

# EXHIBIT 1

**DUVALL SETTLEMENT AGREEMENT REPORT**

**May, 2022**

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## OVERVIEW

Consistent with provision 38.d, when the Commissioner claims to have attained substantial compliance with any provision of the Settlement Agreement, the Monitor is to issue a report within two months of the claim of substantial compliance. The Commissioner has no new claims of substantial compliance. The report will include a brief executive summary. Each provision of the report will be stated verbatim in italics as a Settlement Agreement Statement. Following that I will give a compliance rating for that item. The Settlement Agreement defines compliance as meaning:

“(a) full compliance with the components of the relevant substantive provision of this Settlement Agreement; or (b) sufficient compliance with the components of the relevant substantive provision of this Settlement Agreement such as to remove significant threat of constitutional injury to the plaintiff class posed by any lack of compliance with the components of that substantive provision.

The Settlement Agreement requires that judging compliance be done for each of the eight substantive provisions which are delineated in the single numbered paragraphs of Section III of the Settlement Agreement. That will be done. The Monitor provides a compliance rating for subsections of each provision to give Defendants a more focused gauge on what they need to work on to attain compliance.

## EXECUTIVE SUMMARY

There are eight substantive provisions. Provision 23 is compliant; provisions 19 and 22 are noncompliant; and provisions 17, 18, 20, 21, and 24 are partially compliant.

There are 37 subsections of the eight provisions. The current status of the 37 subsections is:

- Twelve provisions are substantially compliant. Fifteen provisions are partially compliant. Ten provisions are still non-compliant.

Defendants recently sent the Monitor a letter<sup>1</sup> communicating several concerns.

**One concern related to interpreting compliance.** The Monitor agrees with this and will interpret compliance exactly as stated in the Settlement Agreement.

**Four concerns relate to recommendations that the Monitor has given.** DPSCS wants the Monitor to withdraw or not give these recommendations.

**Two additional concerns of DPSCS involve disagreements with the Monitor’s interpretation of the Settlement Agreement** with respect to compliance ratings.

As background, the Settlement Agreement assigns responsibilities to the Monitor which includes:

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<sup>1</sup> Letter from counsel for Defendants to the Monitor on 3/21/22 as appendix A to this report.

“provide technical assistance to the Commissioner to achieve compliance with the terms of this Settlement Agreement by informing the Commissioner what the Monitors considers necessary to achieve compliance, and how the Monitors believe such compliance might be achieved”.

### **Expanding clinical space for females<sup>2</sup>**

In one concern, DPSCS asks that the Monitor withdraw a recommendation to expand clinical space for females.<sup>3</sup> At question is the Monitor’s comment that there have been no changes to the woman’s clinic which was scheduled to be renovated in 2019. Several years ago, DPSCS demolished several of the old jail structures which eliminated housing for females. Some female inmates were moved into the prison housing and females were housed on two floors in the BCBIC building. Those floors had no clinic. Two administrative spaces in the elevator foyer were made into female clinic space. Doors for these rooms opened onto the foyer and the space was a risk for privacy concerns if the door was opened during an examination and were insufficiently sized to adequately accommodate need. DPSCS agreed to renovate a different space but this has not occurred. The Monitor continues to evaluate for compliance and has given recommendations that help DPSCS attain compliance with or without renovation of this space.

### **Improvement of clinical space in intake<sup>4</sup>**

The next concern involves clinical space in intake. DPSCS states that the Monitor has “concluded that ‘space in the intake area’ is a significant contributor to an intake exam of poor quality”. From the beginning of the Settlement Agreement, the Monitor has advised DPSCS that space deficiencies in the areas used by medical in reception were a significant barrier to compliance. Rooms used by medical staff for intake screening were not built or intended for the purpose for which they are now being used. Lack of privacy, problems with flow of patients, and lack of space for medical operations have consistently been problematic. Several years ago, when DPSCS demolished part of the jail, they said that a new building would be built that would include an intake area. This was not done. The problems remain and DPSCS, in addition to not building or renovating the intake area, stated they have no additional space for a renovated space and ask that the Monitor withdraw a recommendation to renovate or replace the medical intake space. When it was obvious to the Monitor that DPSCS was not going forward with either a renovation of the existing space or a new structure, the Monitor gave a recommendation to perform a root cause analysis<sup>5</sup> of the intake process in an attempt to have DPSCS resolve process and flow issues as an alternate path to building a new space.

An initial root cause analysis was done and reported that multiple factors affected adequate completion of the IMMS.<sup>6</sup> Space and flow issues *were identified by DPSCS* as an issue, confirming the suspicions

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<sup>2</sup> This is the 2<sup>nd</sup> concern in DPSCS’ letter.

<sup>3</sup> DPSCS states this recommendation is on page four of the November 2021 report.

<sup>4</sup> This is the 3<sup>rd</sup> concern in DPSCS’ letter.

<sup>5</sup> The recommendation is, “Perform a root cause analysis of the intake process to include interviews with intake nurses to establish whether time-pressures, privacy issues, or space conditions contribute to the poor quality of care of nursing intake evaluations. Take corrective actions on these items. Identified problems need to result in corrective actions to result in compliance with the Settlement Agreement.

<sup>6</sup> The root cause analysis (RCA) included as root causes of poor intake screening 1) space, 2) rooms not set up for proper flow, 3) inadequate room for advanced practitioners to work and labs to be drawn, 4) lack of room for mental health and medical, 5) feeling rushed to do things, 6) lack of ability to attain privacy, 7) needing to keep supplies in a remote room which was inefficient, 8) having to go to the medical clinic to get lancets which was inefficient, and 9) doing an HIV test on the desk among others.

of the Monitor. Follow up of the root cause analysis was not completed and re-testing to assess whether corrective actions actually corrected the deficiencies was not done. Indeed, the problem of poor quality of nurse screening, absence of intake screening documentation, loss of medication records, and inability to track medication administration continue to be major problems. The analysis resulted in some corrective actions to clean and reorganize existing space and make other changes to the process but the vendor staff who conducted the analysis were reassigned to other corporate duties and the process terminated. In any case, the quality of nurse intake screening remains poor and the process of performing intake screening in this area still appears chaotic. DPSCS planned to audit quality of nurse screening but has not yet begun those audits. The root cause for this has not been explored further. The Monitor still believes that the space issues are a significant barrier.

DPSCS asks the Monitor to withdraw the recommendation to renovate or replace the intake space. However, because DPSCS has no plans to improve the space, the Monitor continues to recommend the root cause analysis in order to identify root causes of their process issues intake and fix them.

### **Detoxification housing**<sup>7</sup>

In another concern, DPSCS questions whether the Monitor's recommendation to house detoxification patients in specialized housing "is consistent with the Agreement, which does not address the needs of such detainees, and the constitutional standard". Provision 19 c requires that ordered vital signs or blood sugar tests be done and that results be documented in the medical record. One of the main reasons for ordered vital signs at DPSCS is in the evaluation of persons who are undergoing detoxification. These patients have orders for vital signs twice or three times daily for up to a week or more. In the current DPSCS report, vital signs were completed as ordered about 41% of the time. Housing detoxification patients on a single housing unit makes taking vital signs much more effective because a nurse can complete vital signs in a single unit and not have to find inmates who may be located throughout the jail. The Warden was previously able to do this but the practice was disrupted during the COVID pandemic due to the need for quarantine housing. The Monitor believes that the recommendation is sound, is not expensive to implement, and is consistent with the Monitor's duties in the Settlement Agreement. In any case, DPSCS must be able to complete vital signs as ordered and appropriately review them which they are currently unable to do. If the Monitor's suggestion is not something DPSCS is willing to do, it must still figure out why vital signs are taken only 41% of the time and take corrective action to fix this problem.

### **Device survey**<sup>8</sup>

Audits performed by DPSCS<sup>9</sup>, have consistently documented a lack of computers or other electronic devices to document nurse findings resulting in low audit scores. As a result, the Monitor gave a recommendation to complete a device count<sup>10</sup>. This is not an extraordinary recommendation because a

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<sup>7</sup> This is the 4<sup>th</sup> concern in DPSCS' letter

<sup>8</sup> This is part of the 5<sup>th</sup> concern in DPSCS' letter

<sup>9</sup> In discussion of provision 19c on page 20 of the Corizon report, it states. "Space limitation and lack of computers continue to pose a challenge for nurses to meet documentation requirements. Future EHR collaboration discussions have identified the need for handheld devices for real-time documentation of vital signs and blood glucose results.

<sup>10</sup> A device count is a typical preliminary step before introducing an electronic medical record. It consists of establishing how many devices will be needed to ensure that every employee needing access to the record will have the appropriate devices and equipment necessary for their work. Devices will vary. For example, the type of computers needed for

device count is a typical step in implementing an electronic record. Staff should be provided the of number of devices necessary so that all staff have ability to use the electronic record. DPSCS recommends that the Monitor refrain from using this recommendation. However, as will be discussed in this report, DPSCS's own staff said that a reason why data necessary for compliance was not entered into the electronic record was a lack of devices to do so.

### **Early roll out of the electronic medical record at BCBIC<sup>11</sup>**

Since the beginning of the Settlement Agreement, DPSCS has had a hybrid electronic medical record system. The custody database, OCMS, is used to document medical intake screening and is uploaded to the electronic record but this is not effectively done. Some screenings are not uploaded. Screenings of people booked with two charges result in initiation of two intake screenings, one of which is blank. To date, DPSCS has not completely fixed issues due to using two parallel electronic record systems. Effective electronic interfaces are also not in place between pharmacy and OCMS, the laboratory and the electronic record and between OCMS and the electronic record. These faulty interfaces still result in multiple process and document errors including the following. Laboratory and other data are sometimes absent in the electronic record. Medication is sometimes sent to the wrong housing unit. DPSCS is unable to track scheduled appointments in an effective manner and thereby is unable to verify that patients actually show up for their appointments. Additionally, because the electronic record was incompletely implemented years ago, there is no electronic medication administration module and documentation of medication administration is done by hand and necessitates maintaining paper medical record files in addition to the two parallel electronic systems. This results in a very high rate of missing medication records with DPSCS being unable to verify that patients receive their medication. Because DPSCS has been unable to establish an effective paper or electronic medical record process, it has been impossible for them to verify several provisions. This has been ongoing for years. Parts of the electronic record are still paper documents resulting in three medical records systems; two electronic (OCMS and NexGen) and one paper. There are many process errors as a result.

For all of these reasons, the Monitor recommended that DPSCS implement a new electronic record. After several years, DPSCS bid out for a new electronic record. That first attempt failed due to issues with the request for proposal. After another year, DPSCS released another request for proposal and a contract was awarded. Some disputes have arisen and work is now stalled and an implementation date was delayed to late 2024. Because the jail is part of the State of Maryland prison system, the implementation of the electronic record was initiated statewide. The Monitor has recommended that DPSCS consider using the jail as the pilot for the implementation so as to ameliorate any delays related to implementation on a larger statewide basis. Even though delays in implementing an electronic record have been years-long, DPSCS asks the Monitor to remove this recommendation to perform an early implementation of the electronic record at the jail. Removing this recommendation will prolong obtaining compliance unless DPSCS can make the current hybrid paper/OCMS/electronic record system functional. In the Monitor's opinion that seems unlikely given past performance.

### **Data Analysts<sup>12</sup>**

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medication administration may vary from those needed in clinics. Medication administration requires nurses to take a device with them on a cart when they administer medication in inmate housing units or elsewhere.

<sup>11</sup> This is part of the 5<sup>th</sup> concern in DPSCS' letter.

<sup>12</sup> This is part of the 5<sup>th</sup> concern in DPSCS' letter.



The Monitor has recommended hiring 1-2 data analysts. DPSCS asks the Monitor to refrain from using this recommendation as an underlying part of achieving compliance.

For the first several years of the Settlement Agreement, DPSCS produced reports with data that was inaccurate and not credible. DPSCS changed vendors and a manual auditing process was established. While this process is now credible it is extremely time consuming and in the last report several areas were not audited due to lack of staffing. In addition, multiple areas are not audited or are ineffectively audited (scheduling, placement in ADA housing, receipt of medication, review of laboratory tests, etc.) because data cannot be obtained manually or cannot be obtained from the existing electronic or paper records. Because of DPSCS' inability to effectively obtain data, the Monitor has recommended that DPSCS hire data personnel to obtain data from the existing electronic record and to establish processes to obtain data in the future electronic record. DPSCS asks the Monitor to refrain from using this recommendation but the Monitor is not sure what else to recommend to guide DPSCS to obtain better data which they need to verify compliance. DPSCS has not been otherwise able to obtain this data.

### **Hiring a Process Analyst and Train DPSCS Staff in Six-Sigma<sup>13</sup>**

Multiple processes related to the Settlement Agreement are not working as intended and DPSCS has not been able to improve the processes to demonstrate compliance. These defective processes include intake screening, medication administration, medication renewal, continuity of medication, scheduling and ensuring that patients keep their scheduled appointments, provision of supplies to persons with disabilities, ordering and completing laboratory tests and vital signs, etc. Because of DPSCS' inability to identify causes for these defective processes and to initiate corrective actions, the Monitor gave multiple recommendations to perform root cause analyses to remedy these defective processes and recommended that DPSCS hire persons qualified to perform the analyses and to train their leadership staff on these methods. Now, DPSCS requests that the Monitor refrain from including this recommendation as an underlying part of achieving compliance. There is no dispute that these processes are defective. The Monitor has made the recommendation to hire staff and to initiate training because DPSCS has shown no ability to do this in another way. The Monitor believes that DPSCS will need to fix the defective processes to verify compliance. How they do this is their decision. The Monitor believes the recommendations to be reasonable and will continue them unless DPSCS can find another way to correct the defective processes.

There are two concerns of DPSCS that involve disagreements with the Monitor's interpretation of the Settlement Agreement. One involves poor quality nurse intake evaluations and the second involves continuity of receipt of medication after intake screening.

