Health Services Administration (SAMHSA) linked to OTP accreditation through the National Commission on Correctional Health Care. The requisite standards for accreditation are available in the 2004 NCCHC publication, Standards for Opiod Treatment Programs in Correctional Facilities.

- Individual physicians employed by CHS might complete the additional training needed to obtain a SAMHSA DATA (Drug Addiction Treatment Act of 2000) Waiver for use of Suboxone (buprenorphine) and Subutex (buprenorphine plus naloxone hydrochloride) in treatment of opiate addiction.

All of these options involve approvals from state and federal agencies including the US Drug Enforcement Administration. I estimate that another three months (July 1, 2011) will be needed to establish a feasible plan, implementation of which can hopefully be completed by December 1, 2011. This projected date reflects the substantial time required to complete any of the three options outlined above.

CAP – 8 – **Review and Revisions of Policies and Procedures**

On concert with its application and preparation for an accreditation survey by NCCHC, CHS has reviewed and revised numerous policies, procedures, clinical guidelines and

protocols. This ongoing work is consistent with the following objectives as stated in my August 20, 2010 Expert's Report:

- Clinical guidelines that meet nationally established professional recommendations are in place for evaluation and management of chronic diseases (including asthma, chronic lung disease, epilepsy/seizure disorders, cardiac disease, diabetes, lipid disorders, hepatitis c infection, chronic liver disease, chronic kidney disease, human immunodeficiency virus infection/AIDS);
- Nursing policies and procedures and protocols for assessment are to be reviewed in detail and any changes necessary have been made to assure appropriate nursing care in handling sick call requests and encounters, emergency encounters and appropriate referrals to physicians, physician assistants or nurse practitioners;
- Nurses have been properly trained, oriented, and evaluated in their use of these policies, procedures and protocols.

CHS is making progress in accomplishing the foregoing objectives. I will be reviewing their continued efforts regularly and in detail with Dr. Alvarez, Thomas Tegeler and Katie Wingate. It is reasonable to project that the foregoing objectives can be completed by August 1, 2011.

CAP – 9 – **Continuous Quality Improvement (CQI) Program**

Through application of the methods established in its current CQI Annual Plan, CHS will include the following actions:

- Systematic reviews of patient records by senior and peer medical staff to measure access, timeliness, appropriateness, coordination, and continuity of medical and nursing care. Written findings and recommendations will accompany identification of any lapses or problems in care.
- Medical record reviews will be sufficient in number to be representative of broad range of acute (for example, alcohol withdrawal syndrome) or chronic conditions and of patients residing in all jail facilities.
- Medical record reviews will assess whether clinically appropriate care is documented, including patient assessments whenever orders for medication or diagnostic tests are initiated.
- Under the direction of the Medical Director, CHS will conduct annual clinical performance reviews of the employed physicians, physician assistants, and nurse practitioners. These reviews will be documented and include consideration of the results of medical record

reviews, professional development and education, and maintenance of specialty board certification.

- CHS clinical and executive leaders will regularly identify and review all deaths or other adverse patient outcomes and occurrences. When indicated, methods of root cause analysis as recommended by the Joint Commission on Accreditation of Health Care Organizations will be employed and documented.
- At least quarterly, CHS utilization management activities will be reviewed and evaluated to document that practitioner requests for specialist consultations, offsite diagnostic and treatment procedures are completed in a timely manner.
- CHS will institute and maintain comprehensive tracking and monitoring systems for Patient Health Care Requests. Regular reviews will be conducted to validate that inmates are seen in a timely manner and that written responses to their requests are informative and professional.
- CHS will track and monitor of individual medication profiles and medication administration records to ensure continuity of administration, prevention of adverse drug reactions, and dosages consistent with individual patient needs and physiological characteristics. Fully adequate attention to this action remains dependent on initiation of the electronic medical order entry and medication

administration record systems currently being developed jointly by CHS and Diamond Pharmacy Services.

Most of the foregoing actions are either already in place or implemented by CHS. For those actions not already in place, it is reasonable to expect completion by September 1, 2011.

CAP – 10: **Electronic Order Entry, Medication Administration and Health Record Systems**

There has been a delay in implementation of the electronic pharmacy order entry project due to a recent Drug Enforcement Administration directive that each CHS clinic site have a separate DEA license. Another factor was the need to add data lines to the older Durango and Estrella Sites. The new "go live" timeline for the electronic order entry and medication administration record systems is June 1, 2011. I agree with this timeline as part of the Corrective Action Plan.

