Executive Summary

Documents and reports were reviewed, over thirty key staff were interviewed, and eight correctional facilities were visited in order to evaluate the effectiveness and efficiency of the health care operations, and to make recommendations for improvement. Employees were cooperative and frank in their discussions of problem areas and frustrations.

One of the major problem areas is the lack of an optimally effective working relationship between the central office staff and the key staff in the institutions. In part this is attributable to inadequate assistance for the Medical Director in his clinical oversight role, and to a discontinuation of statewide medical staff meetings. The multiplicity of contracts and subcontracts has also complicated relationships. It is recommended that an Assistant Medical Director position be established, and that statewide or regional medical staff meetings be resumed. It is also recommended that the division of labor among the central office bureau staff be studied with an eye to possibly consolidating some roles and adding a Nursing Director position. In addition, part-time regional medical directors and regional nursing directors or health care administrators are suggested.

The quality assurance (QA) program is weak and ineffective, lacks widespread commitment and understanding, and lacks sufficient staff dedicated to the program at the institutions. It is suggested that technical assistance be considered. It is also recommended that each institution have one nurse whose full-time responsibility is coordinator of QA, infectious disease, and chronic illness care.

QA is only one of the important aspects of care that has suffered from staff reductions. There is other evidence of over-stressed staff, including a vacancy rate of 16%, poor employee morale and frustrations with inefficiencies, and difficulties in recruitment and retention. Woefully inadequate clinic space at ORW and at PCI are also significant factors impacting working conditions and morale.

A very significant inefficiency results from the lack of a uniform interconnected computerized information system. Data are collected and reported in a variety of ways, some manual and some using individually designed computer programs. Reliable tracking and analysis of timelines of the intake procedures, sick call, chronic illness care, dental appointments, and off-site appointments all require a consistency that could easily be provided with a uniform computerized system. The initiative shown at a few institutions in designing their own such programs deserves acknowledgment, and model programs should be replicated statewide.

The relationship with OSU Medical Center, while very advantageous, is less than wholly satisfactory. Excessively long waiting periods for specialty appointments, last minute cancellations, attitudes of residency physicians, and reluctance to share
autopsy reports and death summaries (thereby negating effective ODRC mortality reviews) are among the several issues that were brought to my attention. It is recommended that OSU designate one physician to serve as liaison with the CMC and ODRC medical directors, to add efficiency to a process that is now mainly committee driven. I also recommend that the utilization review responsibility for OSU hospital admissions, currently carried only by OSU, have a counterpart ODRC employee. In addition, to facilitate gynecologic care of women inmates and avoid frustrated trips to the CMC/OSU clinic, an on-site GYN clinic at ORW should be established.

The CMC inpatient service needs tighter oversight in regard to medical record completeness and required frequency of physician rounds. Designated levels of care should be conspicuously indicated on the chart and problem lists should be present. Absent problem lists, illegibility, and excessive brevity of physician notes were issues in medical records in all institutions, speaking for the need for more oversight.

Although confidentiality dictates the need for separate mental health records, some of the important mental health information should be readily available to the providers of medical care. I recommend that the mental health diagnosis appear on the master problem list, and that a copy of the initial mental health assessment appear in the medical record. I also recommend that consideration be given to ways for the psychiatrist to share information with the medical physician, in the record.

Another issue regarding medical records is that of retrieval of old records when an inmate is admitted on a new sentence. Such retrieval is now optional, on request of the physician. I recommend that it be done routinely, since the old records may contain vital information.

The contentious hernia repair issue needs resolution by means of selection criteria developed through a consensus of involved ODRC and OSU physicians. There will still inevitably be differences of opinion regarding some individual cases, but the current lack of guidelines causes unnecessary friction.

Other recommendations include an analysis of the discrepancies in dental waiting periods; the provision of peak expiratory flow meters at all institutions for following the care of patients with asthma; revision of the chronic illness guidelines and flow sheets; retaining the health services requests in the medical record; establishment of a physician peer review activity; streamlining of the medical grievance procedure to bypass the Chief Inspector's office; clarification of the tuberculosis surveillance program reporting inconsistencies; and streamlining of the non-formulary drug request procedure.

Finally it is recommended that health care staff be urged to take advantage of the educational and networking opportunities provided by national correctional health care organizations and their conferences, and that educational leave be granted for attending such meetings.
Introduction

In September 2003, in response to a request from Director Reginald Wilkinson, I agreed to conduct a review of the medical care program in the Ohio Department of Rehabilitation and Correction (ODRC), to evaluate the effectiveness and efficiency of the operations, and to make recommendations for improvement. Accordingly, I requested a number of documents to be sent to me for my review. Subsequently I visited ODRC offices and correctional institutions, traveling to Columbus on October 14 and returning on October 23. My work was greatly facilitated by the cooperative attitude of all ODRC and contract staff. This report summarizes my scope of activity, sources of information, findings, conclusions and recommendations.