### **Failure of nurses to identify medical problems or medications at intake<sup>14</sup>**

This concern relates to poor quality nurse intake evaluations. In this concern, DPSCS focuses on only two aspects of poor quality of nurse screening which are not the only reasons for poor quality. These two aspects are failing to identify an inmate's medications and failing to identify an inmate's medical conditions. The disagreement involves a position of DPSCS that nurses are unable to obtain accurate information because inmates are not candid and they state, "the Agreement as negotiated and written

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<sup>13</sup> This is part of the 5<sup>th</sup> concern in DPSCS' letter.

<sup>14</sup> This is the 6<sup>th</sup> concern in DPSCS' letter.

supports and reflects the defendants' assertion that newly arrested detainees may not be candid during an Intake exam".

Also, for nurse identification of medical conditions and for continuation of medication, DPSCS argues that the Monitor must judge compliance based on the inmate's *report* of taking medication or having a condition and not on the fact that they actually have a medical condition or are on medication. If an inmate doesn't report a problem or medications, they contend, nurses cannot be blamed for performing a poor-quality intake screening. There are three problems with this reasoning. One problem with this reasoning is that the providers who evaluate the same patients after nurse screening, on average, hours later are consistently able to identify an adequate medical history including medical problems and medications. Why can providers do this and nurses cannot? DPSCS argues that inmates are dishonest before they are booked but honest afterwards. A second problem with this reasoning is that there is a health information exchange in the Baltimore region that contains medical information (including medical conditions and medications) from disparate medical systems.<sup>15</sup> This system, called CRISP, is available for both nurses and physicians at BCBIC. Providers at BCBIC use this system and it often contains information about chronic conditions of incoming inmates and medications that the patient is on. Nurses at BCBIC refuse to use CRISP. The Monitor was told that nurses refuse to give the personal information required to access the system. Even if an inmate were not candid, CRISP would provide the information about the patient. Nursing refusal to use this system is a barrier to obtaining accurate information and there is not a reasonable explanation for why nurses will not use this information. Lastly, a third problem with this reasoning is that nurses should be able to obtain accurate information from the patient and have not yet shown why this cannot be done. The Monitor is very skeptical of the assertion that all poor-quality nurse intake evaluations are a result of inmates who lie about their health only on a nurse intake screening examination. To prove this would be extremely complicated.

In any case, inability to obtain the medical problems and medication history are not the only reasons for poor quality nurse intake evaluations which is why DPSCS fails to achieve compliance on this provision. DPSCS has not performed any audits or evaluations on nurse quality of intake screening. About a year ago, the Monitor worked with DPSCS to initiate audits of nurse quality but those audits have not yet been initiated. Also, based on the Monitor's record reviews, aside from not identifying all medical conditions or medications of incoming inmates, nurses also fail to consistently complete the intake form; do not consistently document a proper triage decision, do not always complete required vital signs or take prompt action on abnormal vital signs or findings. There is no dispute that any of these are not performed adequately.<sup>16</sup> All of these failures of nurse intake screening need to be corrected. With respect to how to correct this, the Monitor has recommended that DPSCS continue the root cause analysis until corrective actions have remedied the poor quality.

### **Provision of medication within 24 hours**<sup>17</sup>

Provision 17d requires that inmates who take medication as civilians will have their medication continued and that the first dose of continued medication is to start within 24 hours of arrival at the jail. DPSCS wants the Monitor to accept for verification that the inmate receives only a first dose of medication. For example, if an inmate is on insulin for diabetes, DPSCS wants the Monitor to accept

<sup>15</sup> The Chesapeake Regional Information System for our Patients (CRISP) is a non-profit health information exchange that facilitates sharing health information between disparate health systems.

<sup>16</sup> A recent audit by DPSCS on diabetes found that only 55% of a sample of 20 records of persons with diabetes had a capillary blood glucose done during intake screening. Findings of the Monitor have not been disputed.

<sup>17</sup> This is the 7<sup>th</sup> concern in DPSCS' letter.

for verification of continuity of medication that the inmate receives only the first dose of insulin even if the inmate receives no further doses of medication. The Monitor has insisted that it be shown that the inmate has received medications during that first month of care and that the first dose is received within 24 hours. DPSCS counters by saying, “While that recommendation may reflect good clinical practice, the Agreement itself does not require proof of continuity of medication under 17(d). The defendants request that you withdraw this requirement”. To the Monitor continuity of medication is not proved by receiving only one dose of medication at the jail.

The Corizon audit report results are not much different from the prior reporting period. DPSCS’ expressed concerns over several Monitor recommendations and desire to have the Monitor change his criteria for judging compliance appear to indicate less willingness to implement prior commitments. Ultimately, the data provided to verify compliance for this Settlement Agreement is the test that DPSCS must pass. The recommendations of the Monitor are suggestions to obtain compliance based on experience. If DPSCS has a different way to achieve compliance, they should proceed in whatever way they feel will be most effective.

Progress on the Settlement Agreement has stalled somewhat. DPSCS lost a key staff person who was responsible for auditing. Though a replacement was recently hired there was a delay in obtaining audit results which prompted DPSCS to ask for a delay in providing their semi-annual report. Some audits were incomplete or not done due to staffing.

The electronic medical record, initially slated to be implemented in May, 2022 will be delayed until sometime in 2024. Work on implementation of the electronic record has stopped until DPSCS and the vendor work out disputed issues. In the meantime, DPSCS has initiated some upgrades to the existing record which is expected to help with respect to several provisions.

## **17: INTAKE AND INITIATION OF MEDICATION**

**Provision 17 Compliance:** Partial Compliance

**Settlement Agreement Statement: 17.a.** *The Commissioner shall promulgate and implement policy and procedure to provide adequate medical and mental health intake screening to all plaintiffs accepted for admission at BCBIC. Such policy shall provide that initial medical and mental health screening, including rejection or acceptance for admission of the plaintiff, is performed by a RN within four hours of arrival at BCBIC, provided the plaintiff is present for all four of those hours. If the plaintiff is rejected for admission and later returns to BCBIC, a new four-hour period within which the initial medical and mental health screening must be performed shall commence.*

**Compliance Rating:** Partial Compliance

### **Findings:**

This provision requires verification of several items including:

1. Verification that IMMSs are completed within 4 hours of booking.
2. That an RN perform all IMMS evaluations.
3. That persons rejected have an IMMS within 4 hours of return to the facility. This would require knowing all those who are rejected.

4. That the IMMS be of adequate quality.

The Department of Public Safety and Correctional Services (DPSCS) does not claim compliance for this item. Corizon reported data based on a sample of records looking at the scan time to time of IMMS. 98% of IMMS evaluations were completed within two hours. RNs consistently performed the IMMS. DPSCS still finds that transfer of the IMMS to the electronic record does not consistently occur and affects scoring. IMMS results transfer to the electronic record from 61-94% of the time. This data is used by the Monitor to verify provision 17.e. Similar results were seen for the persons who were initially rejected, sent to a hospital and then returned to the jail. This electronic transfer process still does not work without problems.

As a remedy to deficient transfer of the IMMS to the electronic record, DPSCS uses a paper copy of the IMMS which is scanned to the electronic record, but on my own record reviews, this copy is not the complete IMMS but is only the short booking screening form. Process issues were identified on the transfer of the IMMS to the electronic record. For some patients, if a nurse did not answer “YES” to a question in the drug use section, the document was not saved and transferred.

With respect to quality of nurse screening, there is no dispute that nurse quality of the IMMS is inadequate. However, neither Corizon nor DPSCS provide any data or information related to quality of the IMMS which the Monitor has found inadequate. DPSCS has worked on an audit format but has not yet performed any audits of quality of IMMS screening. DPSCS will need to determine what process issues are inhibiting nurse quality. For that reason, the Monitor recommended a root cause analysis. An initial root cause analysis was done but stopped short of identifying corrective actions for all problems resulting in nurse failure to adequately complete the IMMS. The root cause analysis could be more focused if DPSCS actually audited nurse quality to identify potential reasons for poor nurse quality.

The Monitor has found several areas of concern with respect to nurse quality: failure to completely fill out the nurse screening form; failure to use the long IMMS form for all inmates; failure to answer all questions on the form; failure to take vital signs<sup>18</sup>; failure to take appropriate action based on vital signs or other findings; failure to document an IMMS acuity ranking and referral disposition; failure to identify the medical problems of the patient and failure to identify the medications the patient is on.

The DPSCS contention that the quality of nurse screening is poor because inmate’s are not candid is not credible. Failure of nurses to identify problems and medications can be ameliorated by use of CRISP to identify medical conditions and medications. DPSCS should initiate audits on nurse quality to identify and then improve the process so better results can be obtained. The multitude of other process issues that are barriers to a better-quality result should be evaluated and corrected. For that purpose, the root cause analysis work should continue until the process works as expected.

With respect to Monitor recommendations, DPSCS has developed an audit instrument for quality of nurse screening but has not yet started using it. A root cause analysis was initiated but corrective actions were not undertaken until the problems were resolved. A standardized intake process is not yet evident. Corrective actions based on prior DPSCS audits have not been undertaken. A methodology of auditing nurse quality has not yet been undertaken.

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<sup>18</sup> A diabetes audit for this visit showed that only 55% of persons with diabetes had a capillary blood glucose taken at the nurse intake screening.

In summary, quality of IMMS evaluation is not verified. For that reason, this provision is still partially compliant. Identified problems in the root cause analysis should result in corrective actions that will result in compliance with the Settlement Agreement. Self-audits should be initiated to better identify problems.

**Recommendations:**

1. Develop a better method to assess quality of intake evaluations as part of your validation of this provision item.
2. Perform a root cause analysis of the intake process to include interviews with intake nurses to establish whether time-pressures, privacy issues, or space conditions contribute to the poor quality of care of nursing intake evaluations. Take corrective actions on these items. Identified problems need to result in corrective actions to result in compliance with the Settlement Agreement.
3. Develop a standardized intake process.
4. Develop corrective actions based on the root cause analysis and problems identified in Dr. McIlree's Alcohol Substance Abuse history document and in Dr. Abebe's audits.
5. Develop a method to review the quality of nurse IMMS performance that gives feedback to nurses. I suggest that supervisory nurses review ten IMMS evaluations each week, with a different nurse being evaluated each week. The supervisory nurse needs to give feedback to the nurse on problems and on how to correct the problem. Corizon nurse quality audits would be a useful substitute.

**Settlement Agreement Statement: 17.b.** *The Commissioner shall ensure that any plaintiff who reports during intake screening that he or she is currently prescribed medication for a medical condition, or who presents with an urgent medical need, shall receive a physical assessment by a Clinician within 24 hours of the intake screening, or sooner if clinically indicated*

**Compliance Rating:** Substantial Compliance

**Findings:** DPSCS previously claimed compliance with this item. 17b requires verification of two things:

1. Evaluation by a clinician within 24 hours of anyone on a medication, with a medical condition, or with an urgent medical need.
2. Evaluation by a clinician is of sufficient quality.

Corizon audits compliance with the timeline of performing the clinician assessment. Anyone who answers "yes" to any question on the IMMS is a subject of the audit. Any "yes" response is deemed an urgent evaluation. Sixty persons a month are audited and Corizon reports that 96% of persons audited are evaluated within 24 hours. A diabetic audit by DPSCS showed that on average for 20 persons with diabetes, their intake physical assessment occurred within 7.23 hours with the longest wait being 12.51 hours. The Monitor evaluation of medical records shows continued adequate quality of provider evaluations.

**Recommendations:**

1. Include record reviews of provider quality of intake assessments and demonstrate how these verify compliance.

**Settlement Agreement Statement: 17.c.** *The Commissioner shall ensure that any plaintiff who is identified during intake screening as currently prescribed psychotropic medication (unless he or she receives a bridge order as provided in paragraph 25.b.) or as having an urgent mental health need, including a suicide risk, shall receive a mental health evaluation by a Mental Health Practitioner within 24 hours of the intake screening, or sooner if clinically indicated.*

**Compliance Rating:** This is a mental health issue not evaluated by the Medical Monitor.

**Findings:** None

**Recommendations:** None

**Settlement Agreement Statement: 17.d.** *To address the needs of plaintiffs who, prior to being taken into custody, were prescribed medication that, if interrupted, would pose a risk of adversely affecting health, the Commissioner shall promulgate and implement policy and procedure to ensure that such plaintiffs receive such medications within 24 hours of the intake screening or subsequent encounter at which the plaintiff first reports such medications to a Medical Professional or Mental Health Professional, or sooner if clinically indicated, unless: (i) a Clinician determines that such continuation is not medically appropriate, including without limitation a determination that continuation is not medically appropriate pending verification of the reported prescription, provided that appropriate verification efforts shall be promptly undertaken; or (ii) despite reasonable efforts consistent with the gravity of the need for the medication, DPDS is unable to timely obtain the medication. The Commissioner shall promulgate and implement policy and procedure requiring reasonable efforts, consistent with the gravity of the need for the medication, to ensure that such plaintiffs are timely provided with the medication or a pharmaceutical equivalent.*

**Compliance Rating:** Partial Compliance

**Findings:**

DPSCS does not assert compliance on this item. The DPSCS policy<sup>19</sup> is clear.

Regardless of the outcome of verification attempts, the medical mid-level/provider will be responsible for identifying and maintaining the arrestee on the pre-incarceration treatment regimens as reported by an arrestee or a pharmacologically equivalent substitute for medical and mental health conditions whenever possible, i.e., the clinician can identify the need for those treatment regimens.

This is consistent with requirements of the Settlement Agreement.

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<sup>19</sup> DPSCS Medical Evaluations Manual, Chapter 1 Medical Intake, Section A Initial Medical and Mental Health Screening (IMMS) Part 1

For 17d, DPSCS will have to show:

- A provider must perform an evaluation of the patient's medication as identified at intake.
- There needs to be a timely order for necessary medications.
- The patient *begins* receiving ordered medications within 24 hours.

The Corizon audit only questions whether the patient received a first dose of medication, but the patient must receive more than the first dose to ensure that continuity of medication is verified. Receiving only the first dose of medication would not ensure that the medication continues into the jail. For that reason, the Monitor asked that DPSCS verify that the medication continue into the housing unit assigned after intake. This could be verified using the first monthly medication administration record.

