initial mental health assessments are never completed thus leaving her with little historical information prior to her initial patient encounter.

### Summary of interview with NLCMHA clinical supervisor

Ms. Kominsky serves as the immediate supervisor of both the behavioral health specialist and peer support specialist and meets with them at least once per week. She reported that NLCMHA received direction from County officials to develop a therapeutic program based on one established in Harris County, Texas. She disavowed any knowledge that NLCMHA personnel were expected to complete initial mental health assessments, segregation rounds, post-suicide watch follow-ups, and other essential correctional mental health services. Ms. Kominsky asserted that an additional behavioral health specialist position would be required if NLCMHA staff were required to deliver those services.

Ms. Kominsky reported that there are designated NLCMHA mental health professionals who conduct initial and daily suicide watch assessments and do so 7 days per week. She explained that those mental health professsionals are part of the NLCMHA's emergency response team and thus uniquely qualified to conduct such assessments. She indicated that the behavioral health specialist schedules a follow-up assessment of inmates recently discharged from suicide watch, but is unaware of any plan or structure for further post-watch contact.

### Summary of interview with NLCMHA behavioral health specialist

Mr. Prevo reported that his primary responsibility is to conduct psychoeducational group programming for male and female patients who volunteer for this service. He claimed that the number of program participants has dwindled because of the County's decision to not mix inmates of various security classifications. Accordingly, only three male patients currently participate in the program and no female patients are enrolled.

Mr. Prevo stated that he also responds to patient self-referrals and provides individual therapy services to several individuals. When asked about documentation, he explained that he enters notes into the County's "jail log" and otherwise records his notes in the NLCMHA Aegis system. He confirmed that virtually none of his clinical notes are forwarded to Wellpath for placement in the health chart (Ms. Kominsky added that whenever Wellpath or County entities request information, it is provided). Mr. Prevo described a Monday morning meeting, dubbed "the huddle," routinely attended by NLCMHA personnel, the Wellpath HSA and/or nurse, and a County lieutenant. He also characterized the relationship between NLCMHA and Wellpath as "great."

### Summary of interview with peer support specialist

Ms. Johnson outlined a comprehensive discharge planning program wherein she assists inmates with securing the following: housing, food, transportation, employment, insurance, initial community-based mental health appointments, and Social Security cards. She has created a four-page form which documents her efforts regarding discharge planning. However, this form is not forwarded to Wellpath for placement in the health record. She indicated that she also assists Mr. Prevo in screening patients for the group program and makes regular rounds in the housing units to see if inmates require any mental health services. These rounds and subsequent referrals do not appear to be documented.

### Summary of interview with jail commander

Capt. Barsheff expressed reservations regarding the type and breadth of mental health services provided to jail inmates. Specifically, he voiced concern that NLCMHA professionals were providing services to a narrowly defined and relatively small number of inmates. He questioned the behavioral health specialist's use of time and reported that NLCMHA officials had objected to his decision to restrict high security inmates from residing in cell #207 thereby depriving them of access to the NLCMHA group program. Capt. Barsheff presented our team with a document indicating that the specialist had seen only 50% of the patients currently assigned to the jail's mental health caseload. However, up to 40% of the behavioral health specialist's time was devoted to a group program for only three patients.

### Conclusions

The following conclusions were formulated following review of health records and the above interviews with patients, Wellpath health care professionals, and NLCMHA mental health professionals:

1. Mental health service delivery and documentation are fragmented and discontinuous. Specifically, the HSA, who is responsible for all facets of health care delivery at the jail, appears to have little or no idea which patients are seen by NLCMHA personnel. Likewise, the part-time psychiatrist has minimal contact with NLCMHA professionals and reports no multidisciplinary treatment planning. Moreover, there is no integrated system of tracking and monitoring inmates who require essential mental health services. Finally, documentation of NLCMHA professionals' clinical encounters is not filed in the County

health record. Instead, it is maintained in a separate NLCMHA electronic health record unavailable to Wellpath personnel, County officials, or third-party reviewers.

