A Report on Health Services at the Idaho State Correctional Institution

April 2-3, 2012
Introduction

The Idaho State Correctional Institution (ISCI), located in Kuna, Idaho is the State of Idaho’s largest state-run correctional facility; providing security and services to 1,661 adult males. Medical, psychiatric, and dental services, including biomedical, pharmacy, radiology, hospital, and laboratory services, are provided through a contract with Corizon Health, Inc. (Corizon). After a report from a Federal Court Special Master, Corizon requested the National Commission on Correctional Health Care (NCCHC) to conduct an independent assessment of the health care at ISCI. NCCHC conducted its review on April 2 and 3, 2012.

The National Commission on Correctional Health Care is a not-for-profit organization that sets standards for health services in correctional facilities and is widely recognized for its expertise in measuring compliance and health system performance. NCCHC grew out of a program begun at the American Medical Association in the early 1970s. Its board of directors is composed of liaisons from thirty-six national professional associations including the American Medical Association, American Psychiatric Association, American Nurses Association, American Dental Association and the American Psychological Association. A complete listing of NCCHC’s Supporting Organizations can be found at the end of this report.

Methodology

A three-person expert team conducted the health system assessment. NCCHC’s national standards for prison health care: Standards for Health Services in Prisons (2008)
were used as a guide. The team was tasked to (1) determine if an adequate delivery system is in place to address patients’ serious health needs, (2) determine if those services are provided in an acceptable, appropriate, and timely manner and, (3) provide recommendations to facilitate improvement in the prison’s health services.

Team members included a physician investigator for the California Inspector General’s office, a physician director for mental health services of the Texas prison system, and NCCHC’s vice president for clinical services and policy. Among them, the group represents 40 years of correctional health care experience.

To assess the effectiveness of health services NCCHC used a methodological approach that focused on health care practices and operations. Team members carefully reviewed 83 health records (also referred to in this report as charts). Record selection was not random; the team hand chose the records and purposely selected patient charts that were most likely to contain challenges to the professionals providing care. These charts were in the categories of chronic care, sick call, denials of specialty services, death review, and emergency care. Further, from within these categories, we selected records that appeared to present particular challenges, such as patients with multiple chronic care diagnoses or unplanned emergency transfers to outside facilities. In addition, we selected charts that would allow review of a cross section of provider types, including physicians, mid-level providers, registered nurses, and licensed practical nurses. The records that were selected included: 16 chronic care encounters, 7 emergency care encounters, 2 deaths, 2 specialty service referral denials, 1 record at an offender’s request and 10 intake charts for receiving screening and initial health assessment. In addition, we randomly selected 14 charts for intake screening, initial health assessment, and sick call encounters. Behavioral health was
outside the scope of this analysis although we reviewed 31 patient charts of psychiatric patients.

We interviewed key personnel including the health administrator, prison physician, health and mental health staff, and an assistant warden. We reviewed existing policies and procedures, and supporting documents such as meeting minutes, logs, and training rosters. We also reviewed the Special Master’s Report of February 2, 2012.

In addition, we toured the Reception and Diagnostic Unit (RDU) at Unit 15, the Health Services Unit (HSU) at Unit 20, the Segregation Unit at Unit 8 and the Medical Annex at Unit 20a.

Chief Finding

We found the health care system to be sufficiently organized and in substantial compliance with NCCHC’s standards for health services. Many areas show improvement over the record review period. As is common to many health systems, some areas lack coordination and are in need of improvement. We also identified areas where the quality of patient care is inconsistent, and found it to be either satisfactory, improving, or in need of further improvement relative to nationally accepted clinical practice. Of the 83 patient records we reviewed, 42 records were of complicated patient care as defined later in this report. Of those, the care provided in 23 of the cases was found to be satisfactory, and of the remaining cases, problems ranged from minor to significant. These cases are noted in this report.
Governance and Administration

**Access to Care.** We define access to care as a patient being given the opportunity to be seen by a clinician, receive a clinical judgment, and receive care that is ordered. As we analyzed health records, interviewed staff and patients, and observed, it was evident that all inmates have access to health services and the system generally works well.