The problem in verifying that the first dose or subsequent doses of medication are given has consistently been an inability to find medication administration records. The first dose of medication was verified as given only 62% of the time and the first month of medication was not verified at all. A medication administration record was found only 69% of the time. There were instances where the medication record did not reflect the ordered medication that the patient was on. Provider orders do not give specific detail on when medications are to be started which presents difficulties in determining when to judge timeliness. All of these issues reflect process problems which are not yet corrected.

Two recommendations were given in the last report. The first recommendation to perform a root cause analysis of the medication process was only done for intake. The root cause determined that staff did not have standardized training on administration of medication in intake; that there is not a standardized process in place and there is not a specific assigned person for administration of medication in intake. No corrective action(s) have been identified yet as a result of the root cause analysis. No follow up was undertaken to ensure that corrective actions have had an effect. This recommendation is incomplete until corrective actions correct the process. Also, medication practices outside of intake were not studied. An analysis of the entire medication process will likely identify problems that affect intake. The Monitor also recommended considering an automated medication cabinet in the intake area which would at least address the first dose of medication. This has not been done.

#### **Recommendations:**

1. Perform a root cause analysis of the medication process to include intake to identify defective processes and develop corrective actions.
2. Consider placement of an automated medication cabinet in the intake area.

**Settlement Agreement Statement: 17.e.** *The intake screening, any physical or mental health assessment, and any decision regarding the continuation or non-continuation of reported prescription medication shall be documented in the plaintiff's medical record. If a medication is not continued, the clinical justification for that decision shall be documented in the plaintiff's medical record.*

**Compliance Rating:** Partial Compliance

**Findings:** DPSCS policy adequately addresses this item. DPSCS did not assert compliance with this item. To verify this item, DPSCS will need to show the following:

1. The IMMS is in the EPHR.

2. The physical health assessment and mental health assessment are present in the EPHR.
3. Any decision regarding medication continuation or discontinuation is documented in the EPHR.

DPSCS does not provide data for this item in their report. Corizon provided results of an audit for this item but the audit did not include whether physical and mental health assessments were present in the EPHR. The IMMS was found in the EPHR from 61-94% of the time. The eligible population for the audit assessing documentation of medication was those inmates who reported on the IMMS that they were taking medication prescribed by a physician in the community. If there was an order for this medication, the item was found compliant. However, as documented in the prior report, few inmates who were taking medications or needed medications were actually identified in the IMMS. Most medications were identified in the provider initial history and physical examination. The order for medication was compared against the nursing history and not the provider history. Corizon noted that 100% of records audited showed a provider order for medications identified by nursing. This does not verify that all medications that the patient was actually on, but not identified by nursing, were ordered and it does not verify that there was documentation in the record for any discontinuation of medication by the provider. These items need to be verified for compliance. The eligible population for this audit should be modified to a population of inmates identified by providers as needing medication for a chronic medical condition. This should be done until nurses appropriately identify medications.

Three recommendations were given in the last report. DPSCS provided no evidence that recommendation one to provide an interface that opens the electronic record when the inmate is “scanned in” to the jail was addressed. Recommendation two was to perform a root cause analysis regarding why a medication order doesn’t result in a medication administration record and why nurses fail to document medications of the patient. An analysis was done regarding why a first dose of medication was not provided within 24 hours but did not specifically address why medication orders don’t result in a medication administration record. That root cause determined that adequate policy and procedure was not in place and staff have not received appropriate training. A corrective action is not yet in place. The third recommendation was to include in the root cause analysis, why nurses failed to identify patient medications during the IMMS encounter. This was addressed in section 17a of this report.

### **Recommendations:**

1. Develop an interface so that when a patient is “scanned in”, an electronic medical record is opened which would eliminate the need to use the IMMS in OCMS.
2. Perform a root cause analysis to determine why medication orders are not resulting in a medication administration record.
3. Include in the intake root cause analysis identification of why nurses fail to document medications of the patient.

## **18: MEDICAL PLAN OF CARE**

**Provision 18 Compliance:** Partial Compliance

**Settlement Agreement Statement: 18.a.** *For purposes of this Settlement Agreement, a “Plan of Care” is a combined summary, evidenced by Clinician documentation in the medical record that includes: (a) a summary listing of major medical problems; and (b) a plan for treatment of such identified major medical problems, including, as applicable, medications, testing, records of past periodic chronic care appointments and access to orders for future periodic chronic care appointments, and access to orders*



*for specialist referral. The Plan of Care shall be documented in the EMR. In the EMR existing as of the Effective Date, the Plan of Care shall be documented utilizing the Chart Summary template.*

**Compliance Rating:** Partial Compliance

**Findings:**

This provision requires the following.

- All problems are documented at patient care visits. An accurate list of problems needs to be present in the problem list and in the assessment of every note.
- The history should include review of past care to update the status of the patient's plan of care as well as details of the status of each patient problem.
- There should be a plan for every problem to include medications, tests, future follow up appointments, scheduling of any referrals for specialty care or diagnostic testing, and updating of pending specialty appointments.

For this report, DPSCS did two audits. One audit was an audit conducted each month over the six-month period. This 41-record audit was based on a chart selection of persons hospitalized. The intention was to select admissions consistent with prevention quality indicators<sup>20</sup> but it appeared that only two of the 41 records selected would have qualified as records consistent with prevention quality indicators. Chart selection was therefore inappropriate and some records either had no chronic care problems or the problems were not serious and the reason for admission was inconsistent with the prevention quality indicators (e.g. trauma, erroneous lab result, etc.). The 41-record audit asked nine questions but the nine questions do not address all requirements of provision 18 of the Settlement Agreement. For example, one person with diabetes, hypertension, high blood lipids, and asthma had complications of his diabetes (retinopathy and vascular disease of the lower extremities) which were unrecognized about a month. His blood glucose was not controlled for over a month. The plan of care did not include timely history of the diabetes complications or management of the patient's ongoing poor diabetes control. Point of care blood glucose values were not found in the EPHR consistent with DPSCS' comments in the Corizon report that nurses do not have sufficient devices to enter blood glucose and vital signs. As a result, blood sugar was not monitored and the patient remained out of control.<sup>21</sup> He was not sent to an ophthalmologist for his retinopathy until after he lost vision in one of his eyes and did not timely have his diabetic foot managed. Another patient had bladder carcinoma with prior treatment with a recommendation for follow up. However, the plan of care included no plan for how the bladder cancer would be followed up with an appropriate specialist. Another patient had a negative symptom screening for tuberculosis at intake. Also not noted during IMMS screening was that the patient was underweight; nursing staff did not inquire about weight loss. The patient was sent to a hospital on 11/4/21 at 9:30 am for an abnormal x-ray consistent with tuberculosis but nurses documented recording a negative TB skin test on 11/4/21 but there was no documentation in the electronic record when this procedure was initially done or read. It appeared that the TB skin test was read when the patient was at the hospital. The audit identified no problems related to these issues and failed to appropriately audit for provision 18 items.

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<sup>20</sup> Prevention Quality Indicators are hospital discharge diagnoses that identify admissions that might have been avoided through access to high quality outpatient care. The idea is to evaluate potentially preventable hospital admissions and flag quality problems that need further investigation and to evaluate the outpatient care provided.

<sup>21</sup> I was told that providers need to search for blood glucose results by finding the medication records on which nurses record blood sugar results. As a result, on records I reviewed, providers infrequently reviewed point of care blood glucose values when evaluating patients. The electronic record system was set up for nurses to enter blood sugar results in the EPHR but nurses perform point of care blood glucose testing in areas that do not have devices for entering the data so they enter the data on medication administration records.

This audit could be improved by different record selection. If hospitalized patients cannot be found to satisfy prevention quality indicator criteria, then more serious chronic disease records should be chosen. Also, the audit is not addressing fundamental issues such as:

1. Is the history appropriate for the condition of the patient?
2. Is the examination appropriate for the conditions of the patient?
3. Are timely referrals made that are necessary?
4. Is the plan of care appropriate for the conditions of the patient?
5. Do all chronic care conditions and on-going problems unrelated to chronic care conditions include an appropriate assessment and plan?
6. Are abnormal findings addressed?

Another audit was done on 20 patients with diabetes. The first chronic care visit after intake was on average 32.6 days with a range of one day to 146 days. With a median of 15.6 days. Three of 20 diabetics had a first chronic clinic visit over 90 days. DPSCS does not now track no-show rates making it difficult to assess this problem more thoroughly. The diabetic audit found that because there is no policy or procedure governing scheduling chronic care visits, scheduling is done ad hoc by a scheduler who may be unaware of the acuity of the patient. This should be corrected.

The plan of care for the 20 diabetic patients included an expectation that all would have laboratory tests based on standard of care for diabetes (chemistry panel, lipids, A1c, and urine albumin creatinine ratio). Chemistry panel and A1c tests were **ordered** 85% of the time; lipid profile 60% of the time; and albumin creatinine ratio 15% of the time. The urine for albumin creatinine ratio can be done later during incarceration as it needs to be done once a year. My suggestion is for the initial provider to ask when their last test was and to order tests accordingly. The more important problem is that these test results were **uploaded to the electronic record only approximately 50% of the time**. This is an ongoing defect that impairs the ability of providers to provide care and affects compliance with the plan of care provision.

The diabetic audit showed that all patients eventually had a chronic clinic visit. The expected history based on standard of care was to include type of diabetes, duration of diabetes, medications, complications, use of alcohol, and cardiovascular risks. This expected history was taken only 53.3% of the time and could be improved.

The diabetes audit found 26 problems with diabetes care that should be corrected. Some that were particularly problematic were:

- Nurses in intake fail to take a capillary blood sugar of persons with diabetes during intake screening.
- There is no written policy or guideline to standardize the chronic care schedule which should include a standardized methodology to schedule patients for their first chronic care visit based on acuity.
- Providers fail to consider obesity in the plan of care for persons with diabetes.
- Reasons for elevated A1c and mitigating strategies are not discussed in progress notes.
- Persons with mental health problems and diabetes did not result in interactions between mental health and medical providers to coordinate care.
- Poor health literacy was not addressed.
- Patient autonomy was not considered.

- Treatment decisions were not well documented.
- Use of inappropriate stand-alone sliding scale insulin should be addressed.
- Variability in documentation made information sharing difficult.
- Diabetic eye examinations and dental examinations were not routine and should be standardized.
- There was low frequency of ordering lipid and urine albumin-creatinine ratio tests.

The two audits that were done should be continued. The types of conditions audited can change from report to report. The monthly audits need improved record selection and focus more on the clinical aspects of a plan of care particularly with respect to requirements of provision 18. The diabetic audit was well done. That audit identified multiple deficiencies which if corrected would improve the program and accelerate the program toward compliance. DPSCS has not, to date, been able to take identified deficiencies, study them further, and take corrective action. The Monitor's suggestion to hire a process analyst and train staff on six-sigma methodology would promote the ability to develop these corrective actions. Since DPSCS is unwilling to do this, they will need to find other ways to address their deficiencies. Both audits should also look at outcomes and assess whether the processes being analyzed have an effect on the outcome of the patient's management.

#### **Recommendations:**

1. Emphasize in provider training that for every chronic care note, for every medical problem there is a history, pertinent examination, assessment and plan documented in the medical record.
2. Perform a greater number of record reviews than are now currently being done.

**Settlement Agreement Statement: 18.b.** *For purposes of this Settlement Agreement, an "Ongoing Condition" is a condition that requires ongoing care and that: (i) will not be resolved within a 30-day period; or (ii) constitutes a serious acute injury or illness that will require repeated follow-up (aside from routine medication administration) or has lasting significance for the plaintiff's future health care treatment. For those plaintiffs with one or more Ongoing Conditions, a Plan of Care shall be developed by one or more Clinicians, as appropriate, based on physical examination and the documented medical history of the plaintiff, as provided herein.*

**Compliance Rating:** Partial Compliance

#### **Findings:**

DPSCS does not assert compliance with this provision.

This provision requires:

1. A plan of care be developed for all chronic problems and acute problems that require repeated follow up. This is evidenced by an accurate problem list and listing of current active problems in each assessment and plan.
2. The plan of care requires adequate history and physical examination.

The monthly audits found that all patients had an updated problem list but did not assess whether the history or physical examination was appropriate.

The diabetes audit of history was described in 18.a, above. The audit also looked at examinations that are standard of care but which are often missed. These included height, weight, blood pressure, foot

examination, peripheral pulses, and microfilament testing. These tests in aggregate were performed 63% of the time with examinations of the feet and distal pulses done least frequently. These results need to be improved. This audit also found that the diabetes education was addressed in all individuals but hypertension was addressed only 45% of the time; obesity was addressed only 44% of the time; smoking was address only 31% of the time for persons who smoked; aspirin was prescribed 60% of the time for persons who qualified for this therapy; and a statin was prescribed 80% of the time for persons who warranted treatment.

### **Recommendations:**

1. Only physicians, physician assistants, and nurse practitioners should be authorized to make entries to the medical record problem list.
2. Physicians physician assistants, and nurse practitioners must maintain the problem list at every chronic illness encounter.
3. The electronic medical record should be capable of automatically providing the current problem list in each provider note.
4. A group of BCBIC physicians need to develop:
  - a. A standardized methodology to entering problems onto the problem list in the future state electronic record,
  - b. Where providers would want the problem list in their notes,'
  - c. How providers would add or subtract a problem, and
  - d. How temporary problems would be presented on the problem list.
5. This methodology needs to be included in requirements for the electronic record for the BCBIC implementation.

**Settlement Agreement Statement: 18.c.** *The Commissioner shall promulgate and implement policy and procedure to ensure that initial diagnosis and identification of Ongoing Conditions, along with any elements of a Plan of Care that do not require development at chronic care clinics or through specialist referral, shall be conducted and entered into the EMR within seven days of the plaintiff's admission, or sooner if clinically indicated.*

### **Compliance Rating:** Partial Compliance

### **Findings:**

This provision requires that serious medical conditions that are not chronic care problems must be addressed as soon as clinically indicated. These might include, as examples, detoxification, infections, trauma, orthopedic injuries, etc. Each of these problems should include the following.