Regarding development of the Electronic Health Record System, a Request for Proposals (RFP) document has been approved by the Maricopa County Materials Management Department. Selection of a Vendor/System and the HER Contract Award is slated to occur in July 2011. This will be followed by a series of steps including hardware installation; Net deployment; building work flow; content design; testing;

and training. Full activation of the system is projected for June 2013. As part of this Corrective Action Plan, the foregoing milestones will be incorporated and monitored.

CAP – 10: **Internal and External Validation of Structure, Processes and Outcomes Pertinent to SAJ Requirements**

The new CHS leadership team is settled in place. It is now appropriate and feasible to establish a more robust and consistent framework to evaluate compliance with SAJ requirements. Going forward, there are three components I believe are most important:

- CHS and the MCSO need to complete their preparations for a NCCHC accreditation survey and to achieve full accreditation. Many of the structure and process requirements for NCCHC accreditation are essential for a stable and effective jail health care system. Achievement and maintenance of accreditation are also a positive factor in recruitment of qualified practitioners and nurses.
- CHS will continue to enhance its CQI program and to accomplish the tasks and objectives specified in CAP-8 and CAP – 9 as previously described.
- Beginning in late May 2011, I will be conducting quarterly medical record reviews jointly with CHS. The

standardized methodology of these reviews will allow for sequential comparison of results from one quarter to the next. Medical records selected for review will be sufficient in number to characterize and compare outcomes for typical patient populations, including those with and without chronic illnesses.

This concludes my Sixth Report.

Respectfully submitted,

/s/

Lambert N. King, MD, PhD, FACP

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

Graves v. Arpaio No CV 77-0479-PHX-NVW

SIXTH REPORT OF KATHRYN A. BURNS, MD, MPH
ON CORRECTIONAL HEALTH SERVICES COMPLIANCE
WITH SECOND AMENDED JUDGMENT
APRIL 2011

This report is being filed following a February 2011 site visit to the Maricopa County Jails. I visited the jails February 14-17, 2011. I toured the Mental Health Unit (MHU) and other mental health treatment space, met with mental health supervisory staff and reviewed a number of documents in addition to reviewing medical records. The medical records reviewed focused almost exclusively on records of inmates with serious mental illness.

I toured mental health treatment space and reviewed medical records at Lower Buckeye Jail, 4th Avenue Jail, Estrella and Durango. Since the time of the last site visit in 2010, Towers Jail is no longer being used to house pre-trial detainees; it is housing only sentenced inmates. I did not visit Towers Jail. Fifty (50) medical records were reviewed.

This report is organized around the item headings in my August 2010 Compliance Report and January 2011 site visit report and addendum. It is focused on the activity and progress of Correctional Health Services (CHS) and the provision of mental health care to pre-trial detainees. Information from the medical record reviews is included under the relevant topic areas but also summarized at the end of the report.

Intake/Receiving Screening

CHS continues to conduct intake screening of all inmates as they are booked into the jail. Timeframes for follow-up of positive screenings have been updated and are in the process of implementation. The screening instrument has been updated and will be entirely electronic starting in early April.

Review of the medical records indicates the screenings are timely and appropriately identify persons in need of immediate mental health attention, medication orders and other types of referral. The screening instrument and process appear to be appropriately sensitive and specific. However, there were three instances in which follow-up was not timely in response to a positive screen; two of the three involved female inmates. CHS is aware that responsiveness to a positive screening is a critical necessity. A Quality Improvement study is planned to address implementation of the electronic screening process and compliance with follow-up timeframes.

Health Need Requests (Inmate Self-Referrals) and Staff Referrals

The new Health Needs Request (HNR) system was put into place in November 2010 and includes a mechanism to track referrals and responses. It was too soon to have seen dramatic improvement in the HNR process in February, though all mental health-related requests were seen face-to-face rather than screened on paper only. Three of the 50 clinical files reviewed contained problematic HNR responses; one case involved HNRs from August and September (before the new processes were implemented) and in one case the HNR was incorrectly routed to medical rather than mental health. By the time the error was discovered, the inmate was released. (The HNR was incorrectly routed through medical because the inmate had identified it as a medical rather than mental health request

though the narrative clearly identified it as mental health; a careful read by medical triage would have sent the request to mental health initially saving time and permitting a response though this particular HNR was not of a critical nature.) In the third instance, the handling of the HNR was of less concern than the larger issue involving screening and Mental Health Unit follow-up.

Mental Health Unit (MHU)

Admission and discharge criteria have been formalized and implemented. Length of stay data is being maintained. Staff have been educated about the availability of the Maricopa County Health System for psychiatric hospitalization if hospitalization is deemed necessary though the transfer process had not yet been utilized at the time of the site visit. Inmate-patients returning from outside mental health emergency treatment or hospitalization are automatically admitted to MHU upon return to the jail. Much progress has been made in privacy of care and group treatment in the MHU. Confidential individual and group treatment space has been identified, physically modified as necessary and is in use. The culture of seeing patients at the cell front is changing.

