

APPENDIX 1

Reception Center

Intake Screen and Health Assessment Update

California State Prison, San Quentin

May 21st, 2008

Overview

Many changes have occurred over the last year at San Quentin, foremost among them, the implementation and design of a new intake process for the Reception Center (RC). Identification of medical, dental and mental health needs must begin at the point of entry into the institution at RC. This identification allows for appropriate management, treatment and referral of patients in need of acute and chronic medical care. The new intake process triages patients to appropriate levels of care immediately upon arrival at San Quentin.

Previous studies have shown that approximately one third of all RC inmates have significant health care “risks and needs”. The RC re-design allowed a comprehensive approach to triaging patients, coordinating care between mental health, medical, nursing management, and dental care.

Outcome Measures

The RC intake process was entirely redesigned and therefore has affected numerous aspects of operations at San Quentin. However, in order to best understand the impact of this redesign, we followed several outcome measures to determine if our changes resulted in actual improvements in critical aspects of healthcare management. Broadly, we focused on issues of timeliness, continuity and comprehensiveness of care. Particular attention in the evaluation was paid to the provision of medications for patients presenting with existing medication and to the establishment of a primary care continuity relationship for those patients with chronic and high risk conditions.

Clinical Evaluation Process

- RN Triage
 - 100% of patients are evaluated by RNs upon intake in RC
- Primary Care Provider (PCP) Evaluation and Follow Up
 - Data was collected for all of the intakes done during the first week of March. RN nursing logs were used to track all the intakes, follow-up orders were collected by chart review, and follow up appointments were confirmed by the Inmate Medical Scheduling and Tracking System (IMSTS).
 - 305 inmates arrived between March 3rd and March 9th, 2008.
 - 104 (34%) were evaluated by the PCP in RC.
 - 201 inmates remained for chart and IMSTS review.
 - 98 (49% of this 201) of the patient’s charts were unable to be reviewed because the inmates had paroled, transferred, or been discharged.
 - 103 (51%) of these patients remained at San Quentin for review.
 - 32 (31%) of these patients had no chart available for review, or documentation in the chart was unclear.
 - 15 (15%) were scheduled to be evaluated by the housing unit clinic.

○ Mental Health Evaluations

- 2 weeks of data was collected by hand upon intake.
- *Coleman* guidelines state that a patient must receive a mental health evaluation within 7 days of arrival.

Sample	Total Intakes	Seen upon arrival	Seen within 7 days	Seen within 14 days	Out of compliance
March 2008	284	284	0	0	0
March 2007	258	2	145	21	92

- *Clark* Remedial Plan requires all inmates have a documented developmental screen within seven days of intake. This screening is not repeated if one is already documented.

Sample	Total Intakes	Seen upon arrival	Seen within 7 days	Out of compliance
March 2008	103	102	1	3
March 2007	Unknown	0	28	16

○ Laboratory Studies

- SQ has a high parole violator rate. Up to 70% of all RC intakes may be parole violators, recently imprisoned at San Quentin or other CDCR institutions. Although it is rare to have access to the medical records on intake, San Quentin has online access to laboratory data from Quest Labs.
- In the first week of May, lab personnel pulled previous labs available online for all parole violators.
 - 278 parole violators were received at San Quentin during the first week of May. 100% of these patients had previous San Quentin intakes and therefore had previously documented screening tests.
 - 76 patients (27% of the 278 intakes) had their intake and lab tests done in the last **6 months**.
 - An additional 106 (38%) inmates had duplicate tests in the last **year**.
 - Each inmate had several duplicate tests, including positive Hepatitis C screens, random cholesterol screens, and positive HIV screens.
- All labs are drawn before medical and mental health examinations and evaluations. Occasionally, lab personnel will draw multiple tubes of blood. All other ordered labs require “ducing” the patient for an additional blood draw at a later date. Data has not yet been evaluated to review the number of patients requiring additional laboratory studies.

- Medication Delivery
 - New orders upon intake
 - The new RC redesign requires that medications to be delivered before the patients leave for their new housing units.
 - 563 inmates arrived at San Quentin during a period of nine consecutive week days
 - 7 (1%) of these patients had no documentation relating to the need for medications
 - 277 (49%) of these inmates required medications
 - 133 (48%) of these medications were delivered the same day to the inmate
 - Paroling inmates are given up to 30 days of medication upon leaving San Quentin prison.
 - 839 Inmates paroled from San Quentin in March, 2008.
 - There is no medication data for 27 (3%) of these inmates.
 - 650 (77%) of these patients were not taking chronic medications
 - 162 (19%) of the inmates take chronic medications
 - 143 (88%) of the inmates with documented requirements for medications received the medications before leaving San Quentin
 - 19 (12%) of the patients who required medications chose to leave San Quentin before their medications were delivered.