- History of the problems.
- Examination pertinent to the problem.
- Assessment of the status of the patient.
- Plan to include follow up, medication, laboratory tests, diagnostic tests, and specialty referral as necessary.
- Follow up until the problem is resolved.

For this provision DPSCS states that they have an applicable policy.<sup>22</sup> This policy is applicable for intake evaluations but should be expanded to include ongoing conditions that are not identified in intake.

DPSCS does not assert compliance with this item. DPSCS did not specifically audit this provision.

**Recommendations:**

- 1 Continue record reviews including for those items that are not chronic care patients.

**Settlement Agreement Statement: 18.d.** *During this initial diagnosis and identification process, a Clinician shall order that the plaintiff be enrolled in any chronic care clinics that are clinically indicated and recommend any specialty care that is clinically indicated. Any elements of the Plan of Care developed as a result of enrollment in chronic care clinics or specialty care shall be entered promptly in the EMR.*

**Compliance Rating:** Partial compliance

**Findings:**

This provision requires the following.

1. All chronic problems be identified and result in enrollment and follow up in chronic care clinics.
2. Problems exceeding the training or capacity to manage onsite are referred to a specialist depending on the nature of the problem.
3. All chronic care is documented in the medical record consistent with documentation of the plan of care.
4. All referrals, status of scheduling specialty care, review of specialty care reports, and modification of the plan of care based on specialty care recommendations are documented in the medication record in the plan of care.
5. Specialty care and hospital reports are present in the medical record.

The monthly audits showed that 32 of 36 (89%) records reviewed showed that providers reviewed reports of specialty consultations that had occurred. The audit did not study whether patients who needed specialty care received it. The diabetes audit noted only 9 of 20 (45%) of persons were referred for a diabetic eye examination and only 2 of 20 (10%) were referred for a dental examination. These are standard of care referrals and should occur for all persons with diabetes. One person who was referred to a nephrologist had that referral denied. The audit prompted a re-review of the referral.

**Recommendations:**

1. Fix the chronic care list so that it accurately reflects appointments so that chronic care enrollment can be judged against appointments. An alternative method to verify enrollment in clinics can be developed.
2. Verify that specialty care referrals and follow up are documented in the medical record.
3. Provide an accurate specialty care log as recommended for provision 22.

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<sup>22</sup> DPSCS Medical Evaluations Manual; Chapter 1, Section B, Medical Intake Process: Part II

**Settlement Agreement Statement: 18.e.** *If an Ongoing Condition is diagnosed and identified after the initial diagnosis and identification, the Plan of Care shall be promptly updated or created, as appropriate, to reflect such new diagnosis and identification.*

**Compliance Rating:** Substantial Compliance

**Findings:**

The monthly audit found that all 26 patients with a new problem had the problem list updated. The Monitor did not verify these results.

**Recommendations:**

1. None

**Settlement Agreement Statement: 18.f.** *The Plan of Care shall be accessible to any Medical Professional or Mental Health Professional who is providing treatment, including diagnostic services, to a plaintiff, unless the need for emergency treatment precludes access at the plaintiff's location.*

**Compliance Rating:** Partial Compliance

**Findings:** Electronic record functions are still problematic and fail to adequately support the needs of clinical staff based on the Corizon report. Nurses don't have devices to enter all data into the record. The diabetes audit showed that ordered laboratory tests when completed were not uploaded to the electronic record approximately 50% of the time. The Monitor verified that this is the case on a record review of a patient with diabetes. Based on the same diabetes audit, providers submit multiple referrals for the same reason without knowing the status of prior referrals. One patient had six optometry and one ophthalmology consultations over eight months. Routine consultations by optometry and ophthalmology are not readily retrievable in the electronic record making it difficult for providers to know the status of their referrals. Tracking of specialty referrals is not occurring based on requirements in provision 22. The diabetes audit found discrepancies between the medication orders and what the patient actually received. All of these medical record issues make it difficult to develop an adequate plan of care.

**Recommendations:**

1. Ensure that a device survey is done prior to installation of the medical record to ensure that all staff have access to the electronic medical record.

## **MEDICATION MANAGEMENT AND TESTING**

**Provision 19 Compliance:** Noncompliance

**Settlement Agreement Statement: 19.a.** *The Commissioner shall promulgate and implement policy and procedure to ensure that, unless clinically contra-indicated, medications not intended only for short-term use shall be renewed without interruption. Such policy shall ensure that a plaintiff prescribed such*

*medication is seen by a Clinician in sufficient time before renewal would be required for the Clinician to determine whether such medication should be renewed. Nothing in this Settlement Agreement is intended to, or shall, interfere with the exercise of appropriate clinical judgment by a Clinician to prescribe, or not prescribe, any medication.*

**Compliance Rating:** Non-compliance

**Findings:** The DPSCS report does not assert compliance on this provision.

Staffing issues affected this provision and DPSCS' audit showed that medication records showed continuity of medication only 40-60% of the time. Two factors are necessary to verify this item. One is that necessary medication is continuously renewed. Another is that providers evaluate patients in the renewal process to determine if medication is still needed or should be adjusted.

By policy<sup>23</sup> medication is renewed at chronic clinic appointments and therefore, Corizon's audit has focused on establishing through the chronic care registry, whether medication was appropriately renewed at those clinic appointments. Corizon matches the 30-day medication renewal report to the chronic care registry to select a sample population. Corizon has had difficulty auditing because the current chronic care roster ineffectively tracks chronic care appointments causing patients to miss appointment which results in failure to renew medication.

However, in reality approximately 10% of health requests involve requests for renewal or refill of medication which indicates that there are processes other than scheduling chronic clinic visits that drive the refill and medication renewal process. Corizon and DPSCS should begin to consider an audit process once the new electronic medical record and electronic medication administration process are implemented. Ultimately, verification should be made through review of sequential medication administration records as compared to ordered medications.

Three recommendations were given in the last report. None of these recommendations was enacted.

**Recommendations:**

1. Perform a root cause analysis of the medication renewal process to identify deficiencies and to develop an improved process. As part of this root cause analysis, consider the health request process role in the medication renewal process.
2. Consider a stop-order medication renewal backup program to ensure medications are renewed until this item can be improved.
3. Fix the chronic care roster so that it accurately shows appointments or develop in the new electronic record a requirement to accurately show appointments and completed appointments for all appointments including chronic care.

**Settlement Agreement Statement: 19.b.** *Medication Administration Records ("MARS") shall be completed by RNs or LPNs. If medication is not administered to the intended plaintiff on a particular occasion, the MARS shall allow a determination whether the medication was refused by the plaintiff or*

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<sup>23</sup> DPSCS provided the Chronic Disease Management Manual, Chapter 1 Chronic Care Clinics, Section A General Procedures as the policy with respect to this provision. Thereby, renewal of medication is dependent on scheduling of chronic clinics.

*whether some other specified cause prevented administration. Any Medical Professional who makes entries in MARS shall document his or her entries as required by policy, including legibly signing entries, and noting the applicable professional licensure.*

**Compliance Rating:** Non-compliance

**Findings:** DPSCS does not assert compliance with this provision. This provision requires verification of several items including:

- That an LPN or RN administer medication.
- That the nurse document why a patient did not receive medication for all absent doses administered.
- That all entries be documented legibly with licensure noted and that documentation be based on policy requirements.

DPSCS did not present any data on this item in their report. The Corizon report presented data for only two months due to staffing issues. The staffing limitations were not specified. Data that was presented showed that between 30-40% of inmates could be verified as receiving medication with an average of 34%. The score was attributed to lack of proper MAR documentation and failure to appropriately discontinue medications for persons who have transferred. Medication administration record availability was a significant barrier to this audit and reflects a continued broken paper medication administration process. Policy<sup>24</sup> for this item stipulates that medications are to be recorded as administered on the medication administration record (MAR). However, because the interface between pharmacy and the EPHR is not operating as expected, the pharmacy is not informed of the current location of the inmate and MARs are often sent to the wrong unit. This results in a cascade of MAR issues including lost MARs, misplaced MARs, and MARs and medication being sent to the wrong housing units. Management has not provided sufficient support for staff to properly perform their work. Hopefully, when the new EPHR is implemented, this interface will be fixed. Notably, the DPSCS policy presumes that the MAR is accurate, is sent to the appropriate location, and is sent timely to the appropriate location. None of these assumptions is currently occurring.

Three of five recommendations given in the last report relate to obtaining a new electronic record with an electronic medication administration module. This is being delayed. The two remaining recommendations to perform a root cause analysis of medication management and to ensure that until an electronic medication record is implemented that clinicians receive a photocopy of the current medication administration record when they see patients. These have not yet been enacted.

**Recommendations:**

1. Obtain a new electronic medical record with electronic medication administration record capacity.
2. Perform a root cause analysis of all areas of medication management including why patient movement results in missing medication.
3. Perform an evaluation of OCMS to determine if an accurate location of the patient is being transmitted to the EPHR.

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<sup>24</sup> Pharmacy and Therapeutics Manual, Chapter 1, Medication Administration (Basics) is used as the policy governing this provision.



4. Establish a reliable interface between OCMS and the pharmacy.
5. Until a reliable eMAR is available, ensure that when clinicians see patients, a photocopy of the MAR is available for review. Since this should be in the paper record, it should already be part of DPSCS's requirements.

**Settlement Agreement Statement: 19.c.** *The Commissioner shall promulgate and implement policy and procedure to ensure that, when a Clinician orders that vital signs or blood sugar results be documented, the documentation occurs as ordered and that these records are reviewed by a Clinician according to appropriate policy.*

**Compliance Rating:** Non-compliance

**Findings:** DPSCS does not provide a status of this provision in their report and does not assert compliance. The Corizon report provides information about their ongoing audits of this provision. The four questions in the audit were as follows.

1. Vital signs completed and documented as ordered in EPHR.
2. Blood sugar tests completed and documented in EPHR as ordered.
3. Vital signs results documented as reviewed by clinician during patient encounter.
4. Blood sugar tests documented as reviewed by clinician during patient encounter.

The results remain poor. Blood sugar test results documented as reviewed was audited only three of six months. Blood sugar tests documented as ordered and completed was reviewed only two of six months.

Vital signs were completed as ordered approximately 41% of the time. Blood sugar tests were completed as ordered and then documented in the record only 12% of the time. Vital signs were reviewed by a clinician approximately 51% of the time. Blood sugar results were documented as reviewed approximately 89% but were only evaluated three of the six months. Space limitations and lack of computers were given as reasons for these poor scores. DPSCS was concerned that one of the recommendations involved asking for a device count which would increase the probability that all staff had access to a device to record data into the electronic record. Given that DPSCS' own findings are that there are insufficient devices, it is unclear why DPSCS should be concerned with such a recommendation.

Notably, a separate root cause evaluation of the detoxification process in intake started with the data that 50% of CIWA and COWs evaluations were not being documented in the record. A root cause analysis was performed regarding absence of these evaluations. Corrective actions were taken. Corizon reports that these evaluations related to CIWA and COWs are now performed at near 100%. Vital signs overall are still performed at a low rate.

Four recommendations were given in the last report but have not been addressed. One recommendation was to obtain a new electronic medical record which is occurring but is delayed. Interfaces with glucometers and vital sign equipment should be in place to ensure of blood glucose readings and vital sign readings are automatically updated to the electronic record. DPSCS has not provided information that the recommendation to perform a root cause analysis of the process of ordering, obtaining, and reviewing blood sugar and vital sign results has occurred. DPSCS has informed the Monitor that policy

governing this provision is the policy for chronic care clinics<sup>25</sup>. Implementation of the new electronic record is insufficiently progressed to know whether there will be automatic notification of providers of outstanding orders (labs and vital signs) that must be reviewed.

A review of diabetes care by DPSCS found that capillary blood glucose testing was documented as reviewed 75% of the time.

**Recommendations:**

1. Obtain a new electronic medical record and reassess.
2. Perform a root cause analysis of blood sugar and blood pressure ordering with respect to whether the order results in a reliable and functional nursing task list and the extent to which those orders result in the test being performed. This review should also include how a reviewing clinician knows that the prior clinician ordered blood pressure checks or blood glucose testing.
3. Review existing policies related to this provision.
4. The program should investigate whether the banner bar of the new electronic record can have a prompt that notifies that there are outstanding prior order results that need review. This notice or a similar type of notification specifically for provider records would improve scores dramatically.

**Settlement Agreement Statement: 19.d.** *The Commissioner may require plaintiffs who are prescribed medication that they are permitted to keep on their persons to initiate the process for refill of a prescription medication without having to first see a Medical Professional; provided, however, that DPDS shall have a process for expedited refills of keep-on-person medications that are prescribed for potentially urgent needs, such as rescue inhalers.*

**Compliance Rating:** Non-compliance

**Findings:** DPSCS has not asserted compliance for this provision. The audit should address the following questions:

1. Patients who are on keep-on-person (KOP) have a process for refill of their prescription medication.
2. The process of refill of medication includes an expedited process for refill of medication for urgent needs.

DPSCS requires by policy<sup>26</sup> that nitroglycerin, glucose tablets, and asthma inhalers are required to be provided as directly observed medications. Other medications, with multiple restrictions described in the policy, can be ordered as a keep-on-person (KOP) medication. DPSCS mentions medication refill in item II.J of the policy on sick call<sup>27</sup> which states that use of health requests can be used for non-sick call purposes including medication refill. However, the process of how this is to occur is not described in policy or procedure. If health requests are to be used for refill of medication, the procedure should be included in policy and procedure. Anecdotally, the current practice is that inmates remove a sticky label

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<sup>25</sup> Chronic Disease Management Manual, Chapter 1 Chronic Care Clinics, Section A General Procedures. This policy does not specifically address this provision but does state, “Targeted physical examination relevant to the chronic disease; abnormal clinical and laboratory test results documentation” is to be included in the documentation of the clinic visit.