Scope of Activity

An effort was made to identify components of the medical program that were operating well and those in which there were difficulties and problems. Documents, policies and reports were reviewed that were applicable system-wide, and other documents were reviewed at each institution visited. Site visits were made to facilities that represented several levels of custody and medical care. Interviews were held with key staff in the central office and at the institutions visited. Many materials were selected for further study on return to my office.

Sources of Information

Sources of information included the following:

- Organizational charts and resumes of some key central office staff
- Staffing rosters
- Representative contracts of several categories of contract staff (physicians, dental services, pharmacy services, phlebotomy services, podiatrist, optometrist, radiologist and radiology technician, physical therapy services, laboratory consultant, pediatric services for ORW, cytotechnician, gastroenterologist)
- Dental audit reports
• Medical and dental policies and procedures
• Nursing protocols
• Pharmacy protocols
• Quality assurance program materials and committee minutes
• Infection control materials (mostly memoranda)
• Tuberculosis surveillance data
• HIV surveillance data
• Chronic illness care protocols
• Hepatitis C testing and treatment protocol
• Telemedicine manual, information, schedules, and activity data
• Medical records of inmates who have died in the past 11 months
• Monthly statistical reports

In addition to time spent in the central office, I made visits to the following institutions:

• Corrections Medical Center (CMC)
• Ohio State University (OSU) Medical Center ODRC Unit
• Ohio Reformatory for Women (ORW)
• Pickaway campus: Corrections Reception Center (CRC), Pickaway Correctional Institution (PCI), and Frazier Health Center (FHC)
• Hocking Correctional Facility (HCF)
• Chillicothe Correctional Institution (CCI)

At each of these institutions I spoke with key personnel, reviewed some medical records and other relevant documents.

Many health care and custody staff were helpful in providing information. Particularly informative were the following:

In the central office:
• Kay Northrup RN, BSN, CCHP, Deputy Director, Office of Correctional Healthcare
• Bruce Martin MD, Chief, Bureau of Medical Services/Medical Director
• Peter Huling DDS, Dental Director
• John Gardner RN, Medical Operations Manager
• Ramon Perez RN, Infectious Disease Coordinator
• Darlene Smith RN, CCHP, Medical Quality Assurance Manager
• Sue Smith RN, Standards and Accreditation Manager
• Kay Downing, Medical Fiscal Manager

I also met with Director Wilkinson and Assistant Director Thomas Stickrath, and attended an Internal Review Committee meeting chaired by Mr. Stickrath. Rodney Francis, Operations Manager for the ODRC Central
School System, greatly facilitated my work by transporting me to the various institutions, arranging clearance, and introducing me to the key personnel.

At Corrections Medical Center:
- Tammy Hartzler, Warden
- Martin Akusoba MD, Medical Director
- Harry Stephen King MD, staff physician
- Vinolia Fubara PhD, Health Planning Administrator/QA Coordinator

At Ohio Reformatory for Women:
- Annette Chambers, Deputy Warden for Special Services
- Ikenna Nzeogu MD, Medical Director
- Yvette Thornton RN, Health Care Administrator

At the Corrections Reception Center:
- Alvin Brady RN, Nurse Supervisor
- Sheila Blaney RN, Infectious Disease and Chronic Care Clinic Nurse
- Paul Conti MD, Medical Director
- Kurt Ringle MD, staff physician
- Tammy Morris, Dental Assistant

At Pickaway Correctional Institution:
- Adil Yamour MD, CCHP, Medical Director
- Karen Smith RN, Healthcare Administrator

At Frazier Health Center;
- Karen Stanforth RN, MSN, Healthcare Administrator
- (I also met Bernard Oppung MD, Medical Director.)

At Hocking Correctional Facility:
- Marsha Ferrell RN, Acting Healthcare Administrator
- Herbert Estes MD, Medical Director (interviewed at SCI)

At Chillicothe Correctional Institution:
- Pam Garner RN, Healthcare Administrator
- James McWeeney MD, Medical Director
- Scott Bolte RN
- Missy Bartlett, Medical Records Secretary
- Cindy Williams, Medical Records Secretary
Plant and Equipment

Among the institutions I visited there is a considerable variety in the age, quality, and adequacy of the physical facilities housing the health services operations. Frazier Health Center, for example, is a model work environment, and the Chillicothe medical unit is also spacious, light and attractive. ORW and PCI on the other hand are seriously deficient in space. CRC is marginal in this respect. New construction is under way or planned at ORW and PCI, but it is not clear to staff interviewed that this will significantly alleviate space problems for the medical units.