2. Essential correctional mental health services are not provided to jail inmates at this time. Mental health professionals from NLCMHA do not conduct initial mental health assessments for any inmate admitted to the jail. They maintain that they are unaware of this expectation and imply that it falls outside the scope of their contract with the County. Consequently, the only initial assessments found in health records (three of them) were initial psychiatric evaluations. In addition, NLCMHA professionals conduct neither weekly segregation rounds nor post-suicide watch follow-ups in a systematic way. Moreover, there is no evidence of any kind of treatment planning even though an informal multidisciplinary team meeting occurs weekly.
3. The NLCMHA behavioral health specialist devotes a disproportionate amount of his weekly schedule to facilitating a psychoeducational group for as few as three patients. The specialist and his supervisor seem convinced that they are contractually bound to conduct this group for as many patients as possible. However, it is inconceivable that up to 16 hours per week of the specialist's time can be legitimately devoted to three patients while essential mental health services are not delivered to the entire jail population. Strikingly, he has seen only 50% of the patients assigned to the total mental health caseload identified by the HSA (i.e., those patients currently seeing or scheduled to be seen by the psychiatrist as well as those housed in cell #207). Moreover, by virtue of inmates' housing location and programming in a designated area of the jail suggests that it serves as a non-acute RTU. However, the "group program" in cell #207 does not contain the operational and programmatic elements of a bona fide RTU.
4. The peer support specialist is operating a discharge planning program which is robust, timely, and largely compliant with NCCHC standards for both jails and mental health service delivery. However, she meets with inmates for discharge planning purposes pursuant to self-referrals for same. This does not ensure that all inmates are afforded this important service. She also maintains tracking and monitoring logs and performs other duties analogous to those executed by psychiatric assistants or behavioral health technicians in other mental health contexts (e.g., housing unit rounds, responding to routine mental health requests). These duties, however, are not executed in any systematic fashion.
5. The health records (paper charts) at the jail are disorganized, incomplete, and scattered throughout the health care unit. Unless this condition is addressed, third party reviewers will experience considerable frustration and confusion when they undertake record reviews. That said, the most urgent issue relative to health records is the conspicuous and consistent absence of (non-psychiatric) mental health information.
6. We reviewed records for two patients who completed suicide within the last 4 years. Neither record contained a psychological autopsy which is universally expected in the aftermath of an inmate suicide. This highly significant deficiency is most likely the result of the fragmented service delivery model and diffusion of responsibility referenced above.

### Recommendations

1. It is imperative that all facets of the mental health service delivery system are integrated under a single administrative authority and that specific areas of responsibility and accountability are defined. This includes, but is not limited to:

a. Appointment of a single administrative entity (preferably the HSA) with ultimate authority for establishing service priorities and assignment of duties and responsibilities
b. Reorganization of service priorities such that essential mental health services are completed in accordance with contemporary practice standards
c. The requirement that documentation of all clinical encounters is placed in the inmate's medical file located in the health care unit

- Note: In no way does this recommendation alter the current structure of clinical supervision of the NLCMHA behavioral health specialist or peer support specialist, nor does it inhibit their exercise of their autonomy in scheduling patient encounters. However, those two individuals (as well as the part-time psychiatrist) should be administratively accountable to the designated administrative authority who would, in turn, establish mental health service priorities and monitor service delivery.