<sup>26</sup> Pharmacy and Therapeutics Manual Chapter 4 Keep on Person and Direct Observation Therapy

<sup>27</sup> Sick Call Manual, Chapter 1 Sick Call

from their medication packet and place the sticky label on a health request and submit the health request to a nurse. This refill request is then submitted to pharmacy. For urgent medications, the nurse refills medication from a stock maintained by nurses. Nurses document refill of a medication using a “KOP stamp” that documents refill of medication. Use of this stamp is inconsistent and Corizon attributes the poor score for this provision to this problem. This practice is not described in procedure and may not be standardized but should be.

A root cause analysis of the medication administration process that includes the refill process has not been performed. It is possible, and perhaps even likely, that nurses send the health request with the sticky label to the pharmacy but the pharmacy sends the medication to the wrong unit because the sticky label has a previous patient location. This may result in failure to administer the medication because it is sent to the wrong location.

Corizon’s audit for routine KOP refills measures the outcome of whether there is a receipt on the MAR of delivery of KOP medication to patients for each KOP refill request received as a health request. The audit measures whether the patient receipt of medication is documented on the MAR for each refill request. The current score for this is 26%. DPSCS was unable to determine whether there was a lapse in medication between dates refills were received by the patient measured as the number of doses from last fill to the current fill. DPSCS was unable to track the last date the patient received medication. The pharmacy interface with the electronic medical record affects the ability of DPSCS to separate directly-observed orders from keep-on-person orders. Because medication administration records are inconsistently present, tracking month to month receipt of keep-on-person medication has been difficult to do. With respect to emergency medication refills given from stock, Corizon audits this by establishing that there is an inventory of emergency medications (inhalers, nitroglycerin, etc.) available at the time of review. The audit consists of confirming that the list of emergency medications is in stock in health units. However, this does not verify that patients who need a refill of an emergency medication actually received it. The Corizon audit states that emergency medication is available 98% of the time. As stated, this does not confirm that patients actually received the urgent medication timely.

Both 19a and 19d demonstrate a very broken medication renewal process. A root cause analysis should be performed to map out the medication renewal, distribution, and administration process to identify deficiencies that are causing these results. This analysis can address issues related to both 19a and 19d. This root cause analysis should describe the current process and contribute to establishing a clear standard.

Two recommendations were made. Recommendation 1 to obtain a new electronic record is delayed. The second recommendation has not yet been undertaken.

**Recommendations:**

1. Obtain a new electronic medical record and reassess.
2. Perform a root cause analysis on medication renewal in order to describe and improve the current process and to develop a standardized process of medication renewal that is effective.

**Settlement Agreement Statement: 19.e.** *The Commissioner shall promulgate and implement policy and procedure requiring a Clinician to respond to and document in a plaintiff’s medical record the results of any ordered tests. Such policy and procedure shall require that a Clinician:*

- a. *document review of critical or other serious abnormal values, and any actions taken as a result of that review, within 24 hours of the testing results becoming available, or sooner if clinically indicated, provided that review may be documented by a RN based on telephonic consultation with a Clinician;*
- b. *document review of all other ordered testing results within a reasonable timeframe.*

**Compliance Rating:** Non-compliance

**Findings:** DPSCS has not asserted compliance for this provision. The Corizon report provided an audit for this provision. The sample was selected from an EPHR report of abnormal and critical laboratory values.

Results were not good.

- For critical or abnormal test results, the provider was notified timely from 70-90% of the time.
- Patients were notified of abnormal laboratory results only 24% of the time.
- Providers documented a timely review of the laboratory result with follow up orders only 45% of the time.

For this provision and the following provision, Corizon ascribes these results to failure to maintain a lab log and the lack of a bidirectional feed from the laboratory vendor to the EPHR. Corizon notes a lack of a standardized procedure for notification to patients of abnormal test results. In record reviews I performed, I could sometimes not find the ordered laboratory results in the EPHR. Tests performed by the Department of Health are not included in the EPHR laboratory flow sheet.

There is no evidence that the four recommendations were completed.

**Recommendations:**

1. See recommendations for provision 19f below.

**Settlement Agreement Statement: 19.f.** *The Commissioner shall promulgate and implement policy and procedure to ensure that orders for laboratory testing, including but not limited to cultures of potential Methicillin-Resistant Staphylococcus aureus (“MRSA”) infections, are executed within timeframes consistent with the urgency of the test and the capacity of appropriately functioning laboratories to conduct such tests.*

**Compliance Rating:** Non-compliance

**Findings:** DPSCS has not asserted compliance for this provision. Corizon performed audits to verify the status of these provisions. Verification of these provisions require:

1. That ordered testing is executed in timeframes appropriate for the urgency of the test;
2. That the laboratory has capacity to perform testing;
3. That the medical record verifies review and documentation of critical or serious abnormal values within 24 hours; and

4. That routine laboratory tests are reviewed within a reasonable timeframe.

These results were said to include MRSA test results but the number of MRSA tests audited was not clarified. Results were not good.

- Test results and disposition were noted on the laboratory log 0% of the time throughout the entire six-month audit period. This demonstrates a lack of a standardized procedure to complete laboratory tests. If the lab log is not used for purposes of determining a schedule for lab tests, what is?
- Laboratory tests were completed within the timeframe in the order 63% of the time.
- A hard copy was uploaded to the EPHR within 48 hours 66% of the time.<sup>28</sup>

The fact that no orders are present on the laboratory log imply that a non-standardized roundabout process is in place. This implies that management is uncertain with respect to how laboratory tests are ordered and executed. The Corizon report notes that the laboratory log is incompletely maintained and that the bidirectional interface between the laboratory and the EPHR is defective. As a result of a defective interface laboratory results are sometimes printed and scanned in the EPHR. Current problems noted included scanning lab results according to the date of order not to the date that the laboratory tests were resulted. As a result of the defective interface, some labs are found in the laboratory section of the electronic record and some are printed and scanned as PDF files. This makes it difficult for staff using the record to know where a lab can be found. This is especially true because one has to know the date the lab tests was ordered or completed to find where it is. It isn't surprising that so few labs are reviewed. In my own review of records, I couldn't consistently find lab results. This process would also benefit from a root cause analysis so that the problems in this process can be more accurately identified.

There were four recommendations in the prior report. A new interface between the laboratory and the new electronic record is being developed by the medical record vendor. The other three recommendations have not been addressed.

#### **Recommendations:**

1. Fix the bidirectional interface between the laboratory and the electronic medical record.
2. Perform a root cause analysis of ordering of all types to identify an effective standardized process of ordering and ensuring that orders are effectively carried out.
3. Provide to the Monitor the critical laboratory result report showing all critical laboratory values prior to the next visit.
4. Evaluate whether the contract laboratory is in any way responsible for these poor results.

**Settlement Agreement Statement: 19.g.** *The Commissioner shall promulgate and implement policy and procedure that defines those blood sugar and vital sign readings that are sufficiently abnormal to require notification of the plaintiff's Clinician; ensure that such policy and procedure for notification is implemented in practice; and further ensure that Medical Professionals notified of such readings take appropriate medical measures in response.*

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<sup>28</sup> This audit question is an audit of a work-around due to the EPHR not providing accurate and timely laboratory results to providers which may be an issue in all of these audit questions.

**Compliance Rating:** Non-compliance

**Findings:** DPSCS has not asserted compliance for this provision. Corizon reports findings of an audit for this provision. The provision requires verification of several items including:

1. That policy promulgates appropriate blood sugar and vital sign monitoring guidelines with respect to notification of a provider;
2. That abnormal blood sugar and vital sign results are identified; and
3. That medical professionals take appropriate measures in response.

As noted in the last report, the DPSCS policy on hypertension and blood glucose testing creates requirements that are clinically inconsistent with current standards of care, confusing, or lack sufficient detail. This should be addressed as the policy drives practice. There is no evidence that this policy has been addressed.

There are six questions in the audit for this item.

1. There is an order *with parameters* when providers order vital signs or blood sugar results. This score was 52%.
2. There is documentation that the tests were performed based on the order. The score for blood glucose testing was only 15%. This metric was affected by limited space and computers in the towers which impair ability of staff to documents that the ordered test was completed. This speaks to the need for a device count prior to implementation of the electronic record.
3. Abnormal results are referred to a provider. The score for this item was 47%.
4. There is documentation of review by a clinician after referral from the nurse. This score was 78%
5. Blood sugar tests are reviewed by the provider. This score was 69% and was consistent with the DPSCS audit of diabetes care that found that blood sugar test results were documented as reviewed 75% of the time.
6. There is an abnormal A1c level > 9% and it is reviewed. This continued to occur 100% of the time.<sup>29</sup>

These are very poor results and indicate a significant problem with orders for clinical testing and follow up of results of testing. The fact that scores are so low in this area demonstrates a need to review the design of the process that is in place. Every aspect of this process should be looked at including:

1. There is a standardized policy when indicated (e.g. for when to notify a provider for an abnormal capillary blood glucose test or for an abnormal blood pressure)
2. Are tests really needed?
3. Are parameters appropriate and needed for all tests?
4. Every handoff in this process
  - a. provider to EPHR,
  - b. EPHR to lab,

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<sup>29</sup> I noted on record review that documentation of an elevated A1c level does not mean that the provider did anything about the abnormality. One patient had an A1c level of 13.1 which is very high. A follow up test was not done over the 4 remaining months of incarceration. Capillary blood glucose levels were not monitored and little was done to get the blood sugar under control.

- c. EPHR to lab log,
- d. lab to EPHR,
- e. how the order gets to the nurse or phlebotomist who is going to perform the test,
- f. nurse documentation of test result to EPHR,
- g. physician knowledge of whether a test or lab result is ready for review, and
- h. physician documentation of test result and implication for clinical care.

Because the results are so poor, it is likely that there are significant system issues that may be multifactorial.

Corizon did identify several root causes for poor results. These were space limitations that limited nursing ability to obtain vital signs. This may be a real problem that should be addressed. Also identified were the lack of devices to record vital signs which may also be an issue. There should be enough devices for the anticipated number of simultaneous users. Given the results in this area, there are likely additional systemic issues that affect scoring in this area, and I urge the program to correct the space and device issues but continue to seek other system design problems with this process.

Four recommendations were given in the last report. For recommendations one and three, DPSCS states that Corizon and DPSCS have worked to modify thresholds for reporting abnormal vital signs and blood glucose levels, but no modified procedure has been provided in their report. Recommendations two and four were not undertaken.

#### **Recommendations:**

1. Standardize thresholds for nurses to notify providers for both blood pressure values and blood glucose values allowing for modifications as needed.
2. Fix medical record issues so that reportable results are queued to the responsible physician.
3. Review and revise, as indicated, the hypertension and diabetes policies to be consistent with contemporary standards and to improve effectiveness of clinical care.
4. Perform a root cause analysis on the process of blood glucose testing and blood pressure checks to develop an improved system that supports clinical needs.

### **INTERACTION BETWEEN MEDICAL AND CUSTODY**

**Provision 20 Compliance:** Partial Compliance

**Settlement Agreement Statement: 20.a.** *The Commissioner shall promulgate and implement policy and procedure for coordination between custody and medical staff to ensure that custody staff transport plaintiffs to emergency and scheduled internal and off-site appointments with Medical Professionals and Mental Health Professionals, for other specialty appointments, and for medical tests. Such policy and procedures shall also be promulgated and implemented ensuring timely rescheduling of missed appointments.*

**Compliance Rating:** Partial Compliance

**Findings:** DPSCS has not asserted compliance for this issue. This issue requires the following.

1. That there is policy describing coordination between custody and medical staff regarding medical appointments;
2. That **all** appointments, onsite, offsite, emergency and routine for all types of appointments are scheduled and transported to their appointment.
3. That persons who miss their appointment are timely rescheduled.

The policies<sup>30</sup> provided to me as pertinent to this provision did not address all scheduled appointments. The Interagency policy which addresses sick call describes coordination between custody and medical<sup>31</sup> which is appropriate. The DPSCS Interagency Policy on sick call states in item 13 under responsibilities of the medical staff,

“The Office of Clinical Services will coordinate obtaining all scheduling data after clinics have been concluded and summarize these data to show: the number of appointments scheduled; the number of patients who showed up and were seen for their appointments; the number of patients who were not seen; and the reasons for not showing up for those not seen. These summary data shall be presented [and] maintained on a monthly basis and provided quarterly to the quality improvement program”.

Corizon’s audit for this provision only evaluates emergency visits and offsite and onsite specialty visits. It appears that a multitude of scheduled interactions between medical and inmates are not tracked as required in the interagency agreement. ***Any and all*** scheduled appointments need to be included.

This includes as examples:

- Medical health requests including face-to-face encounters,
- Dental health requests,
- Mental health requests,
- All other dental appointments,
- All other mental health appointments,
- Nurse follow ups, dressing changes, etc.
- All types of provider visits,
- Phlebotomy for laboratory tests,
- Internal specialty care consultations,
- Off-site testing and specialty consultations
- Emergency room visits.
- Vital sign assessments
- CIWA and COWs evaluations

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<sup>30</sup> 1) Corizon Health Utilization Management Manual 2017. This utilization manual does not address scheduling processes at BCBIC. 2) DPSCS Directive Number DPDS 110.0007 Urgent and Emergent Medical Transport. This policy addresses movement of inmates for emergencies but not for routine scheduled appointments. 3) DPSCS Medical Evaluations Manual Chapter 4 Emergency Services, Section A Emergency Services. This policy addresses only emergency transportation. 4) DPSCS Sick Call Manual, Chapter 1 Sick Call. Aside from the statement that the sick call schedule is to be provided to ACOM (custody?) a week prior to start of any month and the schedule must be published no later than 5 days before the first day of the month. This fails to address sick call slips which must be scheduled within 24 hours of receipt.

<sup>31</sup> Interagency Agreement between Corizon Health and Maryland Department of Pre-Trial and Detention Services Baltimore Central Booking and Intake Center (BCBIC) in accordance with the Duvall Settlement Agreement Provision 20, Interaction Between Medical and Custody and Provision 23 Sick Call, July 2019



For this visit, the DPSCS and Corizon reports failed to include any tracking data of onsite medical appointments other than specialty care. DPSCS reports that onsite and offsite specialty care and transfers to emergency rooms are completed 98% of the time but this fails to account for the majority of scheduled appointments.