**Responsible Health Authority.** The responsible health authority (RHA) is a contracted health services vendor whose on-site representative is the health services administrator (HSA) as defined in NCCHC’s standards. The HSA is responsible for the overall daily operation of the health service program. The medical director is on-site 40 hours a week. This arrangement appears to function satisfactorily and services are coordinated and have improved over time. However, both the medical director and HSA have been on site for less than six months. The physician started in January 2012 and the HSA started in November 2011. Facility documents indicate that previous HSAs and medical directors did not always monitor and manage health care services adequately.

**Medical Autonomy.** Our review of the health records and interviews indicate that all clinical decisions pertaining to direct health care of patients are the sole responsibility of the medical director and clinical staff as required by the standard. The carrying out of clinical decisions relies on a joint effort by custody and health staff working together to ensure that administrative decisions are coordinated so that patient care is not jeopardized. We saw no evidence of interference by custody staff in ISCI’s health care delivery system.

**Administrative Meetings and Reports.** Administrative meetings are important for establishing an adequate health care delivery system. Analysis of service volume,
proportion of service types, and incidence of certain illnesses, diseases, and injuries targeted for risk management are essential to plan for staffing, space, and equipment needs. Fundamental to developing and maintaining a system that is responsive to patient needs is an RHA that is actively engaged in improving its health care system and services, which was evident at ISCI.

We found that medical administration leadership staff meets with facility administration staff on a regular basis. We found many examples where coordinated planning between the two improved health service efficiency and overall clinical operations. Statistical data are compiled annually. The medical administration committee (MAC) meets monthly. We reviewed meeting minutes for every month dating back to January 2011, and found them to be sufficiently detailed and showing problem identification, decision making, and problem solving.

**Policies and Procedures.** The policies and procedures manual is current as evidenced by recent signatures of the HSA (March 4, 2012); the medical director (March 18, 2012); and the director of nurses (March 6, 2012). The policies and procedures are site-specific and the manual is made available to staff. We found the policies to be consistent with accepted national practices. Annual review of policies, procedures, and programs is good management practice and indicates a desire to modify practices that ensure an adequate health care system.

**Continuous Quality Improvement Program.** A robust Continuous Quality Improvement (CQI) program is a key element in any effective health care delivery system. The makeup of the CQI committee and the record of its deliberations should be given
sufficient attention such that the progress of the prison in identifying health system weaknesses and implementing strategies for improvement are well integrated into daily activities.

The CQI committee meets the third Tuesday of every month. We reviewed the minutes from August 2011 through January 2012. Topics included: CQI studies, man-down drills, RDU screening standards, documentation of medication administration records (MARs), chronic care clinics, offenders being sent to segregation, infirmary criteria, staff development, and missed referrals. The minutes lacked depth and meaningful description of the problems and decisions made during the meetings. CQI minutes should provide sufficient detail to guide future decisions. For example, CQI minutes could include the problems that have been identified, the solutions that have been agreed upon, the person who is responsible for carrying out the corrective action, and the time frame for carrying out those corrective actions.

We saw evidence that data for two 2012 process studies are currently being collected. These studies are: (1) a focused study on continuity of care for patients returning from emergency room visits and (2) nonemergency health care requests and services. These are excellent topics for study in any health care system. Data for two 2012 outcome studies are currently being collected to assess Warfarin (anticoagulation) monitoring and A1c (diabetes) monitoring, which are also good topics. We suggest that, over time, future process and outcome studies look at an aspect of every major service provided within the CQI program year.

One of the benefits of a successful CQI program is that problems can be identified early and strategies developed for their resolution before they become exacerbated; so it is
important that dental, psychiatric, mental health, and pharmacy be involved in the CQI process. There is no evidence of dental staff or mental health/psychiatric staff involvement in the CQI process at ISCI. When a multidisciplinary CQI committee uses a structured process to monitor high-risk, high-volume, or problem-prone aspects of health care provided to patients, facility staff can develop and implement strategies for improvement. In addition, the ISCI quality improvement committee should assess the effectiveness of its CQI plans after implementation.

**Emergency Response Plan.** Disaster and man-down drills have been conducted as required by the standard. The next disaster drill is scheduled for September 2012. Emergency planning requires an appropriate health staff response including coordination with community emergency services, when necessary. We were informed that there are plans to include local emergency services in future disaster drills. Practicing the emergency response plan makes health staff better able to respond to disasters when they occur.

