Recommendations for CHS and DOC

Ensuring the delivery of correctional health and mental health services is a critical part of the Board of Correction's mission. The following recommendations are intended to: 1) identify areas of concern based on this report's data findings regarding scheduled services; 2) address gaps in tracking care to better understand and minimize barriers to access for scheduled services; and 3) improve the ability of CHS, DOC, and the Board to monitor compliance with other key aspects of the Minimum Standards.

1. **Substantive Areas of Concern Identified via Data Analysis:**

    i. Develop a plan to track and address barriers to DOC production, the main cause of non-completed appointments.

    CHS defers to DOC.

    ii. Examine reasons for the relatively high number and rate of non-completion for Mental Health services. This review should include identifying reasons for the relatively high rates of CHS rescheduling.

    CHS Response:

    CHS' current electronic health record is an encounter based system and as a result, the number of rescheduled visits is artificially inflated with load balancing of clinic schedules. Any modification to a future appointment, whether moving forward or backward, results in a count of rescheduling. Attempts to correlate the aggregate number of rescheduled appointments to clinical appropriateness of scheduling patterns is misleading. By late summer, CHS expects to complete the transition to its new Correctional Health Electronic Record system (CHER) and early data exploration suggests that scheduling tasks can be appropriately accounted for in future reporting.

    The Brad H stipulation requires certain services to be delivered to patients at predefined intervals in the care continuum. CHS coordinates and adjusts appointments to respond to production patterns, enabling compliance with timeliness thresholds. This process appears as a rescheduled visit.

    iii. Improve access to on- and off-island specialty appointments. This should involve conducting a detailed process review, clarification of policies related to patient refusals, and identification of strategies to address factors thought to be related to patient refusals such as overbooking, lengthy wait times, waiting area space and conditions, approach to scheduling patients with special security designations, and transportation challenges.

    CHS Response:

    CHS schedules according to clinical need. Every on- and off-island referral to specialty care is reviewed by senior medical staff and assigned a priority for scheduling. This process ensures that patients are scheduled to be seen at clinically appropriate intervals while also taking into account clinic capacity. It is unclear how the Board has linked overbooking with patient refusals using utilization frequency statistics.

    CHS has implemented telehealth with both Bellevue and Elmhurst as well as on-site specialty services in seven facilities to reduce transportation needs and, when clinically appropriate, allow for encounters to occur without the need for lengthy transportation.

iv. Implement policies and training to minimize health and mental health appointment conflicts with court, school, or other known conflicts with services or programs.

CHS Response:

CHS actively avoids scheduling around conflicts with services and programs. As indicated in the April 2019 access report, only 4% (n=1800/50033) of all scheduled health and mental health appointments were missed due to court conflicts. When CHS learns of a conflict, clinic schedules are modified to ensure patients are seen. This process contributes to the rates of rescheduling noted in 1(ii).

It's important to note that the mental health workflow requires "court" to be documented, even in cases where the court date is known ahead of time and the appointment has already been rescheduled. The number of court and rescheduled appointments is not an appropriate measure for identifying barriers to care.

The act of scheduling and rescheduling appointments highlights CHS' commitment to minimizing access conflicts with services and programs.

2. **Gaps in Identifying and Understanding Barriers to Access:**

   i. Identify and track underlying reasons for non-production, such as escorting, lockdowns, searches, scheduling conflicts, and other frequently occurring reasons identified by DOC.

   CHS defers to DOC.

   ii. Identify and track underlying reasons for and time to rescheduling, such as CHS/DOC staffing shortages.

   CHS Response:

   The current electronic health record does not lend itself to tracking this information. However, as indicated in 1(ii), with the implementation of our new system CHER, CHS is exploring new ways of tracking access to clinical services within predefined, clinically appropriate timelines which would not require the functions of scheduling and rescheduling appointments.

   iii. Train both clinical and corrections staff to ensure consistency in data collection across facilities and service disciplines.

   CHS Response:

   All CHS electronic workflows already ensure consistency in data collection. CHS has quality assurance mechanisms in place, both technical and clinical, to ensure quality documentation.

iv. Review best practices from jails with high rates of completed appointments, including North Infirmary Command, West Facility, and Rose M. Singer Center jails.

CHS Response:

The three facilities above have unique patient populations and processes and should not be used as a benchmark without proper context.   By definition, the infirmary is set up to provide increased access to care for CHS' sickest patients. West Facility houses a small number of patients and serves as CHS' communicable disease unit. The average daily population is approximately 22 patients. The Rose M. Singer Center is the only women's facility and is not subject to patient transfers between facilities. With the exception of off-island specialty services, all clinical services are provided on-site and significantly reduce the need for transportation to appointments.

3. **Key Gaps in Monitoring Compliance with Standards**:
    i. Develop new tracking and reporting protocols to assess compliance with Minimum Standards on: (i) intake; (ii) sick call; (iii) timeliness of service delivery and completion; and (iv) substance use treatment services.

    CHS Response:

    CHS already reports the number of completed medical intakes and the average time to completion as requested by BOC research staff.

    CHS reports unscheduled services, including sick call.

    CHS is exploring ways to analyze and report data on the timeliness of service completion and substance use treatment services with our new electronic health record, CHER.

    ii. Set benchmarks and targets for access to care.

    CHS Response:

    As noted above, CHS is exploring new ways to measure access which will incorporate benchmarks and targets for comparable patient populations.

    iii. Update the CHS access to care report to address gaps in current reporting to better inform future action plans.

    CHS Response:

    Addressed through comments above.

Providing access to health and mental health care to people in DOC custody requires coordination between clinical and corrections staff. The Board's Minimum Standards on Health and Mental Health Care reflect that premise and include many access to care and documentation requirements for CHS and DOC. Compliance for certain aspects of the Standards can only be demonstrated via coordinated CHS/DOC tracking and reporting (e.g. intake screening, timeliness of service delivery, sick call).

CHS Response:

CHS has used an electronic health record at all facilities since 2011 which is the sole source for CHS' access report. The electronic health record not only supports compliance with Board Standards but also with community and correctional specific clinical standards.

CHS coordinates with DOC by providing the necessary information so that they may facilitate patient production to appointments. CHS metrics appropriately reflect the extent to which patients receive clinical services, either requested by CHS or the patient.