DPSCS has not yet standardized the scheduling process and aside from the Interagency Agreement there is no policy or procedure for this except for emergency events.

*All* routine encounters between inmates and medical staff need to be scheduled and tracked. What needs to be provided is a table showing all scheduled appointments by type of visit. The table should be a monthly table made up of aggregated data. The audit used by DPSCS for verification is far from expectations of the Settlement Agreement as it only evaluates emergency visits and onsite and offsite specialty care and is therefore still noncompliant.

Four recommendations were given in the last report. The first three recommendations were not addressed. The 4<sup>th</sup> recommendation was to provide policy on this provision. The policies provided either were not pertinent or applied only to emergency events. The scheduling process present in the Interagency Agreement on sick call<sup>32</sup> is adequate if applied to all routine medical events including those in the list above and needs to be established in a DPSCS procedure.

#### **Recommendations:**

1. Maintain a tracking log of **all onsite** appointments to include:
  - a. Appointment date,
  - b. Whether the patient shows up and is seen for the appointment, and
  - c. If the patient doesn't show up why the patient didn't show up.
  - d. Reschedule date if the patient was a no show with show or no show and reason for no show. Repeat this until appointment completed.
2. Perform a root cause analysis of scheduling so that a standardized process can be developed to schedule and track all appointments.
3. Standardize the scheduling process.
4. Provide the policies relevant to this provision.

**Settlement Agreement Statement: 20.b.** *The Commissioner shall promulgate and implement policy and procedure to ensure that when Medical Professionals or Mental Health Professionals direct medical accommodations (such as bottom bunk placement, access to a cane or crutches, specialized housing for medical or mental health purposes, or for purposes of protection from exposure to excessive heat), custody staff follow such directives. In the event that custody staff have concerns about the security implications of a particular medical accommodation, a mechanism shall exist to resolve such concerns promptly in a manner that does not threaten the health or safety of the plaintiff whose accommodation is at issue.*

**Compliance Rating:** Partial Compliance

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<sup>32</sup> Interagency Agreement between Corizon Health and Maryland Department of Pre-Trial Detention Services Baltimore Central Booking and Intake Center (BCBIC) in accordance with the Duvall Settlement Agreement Provision 20: Interaction Between Medical and Custody and Provision 23: Sick Call.

**Findings:** DPSCS does not assert compliance for this provision. Policy for this provision is appropriate but does not include specific details of how the policy is to be carried out in BCBIC including in the sallyport. The Corizon report does provide data for this provision. Corizon audited this provision. The audit includes the following questions.

1. There is an order in the EPHR for any ADA accommodation. The score for this was in the 90% range.
2. There is a completed transfer of housing form in the EPHR. The score for this was 100%.
3. Detainees are housed in designated ADA housing. Scores for this audit question range from 70% to approximately 90% and is about the same as the last reporting period.
4. There is a signed receipt for durable medical equipment. Scores for this were 73%.

These data are still not compliant. Corizon notes that the DME receipt is a paper form that is not always located or present. Corizon is working with the electronic medical record vendor to ensure that receipt of durable medical equipment is able to be captured electronically. The Monitor suggested that for persons on specific ADA tiers, DPSCS may use the ADA coordinators to verify receipt of supplies and equipment. However, that would not capture persons in general population who have a cane or crutch and would not capture low bunk accommodations. Equipment ordered for those in general population still need to have receipt of their equipment verified. In my own record reviews even when patients received a piece of durable medical equipment there is not always an order for that equipment. This calls out the standardized procedure for provision of these devices. Also, the orders for specialized medical housing that go to custody are written on paper forms. This will result in lost paper and result in mistakes and makes it extremely difficult to evaluate. Also, the information is not available on the medical record. As with a few other provisions, a root cause process analysis of the ordering process should be performed, hopefully prior to the implementation of the new electronic medical record.

There were two recommendations in the prior report. The first recommendation given in the last report related to the new electronic medical record. The 2<sup>nd</sup> recommendation was addressed by a review<sup>33</sup> for the prior report which identified the paper processes to order durable medical equipment and housing, and to identify ADA status to the ADA nurse and custody officer. This audit confirmed that nurses and providers did not have similar ADA findings in their evaluations 37% of the time. DME forms were signed by inmates 88% of the time. The audit which was equivalent to a root cause analysis identified lack of electronic record features to integrate or flag pending tasks related to a person with disabilities to better inform providers and nurses caring for the patient. There was missing forms and other paper when patients transferred from one unit to another. Paper forms were not easily accessible. DME and other forms not completed in intake are completed by the ADA nurse meaning that the intake procedures are not standardized or are not completed as expected. There was no monitoring of this process by supervisory personnel or feedback to line-staff nursing. Old forms were still in use. Multiple other problems were identified. Corrective actions related to this review have still not been developed. Identification of problems is only the first part of the root cause analysis. Taking corrective action to fix deficiencies must be done in follow up.

### **Recommendations:**

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<sup>33</sup> An ADA review by Dr. Abebe

1. Fix the order system in the electronic record so that orders for accommodation can be written into the electronic record. Also arrange that delivery of the ordered accommodation to the inmate is tracked in the electronic record so that this data is obtainable in an audit.
2. Based on the process analysis done on the ADA population develop corrective actions to improve the process.
3. The eligible population for the audit needs to include detainees not just on the ADA log but all detainees who are eligible to receive an accommodation.

**Settlement Agreement Statement: 20.c.** *The Commissioner shall ensure that Medical Professionals and Mental Health Professionals have access to current plaintiff location information for all plaintiffs on at least a daily basis.*

**Compliance Rating:** Substantial Compliance

**Findings:** This provision was verified in a prior visit. Paper lists of all inmates with their current housing data were available in health care areas. DPSCS was in process of training all staff to have access to the custody database (OCMS) so that they could look up a current location. I questioned multiple staff who were able to demonstrate how to do this.

**Recommendations:**

1. None

**Settlement Agreement Statement: 20.d.** *The Commissioner shall promulgate and implement policy and procedure to ensure coordination between custody staff and Medical Professionals when scheduling sick call and medication administration.*

**Compliance Rating:** Partial Compliance

**Findings:** DPSCS does not claim compliance on this item. Policies for this item are the interagency agreements with respect to medication administration and sick call which have been completed.<sup>34</sup> These interagency agreements are adequate.

Corizon documented in their report that 20d is audited in conjunction with provision 23. DPSCS, for provision 23, provided a spreadsheet listing all sick call requests, the hour they were received and the date when they were seen. From this, the Monitor was able to do a work-around to verify that people were timely seen. However, DPSCS provided no data to verify that there is coordination between custody and medical with respect to medication administration. Because there is no verification of coordination with respect to medication administration, this item remains partially compliant. The Monitor had recommended that DPSCS develop a method to verify medication administration consistent with the interagency agreement. This has not occurred. The Monitor changed recommendation four to

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<sup>34</sup> Interagency Agreement between Corizon Health and Maryland Division of Pretrial Detention and Services Baltimore Central Booking and Intake Center (BCBIC) for Conducting Medication Administration in accordance with the Duvall Settlement Agreement; Provision 20: Interaction Between Medical and Custody and Provision 19: Medication Management and Testing and Interagency Agreement between Corizon Health and Maryland Department of Pre-Trial and Detention Services Baltimore Central Booking and Intake Center (BCBIC) in accordance with the Duvall Settlement Agreement Provision 20, Interaction Between Medical and Custody and Provision 23 Sick Call, July 2019

a more specific recommendation since DPSCS has not developed their own method to verify compliance.

The four recommendations in the last report were not addressed. The Monitor used a work-around to verify sick call.

**Recommendations:**

1. Verify that the interagency agreement procedure for medication administration is being followed.
2. Verification of adherence to the sick call procedure can be verified by show rates to sick calls for the various discipline.
3. Ensure that sick call for all disciplines are tracked and reported similar to provision 20a.
4. Using the required steps for medication administration for both custody and nursing staff as represented in the interagency agreement, develop a checklist of required steps. A custody and nursing supervisory staff should monthly audit medication administration of one nurse's medication rounds and ensure that all steps are completed as required in accordance with the interagency agreement. A different nurse and jail location should be chosen every month to ensure that all areas and shifts are audited consecutively.

**Settlement Agreement Statement: 20.e.** *The Commissioner shall promulgate and implement policy and procedure to ensure that plaintiffs classified as H1 are housed in temperature-controlled housing, to the extent sufficient temperature controlled housing is available, from May 1 through September 30. Temperature-controlled housing includes those housing units of BCBIC, WDC, JI Dorms 600 and 700, and such other facilities as the parties agree constitute temperature-controlled housing because such units reliably control temperature to less than 88° Fahrenheit.*

**Compliance Rating:** Substantial Compliance

**Findings:** All parts of the jail are now air conditioned and therefore this provision is no longer pertinent to current conditions.

**Recommendations:**

1. None

**Settlement Agreement Statement: 20.f.** *In the event that the temperature control system of a housing unit used for H1 plaintiffs fails to maintain the temperature below 88° Fahrenheit, the Commissioner shall, to the extent possible and safe, transfer such H1 plaintiffs to other H1 housing. If insufficient H1 housing is available, appropriate Clinicians shall determine which H1 plaintiffs are priorities for transfer to the available H1 housing. Respite in air-conditioned areas shall be provided for such plaintiffs, as well as other plaintiffs as required pursuant to Maryland Division of Pretrial Services, Directive 185.008 (2009).*

**Compliance Rating:** Substantial Compliance

**Findings:** All parts of the jail are now air conditioned and therefore this provision is no longer pertinent to current conditions

**Recommendations:**

**Settlement Agreement Statement: 20.g.** *In the event that any housing unit designated as temperature controlled fails to reliably control temperature to less than 88 °Fahrenheit while plaintiffs designated as HI are housed there, such housing unit shall no longer be considered temperature-controlled housing for purposes of this Settlement Agreement until the Commissioner provides evidence that such housing can now be expected to reliably control temperature to less than 88° Fahrenheit under comparable conditions in the future.*

**Compliance Rating:** Substantial Compliance

**Findings:** All parts of the jail are now air conditioned and therefore this provision is no longer pertinent to current conditions

**Recommendations:**

**ACCOMMODATION FOR PLAINTIFFS WITH DISABILITIES**

**Provision 21 Compliance:** Partial Compliance

**Settlement Agreement Statement: 21.a.** *The Commissioner shall promulgate and implement policy and procedure ensuring the timely delivery of necessary medical supplies to plaintiffs with disabilities. The Commissioner shall promulgate and implement policy and procedure to ensure that plaintiffs with disabilities that require special accommodations are housed in locations that provide those accommodations, including, as applicable, toilets that can be used without staff assistance, accessible showers, and areas providing appropriate privacy and sanitation for bowel disimpaction.*

**Compliance Rating:** Partial Compliance

**Findings:** DPSCS does not assert compliance on this item.

DPSCS has completed renovations at the jail to augment the number of ADA beds. Two cells in each tier of multiple units<sup>35</sup> were converted to accommodate ADA needs by installing a wider door and ADA toilet. An ADA shower was placed in the group shower area. Also, dormitory style tiers<sup>36</sup> were renovated to include one ADA toilet and shower in the community shower area. ADA inmates can be housed in any of these locations. The COVID pandemic has made housing for ADA patients more challenging.

The Corizon report addresses this provision with an audit. How the sample audit population was derived was not defined in the report but was said to include all inmates with a disability accommodation and who required issuance or continued durable medical equipment or supplies. There were seven questions in the audit including the following.

1. There is an order in EPHR for medical supplies. Scores for this item averaged 96%.

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<sup>35</sup> 3 North A & B; 4 North A & B; 5 North A & B; 4 South A & B; 3-4 Center A & B.

<sup>36</sup> 3, 4, and 5 South A & B

2. There is a copy of a disability assessment form in the EPHR. Scores for this item were over 90%.
3. There is a copy of a signed receipt for medical supplies. Scores for this item averaged 73% with a low monthly score of 40%.
4. Initial supplies were provided within 12-24 hours of the order. Scores for this item declined to 61%.
5. Subsequent supplies were provided consistent with protocol. Scores for this item declined to 67%.
6. There is a transfer of housing form in the EPHR. Scores for this item were 91%.
7. Detainees listed on the ADA log are housed in designated areas. Scores for this item ranged from 40-60%.

When IDOC asserts compliance, a physical inspection of the ADA housing units will need to be done to ensure that ADA accommodations are present.

Four recommendations were given in the last report. DPSCS has not reported whether the new electronic record will include requirements include in recommendations 1 and 3. That will not be able to be verified until the electronic record is implemented. Recommendation 2 was addressed for the last report by a very good study of ADA patients based on record reviews. Deficiencies in that report have not resulted in corrective actions and other processes regarding ordering, fulfilling orders, and housing ADA patients are still defective. For that reason, DPSCS should initiate the root cause analysis and develop corrective actions until the process issues are resolved.

The audits show a partial compliance rating is still warranted.

#### **Recommendations:**

1. Fix the electronic record so it can document receipt of ordered supplies or develop a paper system that tracks this information based on orders in the electronic medical record. Ensure that the receipt of ordered supplies can be easily located in the electronic and/or paper medical record so that providers and nurses can check if the patient has received ordered supplies.
2. Record reviews being done for provision 18 should include a group of persons on the ADA unit who need supplies. Those record reviews should attempt to identify why the intake assessments are not identifying ADA needs and where there are opportunities for improvement. Results of these reviews should result in revisiting the intake procedure and in development of a standardized procedure to ensure ADA patients receive appropriate intake assessment and receive appropriate orders for supplies.
3. For the new electronic record, improve the intake screening form and provider screens to include identification of durable medical equipment and ordering specialized medical housing.
4. This provision has moved to partial compliance, but I have concerns regarding timeliness of provision of DME and appropriate housing of ADA patients. For the next visit a root cause analysis of these items should be performed and corrective action taken.