The space situation at ORW is woefully inadequate. It has resulted in placing the respiratory treatment booth immediately inside the front door to the clinic, in the same corridor where waiting patients are seated. Two examining rooms are not large enough to contain examining tables. In addition, access to the pill call window requires inmates to descend a steep uneven outdoor ramp into a basement.

The space situation at PCI has created traffic problems such that a nursing office also serves as a corridor, there is inadequate space for storing supplies, and pill call access is through a space that also must serve as a modified treatment room. (During my visit a patient was being prepared for transfer to another medical facility in this area.) Total available floor space of the PCI clinic might be sufficient if extensive interior remodeling resulted in a more efficient design.

The space problems are cited because they inevitably have a marked impact on staff efficiency, job satisfaction, morale, recruitment and retention.

Equipment was adequate in each of the facilities I visited, with the exception of peak flow meters, which were not consistently present. These are important for monitoring the clinical status of patients with asthma and chronic obstructive pulmonary disease. An automatic external defibrillator (AED) was located in each unit, in some institutions there were several, accessible to areas of likely need.

Organizational Structure

The ODRC Bureau of Medical Services is headed by the Medical Director, who has nine positions reporting to him. Each of these has an assigned area of responsibility, and some make visits to the institutions in pursuit of their responsibility. The Dental Director, for example, visits each facility twice a year. The Medical Director also makes an effort to visit each institution, but is not able to do this or meet with institutional medical directors on a regular schedule. Four of the other central office bureau staff are health professionals, registered nurses with clinical training and experience. However, while they provide some clinical oversight, they do not have supervisory authority. There is no ODRC Nursing Director. Clinical supervisory and clinical administrative responsibilities are almost exclusively the province of the Medical Director.
There is a perception that there is not a strong operational connection, or authority, between the central office staff and the medical staff at the institutions. This perception is shared by the central office staff and the field staff, and was confirmed by my observations. It is reflected in the lack of consistency in a number of aspects of care, as will be noted in subsequent sections of this report. Some institutional medical directors do not feel obliged to follow direction from a remote authority with whom they rarely meet, and into whose decisions they rarely have input. There formerly were quarterly statewide medical staff meetings, but these were discontinued, probably for fiscal reasons.

**Staffing and Workload**

I was very impressed by the capability of many of the clinical and administrative health care staff whom I met, and by the workload they were carrying. There have been a number of reductions in staff positions in this past two years, resulting in an increased load for those remaining and also resulting in some aspects of care not receiving adequate attention, conspicuously quality assurance. It is my impression that the staffing constraints, fiscally driven, are having a significant negative impact on staff morale. A recent report showed a 16% vacancy rate statewide in authorized positions.

There is a plethora of contracts with physicians and ancillary providers. I was informed that an Internal Revenue Service ruling required the state to discontinue contracting with individual providers on an hourly basis, unless the state provided benefits. As a result, physicians and dentists, for example, have had to incorporate, either individually or in groups, and bid for contracts for services. The state then has awarded contracts for scope of services, without being able to require a specific number of hours on site. This new arrangement came into effect in fiscal year 2002, and has not been met with much enthusiasm. It was not feasible for the Medical Director to interview all of the many applicants for physician contracts. Additionally, since some of the contracts were awarded to physician groups, which then sub-contracted with individual physicians, another layer became interposed between the Medical Director and the on-site physicians.

These comments do not apply to the institutions where health services have been contracted with pre-existing private management or healthcare corporations, namely NCCTF, LaECI, TCI, ToCI, NEPRC, and NCI. I did not visit any of these facilities, and have no comment on their operations.

Although the contracts do not specify hours to be worked by the contractors, the central office has been able to construct a table of estimated FTE values for these positions.

Monthly statistical reports are received at the central office from each institution. While each one reports the same statistics, it is with varying computer programs, and some reports are manually done. There is no uniform computerized data
system, and any analysis of trends or even totaling of statistical categories must be done manually, a very labor-intensive task which therefore is not regularly performed, if at all.

**Quality Assurance**

The term Quality Assurance (QA) has generally been replaced in the correctional health care field with the term Continuous Quality Improvement (CQI). This terminology change encompasses a change in scope and goals of this important program, and follows the leadership of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). I reviewed the QA Policy and Protocol and many QA documents and spoke with individuals involved in this activity at the central office and the institutions. It is apparent that there is not a high level of institutional commitment to the program, that dedicated staff time is insufficient, that assigned tasks are perfunctorily performed, that meeting minutes are largely narrative commentary rather than action oriented, that central office QA meetings are often canceled for lack of a quorum, that there is a lack of understanding by many of the concept and importance of QA, and that here too there is a lack of meaningful connection between the central office and the institutions. Some elements of a good QA program are in place, such as the Healthcare Occurrences Log and reports. Evidence of follow-through is not strong. Some good QA activity is going on at some institutions, conspicuously at CCI, but statewide consistency is lacking.