**Communication on Patients' Health Needs.** Communication occurs between the facility administration and treating clinicians in such a way that patient health needs are appropriately managed and addressed. Health staff, when asked by classification staff or when health staff otherwise become aware of custody requirements that may compromise a patient’s health, advise classification and custody staff of an inmate’s special health needs that may affect housing, work assignments, program assignments, disciplinary measures, and admissions to and transfers from satellite facilities and other institutions. Psychiatric
services staff work well with ISCI behavioral health program staff in communicating the needs of mentally ill inmates.

**Procedure in the Event of an Inmate Death.** The standard calls for a clinical mortality review that includes (1) a review of the incident and facility procedures used, (2) training received by involved staff, (3) pertinent medical and mental health services or reports involving the inmate, and (4) recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures.

The RHA performs a clinical mortality review on deaths occurring at ISCI. This presents an opportunity to improve clinical competency, and the RHA should provide appropriate feedback to the treating clinicians to determine the appropriateness of clinical care, to ascertain whether changes to policies, procedures, or practices are warranted, and to identify issues that may require further study.

Most of the recent deaths at the prison were due to a terminal illness and were anticipated by staff. We reviewed the death records of two unexpected inmate deaths. In one of those cases staff apparently focused its attention on the patient’s diabetes, which despite various efforts was difficult to control. The staff did not appear to recognize or treat symptoms of ischemic heart disease and congestive heart failure. The death review did not identify this discrepancy which represents an opportunity for improvement. We were told the sentinel event process was completely revised in January 2012 and will address this process improvement opportunity.

**Grievance Mechanism for Health Complaints.** Identifying and resolving problems in health care delivery is an important part of developing an adequate health care system.
Obtaining, responding to, and reducing inmate complaints of health services are means of improving the system.

Grievances for health services at ISCI are managed at three levels. An ombudsman manages first level reviews, the second level grievance is managed by the HSA; and the third level is managed by the IDOC. In addition, grievances are reviewed as part of the CQI Committee. Since timeliness of the response to grievances of health services is an important indicator of quality of care, particular attention should be made to informally resolve inmates’ complaints regarding health services. The introduction of the ombudsman is a good addition and shows an effort to take health grievances seriously.

**Managing a Safe and Healthy Environment**

**Infection Control Program.** The infection control program is a combined effort of representatives of the facility’s administration, medical director, and other health care personnel.

The policy and procedure manual requires topics such as: management of tuberculosis, MRSA, HIV-infected inmates, management of hepatitis-infected inmates, communicable disease practices, inmate bloodborne pathogen exposure, and ectoparasite control. Inmates are screened and observed for hepatitis, tuberculosis, sexually transmitted infections (STIs), scabies, lice, HIV, and AIDS. Inmates with infectious disease are followed in chronic care clinics and may be housed in the infirmary. Inmates testing positive for reportable STIs are prescribed appropriate antibiotic therapy. Health personnel participate in annual infection control in-service training. The infection control
committee meets as part of the CQI Committee. The committee identifies reportable
diseases and outbreaks or occurrences of special infectious disease. We found ISCI to have
an adequate infection control program in place.

**Patient Safety.** The RHA promotes patient safety by instituting systems to prevent
adverse and near-miss clinical events. This is accomplished through informing health staff
of the incident report process during orientation and daily communications with the
medical director. Reported errors are reviewed during the CQI meeting, where patient
safety recommendations are made. We found that staff effectively monitors patient safety.

**Staff Safety.** From all appearances health staff work in a safe environment. As
necessary, the RHA takes measures to ensure the safety of health staff.

**Personnel and Training**

**Credentialing.** There is a formalized credentialing process that is monitored by the
RHA’s corporate credentials committee who is responsible for verifying credential
information of the clinical staff. Once approved, the HSA has the responsibility to maintain
annual verification of credentialing records on site.

**Clinical Performance Enhancement.** We were informed that there is
documentation of annual clinical performance reviews of primary care providers and that
the results are shared with the clinician being reviewed. This is acceptable if the
performance of the conditions meets or exceeds clinical threshold requirements. However,
if performance is below the threshold, then more frequent review and feedback should
occur until such time as clinical performance meets the threshold. ISCI policy and practice
does not support this aspect of the standard.
**Medication Administration Training.** Nurses review, as needed, the appropriate procedures to administer medications. Discussion of medication services are conducted during the health services staff meetings and documented in meeting minutes.