Summary

The redesign of RC has stream-lined care for incoming inmates. These changes in Reception processing have created an institution-wide impact. Inmates are seen and evaluated on the day of arrival for medical, dental and mental health conditions without exception. Because these healthcare disciplines are co-located in RC, there has been a profound decrease in the number of patients that need to be moved throughout San Quentin for Reception screenings. In addition, critical interdisciplinary collaboration has developed through the co-location of the health, dental and mental health providers.

The majority of arriving patients were seen additionally either by a medical provider in RC or in follow-up scheduled at the time of arrival. A comprehensive intake evaluation is performed on high risk and chronic care patients at RC, thus eliminating delay in coordination of care for these patients. In addition, nearly half of arriving inmates without identified medical needs accessed medical care through the sick call system, demonstrating the utility and efficiency of allowing healthy inmates to self-identify healthcare issues as they arise.

After review of resulting follow-up appointments made through RC, it is clear that there is an opportunity for further refinement to the primary care intake process. Because the sickest patients are seen in RC for primary care intake, the relationship with the housing unit PCP who will assume care is unintentionally delayed. Housing unit PCPs are spending a disproportionate

amount of time providing care to patients who have less acute or complex medical needs that have scheduled for a later follow-up appointment through RC.

The use of the TTA has dropped considerably due to the change in the way in medications are ordered for arriving patients. Medications are ordered immediately in RC by the medical provider onsite, obviating the need for TTA transfer or telephonic consultation with the TTA physician. This allows for uninterrupted evaluation of urgent medical needs in the TTA as originally intended.

Ordering and tracking laboratory data through RC has allowed us to document duplication of laboratory studies obtained within specified time periods for inmates cycling through RC multiple times. This has created an opportunity for us to design a method to review previous laboratory results and prevent duplication, at potentially great cost savings.

Finally, there has been demonstration of timely delivery of medication to arriving patients and to those inmates paroling. Several opportunities to improve this process exist and the options we are considering range from the creation of a satellite pharmacy in RC that could provide same day essential medications for all arriving patients to providing a “runner” who could deliver medications more frequently. The need for these improvements has been identified through RC evaluation process.

The Next Generation – Further Enhancements of the Reception Center

Current Practice (Redesigned RC)	New Enhancements	Justification
<p>Care Management Care Management has not yet been imbedded within RC process. RNs have taken it upon themselves to follow up orders and medication delivery.</p>	<p>Care Management will now be a role that one of the RNs must take every day. One RN will be assigned to follow up on all orders, transfers, and medication orders that were not completed during the intake.</p>	<p>It is unclear if patients received their orders or medications when a nurse is not following up the next day. The RN assigned to the role of Case Management has found the job to be necessary to the continuity of care.</p>
<p>RN Competency Training RNs in RC have all been trained in “hands-on” evaluation. However, not all RNs do the evaluation on each patient.</p>	<p>RNs will receive scheduled retraining and testing on a regular basis. A Supervising RN will conduct unscheduled checks of the RNs performance and compliance with training.</p>	<p>RNs are required to do a “hands-on” evaluation on any patient NOT referred to the medical provider. Although data does not suggest that this will be highly effective for gathering further information, it is necessary to evaluate patients who may not provide pertinent medical information.</p>
<p>Borderline Hypertension Follow-Up All patients with borderline blood pressure are scheduled for follow-up with the RN in their housing unit for a repeat blood pressure. This further backlogs the housing unit RN clinic.</p>	<p>RC RNs will repeat a blood pressure at least 30 minutes after the first borderline reading.</p>	<p>Many of the patients in RC are stressed by their transfer to the institution. Frequently, these patients will have normal blood pressure readings within a short period of time within RC. Repeating the readings in RC will decrease the numbers of patients who require follow up in the RN clinics.</p>