2. The NCCHC's 2018 *Standards for Health Services in Jails* should inform the reorganization of mental health service priorities. First and foremost, this requires the assignment of responsibility and establishment of time frames for completion of initial mental health assessments, psychiatric assessments and follow-ups, segregation rounds/reviews, discharge planning, daily suicide watch assessments, and post-suicide watch follow-ups. Remaining time in the behavioral health specialist's schedule can and should be devoted to individual and/or group therapy with those patients with the greatest chronicity and/or severity of mental illness, as determined by multidisciplinary collaboration. An initial treatment plan, with updates at appropriate intervals, must be completed (preferably in collaboration with the psychiatrist, if applicable) for each patient receiving individual and group therapy, as well as those who have been placed on suicide watch.
3. The topical psychoeducational group program currently conducted by the behavioral health specialist for inmates housed in cell #207 can certainly continue with the following caveats:
   a. All essential mental services (see #2 in the Conclusions section above) are routinely completed in a timely manner
   b. Responsibility for group facilitation is reassigned to the peer support specialist
   c. The frequency of group meetings is significantly reduced
   d. Priority assignment for group membership should be accorded to inmates diagnosed with serious mental disorders
   e. The requirement for residence in cell #207 should be eliminated (unless the County wishes to designate it as an actual residential treatment unit with all the attendant operational and programmatic requirements)
4. The peer support specialist should be encouraged to schedule discharge planning services in accordance with a frequently updated list of impending inmate release dates, rather than relying on inmate self-referrals. Additionally, her remaining duties and responsibilities need to be clearly and carefully delineated.
5. The County should strongly consider the adoption of an electronic heath record system so that health records are well-organized, efficiently stored, clinically useful, and immediately accessible to all concerned parties.
6. The County, in collaboration with Wellpath and/or NLCMHA, should develop a plan for the completion of a psychological autopsy for completed suicides. This evaluation should be conducted by a clinical psychologist who does not provide direct care services to inmates.

# NCCHC Standards for Health Services in Jails

The following are notations about the provision of medical, mental health, and dental services that were assessed during the scheduled site visit as they relate to comparison with national health care standards.

The standards that will be addressed are those for which changes in current practice must be made in order to be in line with nationally accepted standards of care. These notations are not in any way intended to imply that if changes are made in the provision of care, that compliance with NCCHC accreditation standards is guaranteed. NCCHC accreditation surveys are conducted by a separate entity and the ultimate decision on compliance rests with an accreditation committee.

- J-A-02 Responsible Health Authority
  - An increase in medical director hours would be required in order to fulfill the administrative responsibilities of that position. The administrative duties include health record reviews, active participation in the CQI process, clinical performance enhancement reviews, and the development and approval of policies, procedures, and protocols.
- J-A-04 Administrative Meetings and Reports
  - The collection and compiling of medical, mental health, and dental statistics in a manner that provides a comprehensive overview of services being provided on a monthly basis is essential for identification of trends and for utilization in an effective CQI program.
  - The NCCHC Resources team notes that they did not have access to mental health statistics during this evaluation of services.
- J-A-06 Continuous Quality Improvement Program
  - Site-specific reviews are a required component of an effective CQI program. Our team reviewed several studies that were for topics required by the corporate office. The HSA would benefit from instruction/training in the concepts of quality improvement and how to work with the medical director and NP to identify site-specific issues (e.g., documentation, chronic care, effective integration of medical and mental health services).
- J-A-08 Health Records
  - Health records are not well organized. Various required components such as a master problem list, notation of allergies, date and time of progress note entries, and mental health assessments and treatments, are not present for all records.
  - The non-integration of mental health information into the current jail health care record is a significant concern. At the very least, a summary of all mental health encounters, treatment plans, and discharge planning should be a part of an integrated record.
- J-A-09 Procedure in the Event of an Inmate Death
  - A psychological autopsy is required within 30 days of all suicides.