**Staffing.** There are 52.8 full-time equivalent health staff required by contract, which include:

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<tr>
<th>Role</th>
<th>Full-Time Equivalent</th>
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<tbody>
<tr>
<td>Medical Director</td>
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<tr>
<td>Physician Assistants</td>
<td>2.0</td>
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<td>Health Services Adm. (HSA)</td>
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<td>Director of Nurses</td>
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<tr>
<td>RN Charge/Supervisor</td>
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<td>Registered Nurses</td>
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<td>Chronic Care RN</td>
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<td>LPN</td>
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<tr>
<td>LPN Pharmacy</td>
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<td>LPN Unit 8</td>
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<tr>
<td>LPN Urgent Care</td>
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<tr>
<td>Off-Site Scheduler</td>
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<td>Psychiatrist</td>
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<td>Psychiatric NP</td>
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<tr>
<td>Mental Health RN</td>
<td>1.0</td>
</tr>
<tr>
<td>Dental Director</td>
<td>1.0</td>
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<tr>
<td>Dentist</td>
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Optometrist 0.1
Dental Assistant 1.3
Dental Hygienist 0.4
Administrative Assistant 1.0
Certified Medical Assistant 1.0
Certified Nurses Aide 2.0 (Long-term care infirmary)
Correctional Medical Spec. 1.0
Health Services Technician 3.8
Pharmacy Technician 1.0
Medical Records Clerk 2.0
X-Ray Technician 0.5
Ombudsman (LPN) 1.0

The RHA has approved the staffing plan based on parameters established by IDOC. The adequacy and effectiveness of the staffing plan is continuously assessed by the HSA and corporate office for its ability to meet the health needs of the inmate population. The use of nursing protocols is common. The RHA should review the state nurse practice act and ensure that all nurses are practicing within those requirements and, as necessary, IDOC and the RHA should jointly reconfigure the staffing plan.

**Health Care Services and Support**

**Pharmaceutical Operations.** A pharmacist conducts a quarterly report on the pharmaceutical services. Our examination of the medications found the facility to be in compliance with applicable state and federal regulations regarding prescribing, dispensing,
administering, and procuring pharmaceuticals. The RHA maintains a formulary for providers. Health staff maintain procedures for the timely procurement, dispensing, distribution, accounting, and disposal of pharmaceuticals. The RHA maintains maximum security, storage for, and accountability of all pharmaceuticals as required by the standard. We randomly selected MARs and stock medications and found no irregularities or expired medications at the time of our review.

**Medication Services.** The medical director approves the prescriptive practices at the prison. The policy and procedure manual addresses topics such as medication administration, prescribing authority, telephone and verbal orders, direct observation therapy, keep-on-person (KOP) medication, medication administration records (MAR), medication errors, monitoring medication compliance, psychotropic medication, and monitoring psychotropic medication. We did not find any irregularities with medication services in our chart review. Start and stop dates for medications are posted on the MAR. Medications are prescribed only when clinically indicated (e.g., psychotropic and behavior-modifying medications are not used for disciplinary purposes). The KOP system allows inhalers, antibiotics, thiazides, cardiac medications, nitroglycerin, Dilantin, Zantac, and prenatal vitamins to be kept by inmates when prescribed by the primary care provider. Medications issued for KOP administration do not exceed a 30-day supply. Controlled and psychotropic medications are not available for KOP. Inmates participating in a KOP medication program are provided education prior to participation.

In our chart review we found gaps in continuity of medications being provided to patients. The CQI program should perform a study looking at receipt of chronic care
medications as well as timeliness of receipt of newly prescribed medications.

**Clinic Space, Equipment, and Supplies.** The clinic area is sufficient for the delivery of health services. The examination rooms, offices, and equipment are sufficient to provide needed care.

**Diagnostic Services.** Specific resources for diagnostic studies and services to support the level of care provided to inmates are important aspects of an adequate health care system.

At ISCI there is an on-site radiology unit and a laboratory room for office based diagnostics. There are multiple-test dipstick urinalyses, finger stick blood glucose tests, peak flow meters (handheld), and stool blood-testing material. Practitioners order laboratory tests for clinical problems; however, our chart review found instances where studies are at times not performed or the reports not filed in the chart. The RHA should perform a CQI process study to address the continuity of care for patients in need of laboratory testing (i.e., completion of test and filing of results in the health record).