**Settlement Agreement Statement: 21.b.** *A staff member with appropriate training shall be designated to address concerns of plaintiffs with disabilities regarding accommodations for their disabilities and to assist in the resolution of any security issues that may threaten provision of necessary accommodations.*

**Compliance Rating:** Substantial Compliance

**Findings:** DPSCS asserts continued compliance for this provision. This provision has been compliant for more than two visits.

**Recommendations:**

1. None

**Settlement Agreement Statement: 21.c.** *Plaintiffs with disabilities shall be provided with access to specialized medical services, such as dentists, mental health treatment, and offsite medical specialist treatment, on the same basis as plaintiffs without disabilities.*

**Compliance Rating:** Partial Compliance

**Findings:** DPSCS does not claim compliance on this provision. This provision requires DPSCS to verify the following:

1. That patients with disabilities have access to medical, dental, mental health, and offsite specialty services as shown by show rates at appointment schedules and have access to specialty care as necessary.
2. That onsite services have rooms that are ADA appropriate with respect to being able to enter and navigate the treatment room in a wheelchair and that examination tables are available to accommodate the person with disabilities.

DPSCS has installed examination tables that will accommodate disabled persons. I viewed these during my last visit and DPSCS has sent videos of these table in their location. These are adequate.

The table on page 35 of the Corizon report states that detainees with appointments for sick call, chronic illness, dental, mental health, and specialty care were documented as having an encounter 95% of the time but rescheduled appointments were completed 67% but there were few patients with rescheduled appointments. The numbers of appointments was not provided.

In the last report, I asked DPSCS to report scheduled appointments for this provision to be reported in the same manner as with 20a. This was not done and the provision remains partially compliant. Of particular concern was access of persons with disabilities to specialty care. The DPSCS audit does not address that concern. The prior report explains this problem in detail.

Two recommendations were given in the prior report. Neither recommendation was addressed. A previous ADA record review by DPSCS identified numerous problems which have yet resulted in corrective actions.

The second recommendation to present scheduling for ADA patients in the same format as requested in provision 20a was not done.

**Recommendations:**

1. Correct access to specialty care for disabled individuals.

2. Present scheduling data for ADA patients in the same format as requested in provision 20a.

**Settlement Agreement Statement: 21.d.** *The Commissioner shall promulgate and implement policy and procedure to use a vehicle with adaptations to make it suitable for the safe transportation of persons with mobility-related disabilities to transport plaintiffs with such disabilities, unless such vehicle is not available in an emergency situation.*

**Compliance Rating:** Substantial Compliance

**Findings:** There has been no change to this provision and DPSCS remains in substantial compliance.

**Recommendations:**

1. None

### **SPECIALTY CARE/CONSULTATION**

**Specialty Care Compliance:** Noncompliance

**Settlement Agreement Statement: 22.a.** *The Commissioner shall promulgate and implement policy and procedure to ensure timely review of requests for routine, urgent and emergency specialty care.*

**Compliance Rating:** Partial Compliance

**Findings:**

DPSCS has a policy<sup>37</sup> on consultation that stipulates that the vendor is to abide by the DPSCS Utilization Management Protocol and Procedure Manual. I have not been able to verify that this policy is implemented and neither DPSCS nor Corizon provide evidence that it is being followed. I was told that DPSCS and Corizon are meeting to revise the current specialty care policy and procedure. A draft policy has not been provided to the Monitor. Corizon's own data shows that 65% of referral forms are completed in their entirety. None are processed in a timely manner. 100% of referrals are scheduled timely after they are approved. For the two months having referrals with alternative treatment plans, none were noted and followed up. 99% of the time the provider reviewed the consultation report<sup>38</sup>. Only 52% of reports were signed as reviewed and uploaded into the electronic record. The average of these scores was 60%. The audit failed to address concerns with specialty care identified by the Monitor in the last report. These concerns apparently are being addressed in joint meetings between DPSCS and Corizon to reformulate a specialty care policy and procedure.

One recommendation was given related to this item in the prior report and it was not addressed.

**Recommendations:**

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<sup>37</sup> DPSCS Medical Evaluations Manual; Chapter 5 Consultations

<sup>38</sup> Notably in the monthly audits performed for provision 18, the DPSCS auditor found that 22/26 (85%) of consultation records were documented as reviewed by providers.



1. Policy requires that the Regional Medical Director document UM decisions in the medical record.<sup>39</sup> Practice<sup>40</sup> requires the facility physician to document decisions of the corporate UM reviewer which in my opinion is inappropriate. The UM physician should document their own decision. The facility physician should not be responsible for documenting the UM physician's decision.

**Settlement Agreement Statement: 22.b.** *Such policy and procedure shall provide that plaintiffs are referred to specialists as medically necessary and that the process for review and approval of specialty consultations does not take more than 48 hours for urgent care and five business days for routine care.*

**Compliance Rating:** Noncompliance

**Findings:** Corizon reports that 0% of referrals are processed in a timely manner. The score was 0% because there was no evidence in the EPHR of the consultation disposition. DPSCS does not adhere to its own policy that requires the vendor Regional Medical Director to document the outcome of the collegial review in the EMR. I would recommend that the utilization management physician document their own decision in the record.

Recommendation 1 was addressed in this audit period with an audit of 20 diabetic records. DPSCS did perform the audit which was done well. However, there is no evidence that multiple recommendations for corrective actions for the 26 identified problems were enacted or initiated. Corrective actions still need to be addressed. That review showed that only 45% of patients were referred for a diabetic eye examination and only 10% had a dental appointment. These low numbers may be accounted for by short length of stays but the review did not take that into account. As well the requirements for diabetic eye examinations and dental examinations for diabetic patients is not defined clearly in policy provided to the Monitor. An additional patient in that audit was deemed to need nephrology consultation which did not occur.<sup>41</sup> Also, on record review the Monitor found several additional patients who were not timely referred to specialist.

**Recommendations:**

1. Incorporate quality record review information based on reviews done for provision 18 to verify quality of care for this provision. These reviews should be performed by the non-Corizon physicians.
2. DPSCS should consider allowing the facility medical director to approve utilization decisions due to poor utilization review done by the vendor.

**Settlement Agreement Statement: 22.c.** *The Commissioner shall promulgate and implement policy and procedure to maintain a log documenting the date a Clinician requests approval of a specialist referral; the date utilization management takes action on the request; the outcome of the request; and*

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<sup>39</sup> DPSCS Medical Evaluations Manual, Chapter 5 Consultations: item G states, "The Regional Medical Director will document the outcome of the collegial review in the EMR on the same date of the review".

<sup>40</sup> In the last report I stated that policy requires the facility physician to document decisions in the medical record but that was erroneous. Policy states that the Regional Medical Director is to do this. The current practice is that the facility physician is assigned to do this.

<sup>41</sup> See problems identified #15, #21, and #24

*whether the referral is to a specialist for the purpose of treatment or for the purpose of evaluation only. Clinicians shall be given training regarding the documentation necessary to support a specialty request.*

**Compliance Rating:** Noncompliance

**Findings:** DPSCS has not asserted compliance for this item. DPSCS failed to provide the vendor's utilization log for review as part of information for this visit. Instead, DPSCS provided a transportation log which is not responsive to requirements of this provision. DPSCS provided no evidence that clinicians receive training regarding documentation to support a specialty request.

Based on the Settlement Agreement the following items are required:

To Be Documented in a Log

1. Date of referral;
2. Date of utilization action;
3. Outcome of utilization action; and
4. Purpose of referral

To Be Documented in the Medical Record

1. Provider request for referral- this can be evidenced by a dated progress note describing the referral;
2. The date and nature of the utilization response;
3. Date the consultation was scheduled;
4. Date the service was provided; and
5. Information appropriate for follow up.

When the utilization team does not approve a referral, the utilization team needs to document that the referral was denied. The log should document that the referral was denied but the utilization physician should document in the EPHR the rationale for the denial. This audit needs revision.

This audit does not identify patients who never get referred but need referral; patients who are referred and are never reviewed by the utilization physician; and does not include a quality review of whether referral, utilization, and follow up care is clinically appropriate. The Monitor reviews these in record reviews but DPSCS has not indicated how this is reviewed for their reports. A vendor specialty care log was not provided to the Monitor so the Monitor couldn't verify if any of the recommendations were accomplished.

**Recommendations:**

1. Denials of care need to be included on the log. All referrals should be on the log with their disposition.
2. Make modifications to the DPSCS tracking log as recommended.
3. Provide the specialty care log as an appendix to the next Corizon report.

**Settlement Agreement Statement: 22.d.** *The Commissioner shall promulgate and implement policy and procedure to ensure that, if applicable, each plaintiff's medical record contains documentation of*

*requests for outside specialty care, including the date of the request, the date and nature of the response, the date any consultation is scheduled, the date of any consultation, and appropriate information, if any, regarding follow-up care.*

**Compliance Rating:** Noncompliance

**Findings:** DPSCS has not asserted compliance for this item. 65% of referrals have a completed Consultation Request form which can be found in the medical record. The date and nature of the response is not found in the medical record and is not audited. Information about follow up care only evaluated whether the consultation report was signed, dated, and uploaded to the electronic record but not whether follow up care was accomplished.

Three recommendations were made related to this provision in the prior report. None of these three recommendations was addressed.

**Recommendations:**

1. Perform a root cause analysis of obtaining specialty care reports, identify deficiencies and take corrective action.
2. Track on a monthly basis and report findings to the quality committee on the number and percent of reports obtain from offsite consultants and diagnostic testing centers within 7 days. Also report the total number of reports received regardless of the timeliness.
3. Corizon utilization physicians should document their utilization decisions in the EPHR so that all physicians working at BCBIC can review their decision and rationale.

**Settlement Agreement Statement: 22.e.** *For the purpose of this Settlement Agreement, referrals for mental health services that are provided onsite at BCDC or BCBIC do not constitute specialist referrals.*

**Compliance Rating:** Not Evaluated

## SICK CALL

**Provision 23 Compliance:** Substantial Compliance

**Settlement Agreement Statement: 23.a.** *Plaintiffs shall daily have the opportunity to request health care. Nursing staff shall make daily rounds to collect sick call requests from plaintiffs who have no access to a sick call box.*

**Compliance Rating:** Substantial Compliance

**Findings:**

DPSCS claims compliance for this item. This item remains in substantial compliance.

During prior visits, I have reviewed all tiers in the jail and every tier has a secure health request locked box. While sick call slips are often absent on the units, interviews during past visits revealed that inmates

told me that they could always get a health request from an officer. DPSCS has a system of collecting the slips daily and tracking pick up of health requests. These elements satisfy structural elements of access. The sick call spreadsheet containing every health request documents approximately 1000 health requests monthly.

Three recommendations were given in the last report. For the first recommendation, DPSCS does track health requests on spreadsheet. This includes date and time of receipt and triage of the request; date of nurse or provider face-to-face evaluation and type of request. Summary data is not provided to the quality improvement committee. The second recommendation is tracked on the spreadsheet. DPSCS has provided no information that recommendation three was enacted.

### **Recommendations:**

1. Track pick up of tracking logs and health request slips on a daily basis and provide monthly aggregate report to the quality improvement committee.
2. Continue to track the number of health request slips picked up daily using the tracking slips and make sure this matches the number of slips triaged daily.
3. Memorialize this process in a document to ensure that it is standardized so that staff can be trained against a standardized process.

**Settlement Agreement Statement: 23.b.** *Requests for health care shall be triaged by RNs within 24 hours of receipt, with receipt measured from the time that the requests arrive at the site of triage following daily collection of sick call slips.*

**Compliance Rating:** Substantial Compliance

### **Findings:**

This provision requires three items to be validated:

1. That a RN triage the health request
2. That this be done within 24 hours; and
3. The quality of the health request triage is demonstrated.

DPSCS claims compliance on this item. DPSCS provided spreadsheets of time to triage which shows that triage occurs timely. Over 5000 health requests were analyzed. The average time from pickup to triage was 3.35 hours which is very good. A number of health requests lacked a stamp time of receipt of the slip, but analysis of almost 90 percent of slips showed excellent results.

DPSCS should continue to work on ensuring that the standardized process of stamping requests is done. The spreadsheet demonstrates adequate triage. Therefore, this provision warrants substantial compliance.

### **Recommendations:**

1. Continue to train triaging nurses on appropriate triaging based on suggestions in the November 2020 report.
2. Make triaging of complaints part of annual clinical updates for nurses.

**Settlement Agreement Statement: 23.c.** *Plaintiffs whose requests include reports of clinical symptoms shall have a face-to-face (in person or via video conference, if clinically appropriate) encounter with a Medical Professional (not including an LPN) or Mental Health Professional within 48 hours (72 hours on weekends) of the receipt of the request by nursing staff at the site of triage, or sooner if clinically indicated.*

**Compliance Rating:** Substantial Compliance

**Findings:**

This provision requires three items for verification including:

1. That for symptomatic complaints for medical and for all mental health complaints a face-to-face evaluation by a RN or higher or a mental health professional occur.
2. That the face-to-face evaluation occur within 48 hours (72 hours on weekends).
3. That the quality of the face to face evaluation is of adequate quality.

DPSCS asserts compliance for this item.

The Corizon data presented in the report was based on a sample of 60 health requests per month. It states that 97% of requests were evaluated within 48 hours or 72 hours if on a weekend.

The Monitor's analysis of all health requests on the spreadsheet provided by DPSCS show that for the over 5000 requests the average time from triage to a RN or provider evaluation was 1.84 days. This is sufficient to maintain compliance and includes a sample of all requests.

Health request evaluations were evaluated in record reviews and continue to be of adequate quality.

**Recommendations:**

1. Improve the documentation on the sick call log so that all items are filled out. Also, identify whether the complaint requires a nurse to evaluate the complaint and whether medical complaints are symptomatic.
2. Develop a method to evaluate quality for nurses, mid-level providers and physicians.