Current Practice (Redesigned RC)	New Enhancements	Justification
<p>On Site Primary Care Triage Current practice allows RC PCPs to spend the majority of their time doing a “primary care intake” on sick patients and referring the majority of inmates with health issues to the housing unit PCPs. The housing units have become backlogged with “RC intake” appointments for patients with minor health problems. Seeing these patients in clinic has created less time to see the regular chronic care patients. The extra time and attention the very sick patients receive in RC help take care of the immediate needs of the patient, but allow for a longer time for the patient to follow up with their housing unit PCP. The PCP will also need to duplicate the intake to fully understand the complicated health problems of the sicker inmate.</p>	<p>RC PCPs need to assess and triage the <i>majority</i> of patients referred to them. They will spend less time with individual patients and will be able to see more patients overall. RC PCP will be able to request appropriate follow up for each patient with their housing unit PCP. Any patient with medical problems will receive a comprehensive and efficient medical evaluation. These patients will be triaged to appropriate follow up with their housing unit PCP.</p>	<ul style="list-style-type: none"> • Primary Care Intake will be done by the PCP and not the RC provider. • Housing Unit clinics will become centers to care for the acutely and chronically ill, not for RC intake. • Housing units will become less backlogged • Patients will receive all the acute medical needs necessary in RC and will not require earlier intervention. This will avoid backlogs in the clinic so that all patients can be seen in the appropriate time frame.
<p>Clinic Space/Equipment/Supplies</p> <ul style="list-style-type: none"> • EKG machine in RC 	<ul style="list-style-type: none"> • Baseline (not acute) EKGs are now done in RC when ordered by the PCP. 	<ul style="list-style-type: none"> • Baseline EKGs in appropriate patients were ordered in RC and the patient would be “duccated” to the TTA for the study at a later date. Patients were not receiving baseline EKGs in a timely manner. If the patient is evaluated as “high risk” for cardiac events by RC PCP, an EKG is done and available if the patient presents at a later date with complaints of a cardiac event.

Current Practice (Redesigned RC)	New Enhancements	Justification
<p>Inclusion of Peer Educators Peer Educators do not have space in RC and do not have access to RC inmates on the day of intake.</p>	<p>We currently do not have the ability to include Peer Educators in the RC process. More space is included in the SQ medical building which should allow inclusion of the peers in 2010.</p>	<p>Although it would be extremely useful to have the peer educators involved in the RC process, SQ is unable to accommodate the group at this time.</p>
<p>Laboratory Studies</p> <ul style="list-style-type: none"> • Lab studies are dictated by <i>Plata</i> guidelines. There is no ability to add extra labs. • Laboratory Studies are repeated for every patient, regardless of last documented laboratory test. 	<ul style="list-style-type: none"> • Lab Technician protocols will be written to specify blood tests for disease states, including patients taking lithium, diabetics, and patients with renal, cardiac, or HIV disease. • RPR, GC, Chlamydia tests will be done on <i>all</i> intakes, regardless of last time of test. • HIV and Hepatitis C tests will be done every 6 months for patients who have previously tested negative. • Random Cholesterol screen will be done every 5 years 	<ul style="list-style-type: none"> • Patients with indicated blood tests are being “duccated” for a later date, delaying evaluation and care. • The Center for Disease Control and Prevention recommends that HIV tests be done in at risk patients “at least annually”. There is insufficient evidence to support screening of GC/Chlamydia in asymptomatic men, however, the infection is easy to diagnose and treat. • US Preventative Services Task Force recommends that cholesterol screens be done every 5 years in men over 35.

Current Practice (Redesigned RC)	New Enhancements	Justification
<p>Evaluation Forms</p> <ul style="list-style-type: none"> • The RN RC form is not used consistently by staff members • The PCP Intake form was developed for use in RC. 	<ul style="list-style-type: none"> • Imbed the quality indicators in the functional RC flow sheet. See Attachment A. • The PCP Intake form will be used in the housing units only. It will no longer be used to collect information by RC PCP unless time permits. 	<ul style="list-style-type: none"> • It has been difficult for busy nurses to complete additional paperwork. There are functional forms already in use in RC which can be edited to collect data without causing more work. • The PCP Intake form is extremely useful to gain a comprehensive understanding of the patient’s health needs. It is important that the patient’s PCP be involved in gathering this data.
<p>Essential Medications</p> <p>More than half the patients requiring medications do not receive them on the intake day. The RN Case Manager must follow up on dozens of patients to ensure appropriate and timely delivery of medications the day after intake</p>	<p>San Quentin is considering the creation of a “Satellite” pharmacy inside RC. The pharmacy would store the most frequently prescribed medications and be able to communicate effectively with the main pharmacy to receive unusual medications in a timely manner.</p>	<p>Less than half of the essential medications for patients are received by the inmate on the day of intake. Missing doses of medications compromise the health of our patients and create further work for the backlogged housing unit clinics.</p>

Report Compiled by:

Elena Tootell, M.D.

Lisa Pratt, M.D., MPH

Susan Wilde, PhD

Maurice Lyons, PhD

Mary Reich, RN

Tim Rougeux

Rahsaan Raimey