**Hospital and Specialty Care.** It is expected that the RHA monitor waiting times for specialty appointments or hospital admissions, specifics about what patient information is transferred between the health authority and the specialist, and the procedures transporting personnel follow while escorting patients to and from the specialty hospital or clinic.

The RHA makes arrangements with local specialty care providers for patients in need of these services. ISCI’s RHA monitors hospital and specialty clinic appointments and efforts to improve timeliness could be further improved. As evidenced in our chart review, there have been occasions when obtaining specialty care was not timely (or a rationale
given for any excessive delay). For example, an orthopedic consultation was ordered by
the physician on July 21, 2011 for a patient with low back pain. However, the consult did
not occur until September 6, 2011. In another case, we interviewed an inmate who
complained that there was excessive delay in starting treatment for his prostate cancer.
We reviewed his medical record and his movement sheet, and interviewed the nurse who
schedules specialty service appointments. We found that although almost eleven months
elapsed between diagnosis and treatment, the time line shows that this time interval was
acceptable under the circumstances, and was in part related to the patient's parole, re-
arrest, refusal, and change in his choice of treatment.

To ensure continuity of care, the RHA should have a system in place that anticipates
and resolves problems in advance of the delivery of specialty care.

Inmate Care and Treatment

Information on Health Services. Upon their arrival at the facility inmates receive
information about the availability of, and access to, health care. There is signage
describing access to health care services posted in the intake area. Inmates are provided
with written information on how to access health care services. Access to emergency and
routine health care services is described in the inmate handbook.

Receiving Screening. Admissions are received directly from county jails and
occasionally probation violators, and are processed at Unit 18 and the RDU. The inmates
may stay in the RDU for several weeks until completely processed and they are assigned
permanent housing. A nurse will complete a receiving screening within several hours of
the inmate’s arrival. The receiving screening form includes all the requirements of the standard. However, occasionally there were unusual delays from time of intake in conducting the receiving screening. In 12 charts that we reviewed for intake screening, the average time between intake at the RDU and receiving screening was 2 hours and 37 minutes, the range was 30 minutes to 8.25 hours and the mode was one hour. The RHA should conduct a CQI process study to assess what can be done to improve the timeliness of the receiving screening.

**Initial Health Assessment.** A physician assistant (PA) offers an initial health assessment to each inmate. A review of completed health assessments found them to be thorough, including the creation of an initial problem list and plan, and on average completed within five to six days of arrival at the prison, which is well within the requirement of the standard of seven calendar days.

**Mental Health Screening and Evaluation.** The PA conducts an initial mental health screen and refers patients to mental health counselors if necessary. Mental health counselors complete a mental health evaluation on all inmates. We did not review the quality of their assessments.

**Oral Care.** Oral screenings are completed by the PA and a dentist completes an oral examination in the RDU. Inmates have access to a dentist for oral health need.

**Nonemergency Health Care Requests and Services.** Inmates have the opportunity daily to request medical, dental, or mental health services. Non-segregated inmates come to the clinic window to present their health requests either orally or in writing. The request is logged and triaged. This method of sick call request is new for ISCI and we have seen this method performed at many other prisons throughout the United
States and it is an accepted practice to meet sick call access when patient confidentiality is maintained. We recommend written communication, or some other method, in public areas to maintain confidentiality.

To determine timeliness of care, we selected a random sample of sick call requests from logged entries for a period of November 2011 to March 2012 and selected the charts. We found the sick call request, logged entry, and sick call encounter to be in order. Generally, inmates were seen either the day of their request or the next, which is quite good.

To assess confidentiality and appropriateness of sick call encounters we observed sick call clinics, which were conducted in clinic rooms and were afforded appropriate and confidential treatment as possible.

We reviewed health records to assess the level of professional judgment rendered at sick call. Inmates are seen at sick call by PAs, RNs, and LPNs. The issue of whether the sick call and urgent care process obligates nurses to work beyond the scope of their license can only be determined by the state nursing board. The RHA should describe the LPN activities and request a determination from the nursing board. If the board determines that the activities exceed the scope of a LPN license, reconfiguration of the staffing plan will be in order.