On another bright note, treatment and programming for patients that are historically very difficult to treat are quite good: treatment plans are comprehensive and individualized and MHU staff do not push to have these patients discharged back into the general population quickly. These are the types of patients that other correctional systems and facilities sometimes view as untreatable and manipulative and mental health staff refuse to treat. CHS MHU staff should be applauded for their work with this subset of patients. Further, there is good coordination with the other jails around discharge planning for this group of inmates.

Unfortunately, there are a sizable number of patients that are getting discharged prematurely and many are not receiving timely or adequate follow-up upon release to one of the other jails. Premature release cases most often involve inmates admitted as a precaution directly from the booking process due to statements made while under the influence or while withdrawing from drugs and/or alcohol. Such inmates are rapidly assessed and discharged quickly from MHU but some return for readmission in short order - an indication that perhaps the assessment was not thorough enough or occurred too soon to accurately assess mental state in the absence of drugs and alcohol. This issue is further complicated by the lack of medical treatment space to manage arriving inmates that are intoxicated or withdrawing and the MHU staff's concern to ensure adequate MHU admission bed space is available for emergency admissions both from booking and other jails. It is complicated but must be addressed jointly by CHS medical and mental health leadership and line staff.

The problem that occurred most frequently with respect to the MHU was untimely and inadequate outpatient follow-up in the other jails upon discharge. CHS planned to address the timeliness issue through changing the process for scheduling the follow-up appointments. The follow-up had been scheduled by the receiving jail but CHS changed the protocol to make MHU staff responsible for scheduling the follow-up appointments in the Jail Management System as a result of this finding. Future audits should find improvement in this critical area. Adequacy of outpatient follow-up is related to the frequency (or infrequency) of contacts with psychiatry and other mental health staff as well as the type(s) of treatment interventions provided. These findings are discussed more fully under Outpatient Treatment.

At the time of the site visit, suicide prevention and clinical restraint policies had been revised. The draft revisions are currently in the process of review and discussion. (Note: There had been one suicide prior to this site visit, another suicide occurred in late February and a third inmate died by suicide in early March. CHS is in the process of critically reviewing these incidents and conducting psychological autopsies.)

Outpatient Care

Problems with outpatient care were identified in fifteen of the 50 records. Problems included infrequent treatment intervals; treatment of caseload inmates only in response to HNR rather than planned, regular contact; and over-reliance of psychotropic medication as essentially the sole treatment intervention. Significant improvement in this area is not expected until CHS develops and implements outpatient admission and discharge criteria; frequency of intervention by discipline; frequency of treatment team meetings and treatment plan updates; and group and individual interventions. By mutual agreement, revising the outpatient level of care was postponed to permit earlier and undivided attention to other critical areas and to encourage the use of line staff to develop the outpatient guidelines through a quality improvement team process.

Coordination of medical and mental health care

CHS undertook a number of initiatives to ensure better coordination between medical and mental health providers for inmates with both types of problems. The medical policy regarding treatment of pregnant women was revised to reflect referral and coordination with mental health; psychiatric disorders are now documented on the medical problem list in front of each chart and the problem list document itself was

redesigned to better integrate medical and mental health care; and psychiatric providers have been instructed to review medical chronic care flow sheets during psychiatric clinics raising their level of awareness. Four files reviewed contained problems related to medical care follow-up of mental health patients: one related to medical handing of a HNR, one related to seizure disorder that doesn't appear to be followed by medical, and one related to not receiving prescription medications timely following MHU discharge. The most serious case involved the lack of coordination with medical in a psychiatric patient with psychogenic polydipsia - a condition that causes metabolic abnormalities that can lead to death. (The patient had abnormal laboratory results but was not treated for them or followed by medical for the problem. Fortunately, an adverse incident did not result and the patient was discharged to inpatient psychiatric care at the state hospital.)

Treatment for Incompetent Criminal Defendants

There is nothing new to report on this topic. As noted previously, use of the Maricopa County Health System for psychiatric hospitalization had not yet started at the time of the site visit.

Psychotropic medications

Thirteen cases involved issues with respect to psychotropic medication management. They were divided into problems of two types: prescriptive issues and follow-up issues. Prescriptive issues included: problems with prescriber medication choice(s); continued problems with medication renewal or discontinuation without a face-to-face appointment; delays in recognition (and subsequent utilization) of Court Ordered Treatment (COT); and one failure to provide a non-formulary medication in spite of receipt

of verification. The issues involving follow-up included cases in which the follow-up interval after starting medications was too long; failure to address noncompliance or reports of side effects timely; and medication continuity problems with inmate housing or job assignment changes. Psychiatric provider peer review processes should begin to identify and address prescriptive and interval issues while the more general medication audits should find and correct noncompliance and continuity with housing moves.