- J-B-02 Infectious Disease Prevention and Control
  - An environmental inspection of all health service areas is conducted monthly to verify that:
    - Equipment is inspected and maintained
    - The health care service areas are clean and sanitary
    - Measures are taken to ensure the unit is occupationally and environmentally safe
- J-B-05 Suicide Prevention and Intervention
  - Acutely suicidal patients must be under constant observation by staff.
  - It would be very advantageous to improve communication and the sharing of assessment findings between the emergency response team and the Wellpath staff. At the very least, a summary of all encounters should be shared in writing for incorporation into the jail health care record.
- J-C-02 Clinical Performance Enhancement
  - All licensed health staff must undergo a clinical performance review at least once per year. This would include the medical director, NP, psychiatrist, nurses, and licensed mental health professionals. These reviews must be documented in a manner that meets all compliance indicators listed in the standard.
- J-C-04 Health Training of Correctional Officers
  - Review all health-related training topics to ensure that the following topics are incorporated:
    - Adverse reactions to medications
    - Dental emergencies
    - Procedures for appropriate referral of inmates with medical, dental, and mental health complaints to health staff
    - Maintaining patient confidentiality
- J-C-07 Staffing
  - Review current staffing levels to ensure that timely access to care is possible when the average daily population returns to higher levels post-pandemic.
- J-D-02 Medication Services
  - This standard requires that patients are permitted to carry medications necessary for the emergency management of a condition when ordered by a physician (e.g., an unstable asthmatic would carry a rescue inhaler, a patient with a serious heart condition would carry nitroglycerin).
- J-D-04 On-Site Diagnostic Services
  - Facilities must have peak flow meters, or a similar device, in order to properly assess respiratory disorders.
- J-D-07 Emergency Services and Response Plan
  - Mass-casualty drills are required to ensure the ability of the health services staff to handle multiple-victim scenarios. All health staff should participate in a mass-casualty drill at least once within a 3-year period. The drill must be critiqued and findings shared with all staff.
  - Man-down drills, or actual man-down situations, should be critiqued on each shift at least once per year and the results shared with all staff.
- J-E-04 Initial Health Assessment
  - Standards, and some state Board of Nursing regulations, do not permit an LPN to conduct health assessments.

- J-E-05 Mental Health Screening and Evaluation
  - Registered nurses who conduct the mental health screening must have received documented training from a mental health professional.
- J-E-06 Oral Care
  - Registered nurses who conduct the oral cavity screening must have received documented training that is either provided or approved by a dentist.
  - Every patient should receive instruction in oral hygiene and preventative oral education within 14 days of arrival.
  - Dental care cannot be restricted to extractions only. Restorative work should be provided when a tooth can be saved.
- J-E-09 Continuity, Coordination, and Quality of Care During Incarceration
  - Diagnostic test results are properly reviewed and filed.
  - Treatment plans are required and must be updated when indicated and shared with the patient.
  - All diagnostic test results are shared with the patient.
- J-F-01 Patients with Chronic Disease and Other Special Needs
  - Clinical protocols are consistent with national clinical practice guidelines. The protocols must be current and approved by the medical director on an annual basis.
  - Individualized treatment plans are required.
  - Documentation in the health record confirms that providers are following the chronic care protocols and special needs treatment plans that are drafted as clinically indicated by:
    - Determining the frequency of follow-up for medical evaluation based on disease control
      - Chronic care lists reveal that follow-up is based on standard intervals and not patient condition and status.
    - Monitoring the patient's condition (e.g., poor, fair, good) and status (e.g., stable, improving, deteriorating) and taking appropriate action to improve patient outcome
- J-F-03 Mental Health Services
  - Outpatient services include, at a minimum:
    - Identification and referral of inmates with mental health needs
    - Individual counseling
    - Group counseling and/or psychosocial/psychoeducational programs
  - Mental health, medical, and substance abuse services are sufficiently coordinated such that patient management is appropriately integrated, medical and mental health needs are met, and the impact of these conditions on each other is adequately addressed.
- J-F-05 Counseling and Care of the Pregnant Inmate
  - Pregnant patients with active opioid use disorder receive evaluation upon intake, including offering and providing MAT with methadone or buprenorphine.
  - Note: use of Tylenol #3 for a gap medication for substance abuse treatment is not appropriate for both therapeutic and legal reasons.