The RHA works to maintain an organized patient flow and confidentiality. The health staff work on sick call requests, and the majority of inmates are usually seen in a timely fashion. We noted occasional problems beyond those that are typically found in correctional settings, some of them serious, with timeliness of response, some charts
lacking detail, and specific instances of problems with patient care and continuity of care; however, there was no discernible pattern to the causes of these shortcomings. A CQI study and appropriate follow up action is recommended to improve the handling of nonemergency health care requests and services.

**Segregated Inmates.** When an inmate is segregated, on a daily basis health staff monitor his health and document contact with the inmate during these segregation rounds. Health staff perform an initial review of the inmate’s health record to determine whether existing medical, dental, or mental health needs contraindicate the segregation placement or require accommodation. Such review is documented in the health record.

**Nursing Assessment Protocols.** There are corporate nursing protocols available for the nursing staff. From our review of the health records it was determined that nursing staff utilize the protocols; however, their use could be better monitored.

**Continuity of Care During Incarceration.** Referrals to specialist care could be better monitored. On average it takes approximately two to three weeks to see a specialist. Individual treatment plans are used and monitored to guide treatment for episodes of illness. The medical director is just beginning to conduct chart reviews. A sufficient number of health records should be reviewed on an ongoing basis to ensure that clinically appropriate care is ordered and implemented by attending health staff. This activity should be documented.

**Emergency Care.** We reviewed several health records of patients who presented to clinic and were referred to the local hospital’s emergency department. In some cases the emergent care in the clinic was appropriate; although in other cases the provider(s) did not
adequately recognize the pending problems. The medical director should oversee annual emergency response training of the mid-level providers.

The recent hiring of an HSA who has a critical care and emergency nursing background has greatly improved the capability of ISCI’s responsiveness to emergencies. She has improved equipment, staff training and drills, and actual emergency response time.

In our review of oxygen tanks, we found the active tanks to be full and in good working order. The reserve tanks were properly secured with chains. It is unacceptable for any program to have oxygen tanks available for emergency response that are not full and fully functional. Other emergency equipment was found to be in working order and properly maintained. We checked the equipment monitoring log and found it to be acceptable.

**Health Promotion**

**Healthy Lifestyle Promotion.** The RHA has made health education and instruction materials available. Our observation indicates that this is being provided to the inmates.

**Medical Diets.** We were informed that medical diets are available for patients with specific dietary needs. We found no irregularities in this regard in the health record.

**Use of Tobacco.** Smoking is not permitted anywhere inside the institution.

**Special Needs And Services**

**Chronic Disease Services.** Chronic disease patients are seen in regularly scheduled chronic care program (CCP) clinics. Patients are transported to outside specialty
appointments as needed. The prison has implemented national clinical guidelines for practitioners to follow. In our review we noted problems with the care provided to several chronic disease patients. These cases illustrate the need for closer monitoring by the medical director for both professional performance as well as continuity of chronic care.

**Infirmary Care.** The 15-bed infirmary is managed in accordance with the NCCHC standard. However, managing patients in the infirmary becomes somewhat difficult since the infirmary forms are indistinguishable from the outpatient forms. We recommend that the infirmary forms be color coded so that infirmary care can be distinguished from outpatient care.

**Basic Mental Health Services.** We were limited in our review and did not evaluate basic mental health services. We did review the timeliness and appropriateness of psychiatric services; patient ratios; psychiatric caseloads; psychiatric assessment, diagnostic and treatment services; psychiatric follow-up/reevaluation; and psychiatric continuity of care provided to inmates through chart review, other documentation, and interviews of designated staff. Inmates presenting with mental health signs and symptoms were referred to the psychiatrist or psychiatric physician assistant in a timely manner. There appeared to be good interdisciplinary collaboration and coordination of care for often psychiatrically compromised and treatment resistant-refractory patients.

We reviewed a representative sample of ten patient charts who were receiving long-acting (Haldol or Prolixin Decanoate) antipsychotic medications for chronic and severe thought disorders. Patients with more severe mental illness, schizophrenia and schizoaffective disorder, and other chronic thought disorders, in particular, receive appropriate evaluation and treatment in accordance with the NCCHC Clinical Guidelines for
Health Care in Correctional Settings: Schizophrenia.