**Settlement Agreement Statement: 23.d.** *Care at sick call and at subsequent follow-up appointments shall be as determined by appropriate Medical Professionals and/or Mental Health Professionals, in the exercise of appropriate clinical judgment, to meet the plaintiffs' medical and mental health needs.*

**Compliance Rating:** Substantial Compliance

**Findings:** This provision requires that the totality of nurse and mid-level decisions regarding their evaluations and referrals to higher level evaluation are clinically appropriate. Also, this provision requires that any clinical follow up of the complaint is timely and appropriate for the complaint on the part of both nursing and providers. Providers did the primary evaluation for approximately 87% of health requests and the remaining 23% of requests evaluated by nursing seldom required provider evaluation. Thus, nurses evaluated mostly non-symptomatic complaints or non-medical complaints. Thus, the judgment of nurses, with respect, to referral to providers, was unnecessary to evaluate. The

timeliness of evaluation of health requests and triaging decisions to providers was adequate. Record reviews by the Monitor showed that evaluation of health requests and subsequent referral were adequate.

**Recommendations:**

1. Develop audits to measure the quality of nurse and provider evaluations of health requests. Ensure that the appropriate professional performs these audits; nurses evaluate nurses and physicians review provider health request evaluations.

**MEDICAL RECORDS**

**Provision 24 Compliance:** Partial Compliance

**Settlement Agreement Statement: 24.a.** *The Commissioner shall promulgate and implement policy and procedure to ensure that the medical records of plaintiffs are available at sick call and other encounters with Medical Professionals and Mental Health Professionals. An on-site Medical Professional or Mental Health Professional who is providing treatment, including diagnostic services, to a plaintiff shall have access to both the EMR and any non-electronic portion of the medical record, unless the need for emergency treatment precludes access at the plaintiff's location.*

**Compliance Rating:** Partial Compliance

**Findings:** DPSCS does not assert compliance on this item. I participated in a zoom call with DPSCS information technology staff and the project manager for the vendor of the newly purchased electronic medical record. The vendor indicated that work had stopped while the vendor and DPSCS work out problems. A two-year delay is anticipated and a new implementation date of 2024 has been established. The issues between the vendor and DPSCS appear serious as the implementation is stalled.

I continue to recommend a device survey.<sup>42</sup> DPSCS states that doing so is “outside of both constitutionally adequate care and the requirements for substantial compliance with any paragraph of the Agreement”. They ask that I refrain from giving this recommendations as an underlying part of achieving compliance even though DPSCS staff have acknowledged that lack of devices impairs their ability to achieve compliance. Sufficient devices need to be available for the implementation to be effective. A device count has only been done with respect to scanning devices that will be used for medication administration purposes. Clinical areas have not been inspected to ensure that sufficient devices are available to operate the electronic record or to input information into the electronic record. Device counts should include terminals or computers in all clinical areas, scanning devices for medical records to scan paper documents to the electronic record, and any point of care devices or equipment necessary to upload point of care information (capillary blood glucose, vital signs, etc.) into the electronic record.

I have asked to be updated monthly on the status of the electronic record and positions for project manager and data employee as these are critical to the Settlement Agreement. Because DPSCS has concerns that these recommendations are outside of both constitutionally adequate care and the

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<sup>42</sup> A device survey is an inspection of all clinical areas to survey how many electronic devices there are with respect to needed devices for the electronic medical record. The devices include desktop, laptop, and mobile terminals; scanners; printers; etc. Each clinical area needs to be evaluated with respect to anticipated use for that area and to ensure that there are sufficient terminals for the anticipated simultaneous users.

requirements for substantial compliance with any paragraph of the Agreement they have requested that the Monitor refrain from including these recommendations as an underlying part of achieving compliance. If DPSCS can fix the existing process problems and obtain the data they need for verification in another way, they should do so. However, over several years, DPSCS has been unable to complete analyses of key processes that don't work and have been unable to obtain data to verify compliance. These recommendations were given due to inability of DPSCS to find alternate solutions.

I continue to strongly encourage DPSCS to use BCBIC as the pilot site so that implementation at this facility can begin earlier than for the entire state system. DPSCS states that doing so is "outside of both constitutionally adequate care and the requirements for substantial compliance with any paragraph of the Agreement". They ask that I refrain from giving this recommendations as an underlying part of achieving compliance. However, the Monitor believes that this suggestion makes practical sense. BCBIC is a stand-alone operational unit. It is a jail instead of a prison. Detainees at BCBIC are not part of the prison system. BCBIC is a small facility. Implementing the electronic record at BCBIC first allows DPSCS to operationally test implementation on a smaller scale. This, obviously, is DPSCS's decision.

Corizon continues to audit whether a paper copy of the medical record was available. 85% of patient clinical encounters including a hard copy of the paper record but only 58% of clinical encounters included documentation that the paper record was available. What is not audited is what paper records are unavailable. Medication administration records are unable to be located which impairs ability to verify compliance. Reports of consultants are not all obtained and are a barrier to adequate care. Lack of these records affects several provisions of the Settlement Agreement.

Six recommendations were made in the previous report. Recommendation 1 to obtain a new electronic record is in process of being accomplished. Recommendation 2 to revise procedures based on anticipated electronic record processes have not been enacted. Procedures for entry onto the problem list is a key issue for the Settlement Agreement and should be done soon. Recommendation 3 has not been initiated. Recommendation 4 is awaiting resumption of implementation of the electronic record. Recommendation 5 has only been initiated for selected devices and needs to be completed for all clinical areas in BCBIC. DPSCS feels that recommendation six is unnecessary to achieve compliance and not required by the Settlement Agreement. That recommendation was given after DPSCS was unable to obtain data necessary to verify compliance.

### **Recommendations:**

1. Obtain a new electronic medical record.
2. Review and revise policies based on new process changes and based on anticipated electronic record processes.
3. Ensure that dental records are available to other clinicians.
4. Consider and plan for the training function with the implementation of the electronic medical record.
5. Perform a device survey prior to implementation of the new electronic record.
6. Hire data staff to ensure data from the record will be available for verification of the Settlement Agreement.

**Compliance Ratings Summary**

Case 1:94-cv-02541-ELH Document 766-2 Filed 06/29/22 Page 48 of 54			
Provision	Mar-21	Nov-21	May-22
17			Partial Compliance
17a	Partial Compliance	Partial Compliance	Partial Compliance
17b	Substantial Compliance	Substantial Compliance	Substantial Compliance
17d	Partial Compliance	Partial Compliance	Partial Compliance
17e	Partial Compliance	Partial Compliance	Partial Compliance
18			Partial Compliance
18a	Partial Compliance	Partial Compliance	Partial Compliance
18b	Partial Compliance	Partial Compliance	Partial Compliance
18c	Partial Compliance	Partial Compliance	Partial Compliance
18d	Partial Compliance	Partial Compliance	Partial Compliance
18e	Partial Compliance	Partial Compliance	Substantial Compliance
18f	Partial Compliance	Partial Compliance	Partial Compliance
19			Noncompliance
19a	Noncompliance	Noncompliance	Noncompliance
19b	Noncompliance	Noncompliance	Noncompliance
19c	Noncompliance	Noncompliance	Noncompliance
19d	Noncompliance	Noncompliance	Noncompliance
19e	Noncompliance	Noncompliance	Noncompliance
19f	Noncompliance	Noncompliance	Noncompliance
19g	Noncompliance	Noncompliance	Noncompliance
20			Partial Compliance
20a	Partial Compliance	Partial Compliance	Partial Compliance
20b	Partial Compliance	Partial Compliance	Partial Compliance
20c	Substantial Compliance	Substantial Compliance	Substantial Compliance
20d	Partial Compliance	Partial Compliance	Partial Compliance
20e	Substantial Compliance	Substantial Compliance	Substantial Compliance
20f	Substantial Compliance	Substantial Compliance	Substantial Compliance
20g	Substantial Compliance	Substantial Compliance	Substantial Compliance
21			Partial Compliance
21a	Noncompliance	Partial Compliance	Partial Compliance
21b	Substantial Compliance	Substantial Compliance	Substantial Compliance
21c	Partial Compliance	Partial Compliance	Partial Compliance
21d	Substantial Compliance	Substantial Compliance	Substantial Compliance



22			Noncompliance
22a	Noncompliance	Partial Compliance	Partial Compliance
22b	Noncompliance	Noncompliance	Noncompliance
22c	Noncompliance	Noncompliance	Noncompliance
22d	Noncompliance	Noncompliance	Noncompliance
23			Substantial Compliance
23a	Substantial Compliance	Substantial Compliance	Substantial Compliance
23b	Substantial Compliance	Substantial Compliance	Substantial Compliance
23c	Substantial Compliance	Substantial Compliance	Substantial Compliance
23d	Substantial Compliance	Substantial Compliance	Substantial Compliance.
24			Partial Compliance
24a	Partial Compliance	Partial Compliance	Partial Compliance

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March 21, 2022

Michael Puisis, D.O.  
[address redacted]

VIA ELECTRONIC MAIL ONLY

In re: *Duvall v. Hogan*

Case no. 94-02541

Dear Dr. Puisis:

I write on behalf of Secretary Robert L. Green and Commissioner Michael R. Resnick in response to your most recent monitoring report of November, 2021. The defendants have concerns that some monitoring recommendations may deviate from both the Settlement Agreement ("Agreement") itself, and the constitutional requirement that the defendants: 1) provide "adequate" medical care to the plaintiffs; and 2) refrain from deliberate indifference to the serious medical needs of the plaintiff class. *See Farmer v. Brennan*, 511 U.S. 825, 831 (1994);

*Martin v. Gentile*, 849 F.2d 863, 871 (4th Cir. 1988).

The defendants raise these issues with the hope of working with you to achieve substantial compliance in all of the paragraphs of the Agreement, but also to stay within the parameters of an agreement that was negotiated in good faith by the parties. The defendants' specific concerns are as follows:

1. **Definition of substantial compliance:** *See Duvall Settlement Agreement Report*, November, 2021 ("Report"), p. 4. The Report defines "substantial compliance" as: "a degree of compliance sufficient to not require any oversight or monitoring." Paragraph 39 of the Agreement, however, defines substantial compliance as "full compliance with the components of the relevant substantive provision" of the Agreement, or "sufficient compliance with the components of the relevant substantive provision" of the Agreement "such as to remove significant threat of constitutional injury to the plaintiff class posed by any lack of compliance with the components of the substantive provision." This definition, which was negotiated by the parties, hews closely to both the substantive paragraphs of the Agreement, and the constitutional standards noted above. The defendants have concerns that the monitor's focus is less on the definition of substantial compliance as it appears in the Agreement, and more on the establishment of a functioning medical system that meets the monitor's own expectations as a clinician. The defendants request that you follow the definition of substantial compliance as it appears in the Agreement.
2. **Clinical space for female detainees at BCBIC:** You have recommended an expansion in the clinical space for women's medical care. Report, p. 4. Presently, there is no room for expansion within the Baltimore Central Booking and Intake Center ("BCBIC"). Although this recommendation may well be desirable, the defendants are concerned that it is not consistent with the Agreement, which requires no expansion of clinical space. The recommendation also fails to rise to the level of a constitutional violation. The Secretary has asked you to provide any guidance from correctional governing bodies that supports your contention, because we are not aware of any such guidance. Although paragraph 27 of the Agreement requires the Commissioner to "implement any reforms necessary" to effectuate the Agreement, it is physically impossible to expand this space at BCBIC, the facility which holds the vast majority of the plaintiff class. The defendants request that you withdraw this recommendation.
3. **Clinical space at Intake:** Likewise, additional clinical space at Intake is simply unavailable at BCBIC. You have concluded that "space issues in the intake area" is a significant contributor to an intake exam of poor quality. Report, p. 9. The defendants are concerned that the recommendation is not consistent with the Agreement, which requires no expansion of clinical space. The recommendation fails to rise to the level of a constitutional violation. The defendants request that you withdraw this recommendation.
4. **Specialized housing for detox patients:** As the Report noted, the defendants have made progress in establishing dormitories for detoxifying detainees, although such assignments are at times disrupted by the need for quarantine housing. Report at

pp. 4-5. However, the defendants question whether the monitor's recommendation to house detox patients in specialized housing units is consistent with the Agreement, which does not address the needs of such detainees, and the constitutional standard.

5. **Electronic medical record ("EMR"):** You have recommended a "device survey," the hiring of a data and process expert, the early roll-out of the new EMR at BCBIC, and six sigma training for key Departmental employees. Report, p. 5. While these may be good recommendations, the defendants believe that they are outside of both constitutionally adequate care and the requirements for substantial compliance with any paragraph of the Agreement. The defendants request that you refrain from including these recommendations as an underlying part of achieving compliance.
6. **Failure of nurses to identify medical problems or medication at Intake:** The Report concludes that there are "other causes" affecting the quality of nurse performance at Intake, in addition to the five factors identified in the defendants. Report, p. 8. You have opined that these obstacles alone do not credibly explain an Intake of poor quality. Report at p. 9. We are not aware of any evidence that suggests that but for these factors or "other causes," detainees would be more candid in their responses. Conversely, the Agreement as negotiated and written supports and reflects the defendants' assertion that newly arrested detainees may not be candid during an Intake exam. Paragraph 17(b) of the Agreement requires the Commissioner to provide medications to any class member who "*reports* during intake screening that he or she is currently prescribed medication for a medical condition." Similarly, Paragraph 17(d) requires that such medication be administered "within 24 hours of the intake screening or *subsequent encounter at which the plaintiff first reports* such medications." The defendants request that your analysis on this paragraph reflect the terms of the Agreement as written.
7. **Provision of medication within 24 hours:** The Agreement at paragraph 17(d) provides that a detainee must receive his first dose of medication within 24 hours of reporting such a need, unless the medication is unavailable, or a clinician determines that the medication is not clinically appropriate. You have interpreted this paragraph as requiring proof of "continuity of medication" beyond the first 24 hours. While that recommendation may reflect good clinical practices, the Agreement itself does not require proof of continuity of medication under 17(d). The defendants request that you withdraw this requirement.

In summary, the defendants look forward to follow-up engagement on the issue of attaining substantial compliance. If you would like to discuss this letter, we can facilitate a meeting in the future.

Very truly yours,

*Laura Mullally*

Laura Mullally  
Assistant Attorney General

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