Staffing

There is no update with regard to staffing other than to report that last year's newly created positions have been filled and there has been notable improvement in the capacity to provide treatment in privacy due to the additional escort officers and treatment space. Additional psychiatric and clerical/support time have also yielded beneficial results.

Continuous Quality Improvement (CQI)

A number of initiatives are underway: the HNR process was revised, implemented and monthly compliance audits were started. An audit instrument for MHU levels of care is under development. A system to track and analyze major mental health incidents is in place. Peer review efforts are underway for mental health staff, psychologists and psychiatric providers. A quarterly medical-psychiatric committee meeting has begun.

Segregation/Discipline

CHS is now notified of all caseload inmates with serious mental illness who receive a disciplinary infraction. The relevant policies must now be written or revised to reflect the practice and inform CHS staff on documentation requirements. Mental health care to inmates in segregation is provided under private conditions. The place and circumstances

of the interaction is documented in the chart note and an audit of the privacy expectation as reflected in the charting is planned.

Training

I was provided the training curriculum lesson plans used in providing 16-hours of mental health-related training to *all* Maricopa County Sheriff's Office correctional officers. In general, the content appears relevant, accurate and appropriate. Further, although I have not seen the actual training, it is clear from the lesson plans that a number of methods are used to convey the information such as lecture, film, discussion and role play; different learning styles are addressed and important points are reinforced in multiple ways. However, for reasons sited in my Fifth Report, I continue to believe that the modest quality improvement recommendation for a joint mental health-custody staff committee to review the curriculum in order to revise or supplement it as necessary for officers assigned to posts dealing with inmates most at risk and at highest risk of serious mental health problems (booking/receiving area, MHU and all segregation unit posts) remains relevant and appropriate.

Medical records review

As noted previously, I reviewed 50 medical records during the site visit. The sample included nine cases that were referred by plaintiffs' counsel; other records were selected at random from lists of seriously mentally ill caseload inmates. Attention was focused primarily on the last six months of care to determine whether more recent changes have lead to improvement rather than focusing on past problems and deficiencies already identified and acknowledged as problematic by CHS.

Most of the findings have been reported when discussing the various topics in the preceding sections and won't be repeated here except in summary/table format at the end of this section. Items not previously mentioned include: 12/50 files reviewed revealed no deficiencies with respect to the level of mental health care provided: the inmate-patient appeared to be receiving an appropriate level of care, was being seen at appropriate intervals, had been enrolled into treatment at screening or thereafter as necessary in a timely fashion, was receiving medications appropriate for condition, etc. (One of the twelve reviewed was identified as being on the mental health caseload according to the caseload list but the inmate-patient was not actually on the caseload nor did he appear to require services based on his screening and assessment results. This is a database clean-up issue, not a care issue. Notably, there were many fewer of these cases identified this visit than in the past and CHS has dedicated some support resources to clean-up inaccuracies and update information in the database.)

Record Review Issue or Problem	**# records***
None	12
Intake/Receiving Screening	3
Health Needs Request	3
MHU Stay	7
MHU Follow-up	12
Outpatient	19
Coordination with Medical	4
Medication prescription	6
Medication follow-up	6

* Some file reviews had more than one problem such as premature MHU discharge and missed timely outpatient follow-up appointment, so the problems total exceeds 50.

Conclusion

There has been significant progress in physical plant modifications for confidential care, policy and procedure implementation and developing processes for self-monitoring through continuous quality improvement. The revised policies and procedures for suicide prevention and clinical restraint are in draft form. The MHU is treating difficult patients, developing comprehensive treatment plans for them and coordinating discharge planning with outpatient providers. More group interventions are being provided to all inmates in MHU. Staffing has improved with psychiatric providers as well as some support staff to assist with scheduling, tracking and filing tasks and there are additional dedicated escort officers which has helped get inmate-patients to mental health appointments in treatment spaces that are private. Pretrial detainees are no longer housed in Towers Jail.

Areas that continue to need improvement include premature MHU discharge, MHU follow-up after discharge, integrating medical and mental health care and psychotropic medications. Mental health outpatient care too often consists of medication management with infrequent supportive contacts by other mental health clinicians though there is a plan to address outpatient level of care after improvements to more critical areas of care such as screening, health need requests and MHU operations are more firmly established.

Respectfully submitted,

Kathryn A. Burns, MD, MPH
April 5, 2011