An additional correctional population sample of 21 established patient charts were also reviewed. This sample was notable for a mixture of clinically challenging dually diagnosed inmates with comorbidity, Axis I and Axis II (antisocial, borderline personality traits versus disorders) and substance abuse versus dependence issues/presentations. Many patients were noted to demonstrate recent/past presentations including a variety of acute and chronic mental health issues, self-injury, recurrent suicidal ideation, and multiple psychosocial and other life adversities and stressors while incarcerated.

There was sound documentation regarding the informed consent process for new medications and for starting, stopping, or changing the dose or schedule of psychotropic medications. Most of the charts reviewed contained documentation by facility psychiatrists and mid-level providers [psychiatric PAs and nurse practitioners (NPs)], which clearly noted their rationale and thought processes in progress notes or other entries. For example, the informed consent included psychoeducation and a description that the provider had explained the potential risks, benefits, and treatment alternatives with a proposed psychotropic medication(s), efforts to minimize short- and long-term side effects, and strategies to improve medication compliance and patient functioning within the correctional settings.

We noted legibility problems in some of the progress notes, deficits in the overall organization, and poor documentation of written entries in several charts. Strategies should be pursued to make the current paper record more organized and efficient.

**Suicide Prevention Program.** The interface between psychiatry, custody, unit-
based state employed mental health staff (psychiatric technicians, bachelors and masters-level unlicensed and licensed clinicians), non-patient offenders serving as trained patient companions during suicide prevention monitoring, and medical staff appeared sufficient. There were several examples of these types of interactions that were particularly well done. Additionally, the overall timeliness and ability to refer acutely unsafe or agitated/psychotic patients to the designated Tier Three single-cell housing location, a specially designated psychiatric state prison housing setting, was noteworthy. The reported success of this unit to be able to keep patient offenders safe while affording them further psychiatric diagnostic evaluation and treatment services and more intensive supervision was also significant.

**Intoxication and Withdrawal.** Individuals with intoxication or withdrawal are to be managed on site by nursing staff. However, in this prison setting it is unlikely to have individuals with severe withdrawal or intoxication.

**Health Records**

**Health Record Format and Contents.** Inmate medical and mental health records are integrated in hard copy format. The Master Problem List (MPL) is insufficiently detailed with patient medical and mental health information. Staff should be instructed on how to properly complete the form.

**Medical-Legal Issues**

**Restraint and Seclusion in Correctional Facilities.** Policy allows the use of therapeutic restraints, physical or chemical, when risk of physical injury to self or others is
significant. The psychiatrist stated that clinically ordered restraint does not occur at this facility.

**Emergency Psychotropic Medication.** Staff reported that any inmate who requires forced medication would be transferred to a hospital.

**Forensic Information.** Health staff do not collect forensic information.

**End-of-life Decision Making.** Policies are in place to inform patients about their diagnosis, prognosis, care options, opportunity to choose an advance directive, and the availability of palliative care and hospice services.

**Informed Consent and Right to Refuse.** Informed consent is obtained for any treatment or procedure that poses some risk to the patient. Inmates can refuse treatment and such refusals are documented appropriately.

**Medical and Other Research.** No health-related research is conducted at this facility.

**Conclusions**

Overall, the health staff are working with sufficient energy and teaming with IDOC in a manner that can result in an appropriate level of care and professionalism. They are to be commended for their effort. The basic structure of health services delivery at ISCI meets NCCHC’s standards, and as in any health system there are many opportunities for improving the quality of clinical care.
Recommendations

Based on the review of the areas cited in this report, we make a number of recommendations which, if implemented, could improve the overall quality of care and health systems management at ISCI. These recommendations include:

1. Reassess the CQI meeting process. Minutes should precisely describe what facility problem, need, or opportunity is being addressed. The minutes should define goals and criteria for desired outcomes. The minutes should reflect the factors involved in the solution.

2. Assure that the responsible physician is involved in the CQI program, through means such as identification of thresholds, interpretation of data, and problem-solving.

3. Conduct an annual review of the effectiveness of the CQI program.

4. Involve mental health and dental staff in the CQI process; as well as any other major health services provided.

5. Conduct a CQI process study to assess what can be done to improve the timeliness of the receiving screening.

6. Ensure that the Master Problem List (MPL) has sufficient medical and mental health information on the patient’s care.

7. Perform a CQI process study to address the continuity of care for patients in need of laboratory testing to ensure that ordered tests are completed.

8. Monitor the length of time between the off-site specialty clinic consultation request to completion of the visit.
9. Monitor the timeliness and appropriateness of follow up by the primary care providers after scheduled offsite services have been rendered.

10. Improve the continuity of chronic care by:
   a. completing CQI process studies to address whether all providers are following the chronic disease protocols;
   b. completing CQI outcome studies to monitor whether patients' chronic conditions are improving under the care provided; and
   c. monitoring whether the ordered frequency of patients' follow-up chronic care clinic visits is consistent with assessed disease control.

11. Explore the implementation of an electronic medical record (EMR) or other strategies to make the current paper record more organized, legible, and efficient.

12. Distinguish the infirmary forms through color coding or other means so that infirmary care can be clearly identified from outpatient care.

13. Ensure ongoing health record review by a physician to ensure that clinically appropriate care is ordered and implemented by attending health staff; this activity should be documented.

14. Improve the monitoring of the nursing staff's skills and use of nursing assessment protocols.

15. The medical director should oversee annual emergency response training of the mid-level providers and training and remediation for all health care staff who may provide emergency clinic care to ensure that they are able to identify pending emergent issues.
16. Provide training and remediation for providers on the documentation of clinical justification for medication orders.

17. Enhance the quality of the death review process by improving the depth of the clinical mortality review. Corrective actions identified through the mortality review process should be monitored through the CQI program; its purpose is to identify areas of patient care or system policies that can be improved to ultimately avoid preventable deaths. Using the external physician review of a death, the RHA should provide appropriate feedback to the treating clinicians, determine the appropriateness of clinical care to ascertain whether changes to policies, procedures, or practices are warranted, and to identify issues that require further study.

18. Complete a CQI process study on the timeliness of provider sick call (after referral from nursing). The urgency of the clinician assessment should be based on the nurse’s assessment of patient need.

19. Expand CQI studies in ensuing years with a goal of looking at an aspect of every major service provided within the CQI program year.

20. When reviewing professional performance, the frequency of the review and feedback to the clinician should be based on whether the assessed performance exceeds required thresholds (subthreshold performance should be reassessed with feedback frequently).

21. Devise a method to document in the medical record the patient’s receipt of the KOP medications.
22. The CQI program should implement a system to calculate the medication administration (delivery) error rate, with a goal of achieving an error rate of less than 1%.

23. The RHA should develop a nursing professional performance enhancement program which includes monitoring the use of nursing protocols.

24. CQI minutes should provide sufficient detail to guide future decisions. For example, CQI minutes could include the problems that have been identified, the solutions that have been agreed upon, the person who is responsible for carrying out the corrective action, and the time frame for carrying out those corrective actions.

25. To address medication discontinuity, the CQI program should perform a study looking at receipt of chronic care medications as well as timeliness of receipt of newly prescribed medications.

NCCHC appreciates the opportunity to provide this in-depth review of health services at the Idaho State Correctional Institution. Additional information regarding this report is available.
About the

National Commission on Correctional Health Care

With support from the major national organizations representing the fields of health, law and corrections, the National Commission on Correctional Health Care (NCCHC) is committed to improving the quality of health care in Prisons, prisons, and juvenile confinement facilities. In this we are guided by an exceptionally dedicated Board of Directors comprised of representatives from our supporting organizations.

NCCHC’s origins date to the early 1970s, when an American Medical Association study of Prisons found inadequate, disorganized health services and a lack of national standards. In collaboration with other organizations, the AMA established a program that in the early 1980s became the National Commission on Correctional Health Care, an independent, not-for-profit 501(c)(3) organization whose early mission was to evaluate and develop policy and programs for a field clearly in need of assistance.

Today, NCCHC’s leadership in setting standards for health services in correctional facilities is widely recognized. Established by the health, legal and corrections professions, NCCHC’s Standards are recommendations for the management of a correctional health services system. Written in separate volumes for prisons, Prisons and juvenile confinement facilities—and now with a manual specifically for mental health services—the Standards cover the areas of care and treatment, health records, administration, personnel and medical-legal issues. These essential resources have helped correctional and detention facilities improve the health of their inmates and the communities to which they return, increase the efficiency of health services delivery, strengthen organizational effectiveness and reduce the risk of adverse legal judgments.

Building on that foundation, NCCHC offers a broad array of services and resources to help correctional health care systems provide efficient, high-quality care.

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