Utilization Review (UR) is a component of QA that focuses on the appropriateness and cost effectiveness of the utilization of resources, particularly resources that are difficult to predict and control, such as inpatient admissions. It is noteworthy that for admissions to the OSU inmate unit, the only person with a UR responsibility is an OSU employee, not an ODRC employee.

The medical grievance procedure may be considered as another component of QA. The ODRC procedure is similar to those in many prison systems, with informal grievances handled at the institutional level and formal appeals coming to the central office. The four registered nurses in the Bureau of Medical Services central office share the task of responding to grievances. I reviewed several grievance packets and found the responses to be courteous and to reflect a careful and thorough investigation. The process for formal appeals may be unnecessarily ponderous and time consuming, however. Rather than medical grievances coming directly to the Bureau of Medical Services, they go first to the Chief Inspector's office, and from there to the Bureau. It is not clear to me why this step is indicated.

There is no systematic physician peer review activity that I could discover, although it is referred to in the QA policy.
Infection Control Program

The infection control program has a beneficial connection with the Ohio Department of Health (DOH), whose infectious disease consultant is in frequent communication with the central office Infectious Disease (ID) Coordinator. I requested information on the infection control program, and received copies of many memoranda between the ID coordinator and the DOH consultant, an occasional anecdotal case report, and data on PPD testing of the past two years. I would have liked to see periodic comprehensive reports on the infection control program activity.

My analysis of the TB testing report for 2002 shows that, excluding the PPD positive results at the reception centers, there were 187 positive reactions out of 36,410 annual re-tests, for a rate of 0.5%. Similarly for 2003 through July there were 121 positive reactions out of 15,226 annual re-tests, for a rate of 0.8%. These are what are classified as converter rates,signifying possible tuberculosis infection acquired since the initial negative test at the time of incarceration. However, since there are inevitably some “false” negative tests at intake, whose true reactivity can be elicited by a second test (two stage testing), this converter rate may be misleading. The reactor rate at intake testing was 5% in 2002 and 5% for 2003 through July. However, at ORW there were no converters reported for the first seven months of 2003, and no reactors in January or June of 2003, raising a question about the reliability of the data.

The reporting of the number of inmates taking INH prophylaxis for TB infection is very misleading. The total on INH for 2002 is reported as 276, and for 2003 through July as 1940. On inquiry regarding this discrepancy, I found that in 2003 an inmate taking INH is counted again each month that he/she is taking the medication, giving a false statistic. The point is that a good correctional health care program needs to monitor this kind of information and should report its data analysis regularly. The DOH should be consulted regarding the advisability of two-stage testing at intake.

Policy rightfully calls for annual PPD skin testing for TB infection. This has lacked consistency among the institutions, some testing in the inmate's birthday month, others doing mass testing once a year. The Medical Director has recently suggested that all institutions carry out mass testing once a year.

HIV surveillance data is available from 1994 onward. They reveal a prevalence rate of about 1%, based on screening of all new arrivals. Each month's report gives the number of inmates with HIV infection and also the number with AIDS. For example, in July 2003 there were 268 HIV infected, plus 130 with AIDS.

The hepatitis C protocol has recently been revised with the approval of two OSU faculty gastroenterologists, and those physicians oversee treatment decisions for hepatitis C patients. Approximately 15 patients are currently receiving treatment for chronic hepatitis C infection.
Mortality Review

There is a small central office mortality review committee that meets monthly. I reviewed the very sketchy minutes of these meetings, which simply list the cases and their disposition, i.e. closed, tabled for further information, or referred to another committee. I also reviewed the medical records of nine deaths that have occurred in the past 11 months. Policy calls for a death summary to be prepared by the medical director of the relevant institution. Most of the deaths occur in the OSU hospital, and the CMC medical director has the task of preparing the death summary. However, there is a serious communication problem in this area, as OSU is reportedly very reluctant to provide CMC with the needed information, such as a death summary. As a result, mortality reviews by ODRC are greatly handicapped, and the records I reviewed often lacked the necessary documents, including autopsy reports.

A meaningful mortality review must include the staff directly involved in the patient's care prior to hospitalization, must examine the care provided at the institution and in the hospital, and must have available all of the essential information. Mortality review in the ODRC fails to meet these criteria.

Policies, Procedures and Protocols

The medical policies are comprehensive and reference related American Correctional Association (ACA) standards. I have no criticism of them. The co-pay policy is in keeping with that of other states that have such a policy, and includes appropriate exceptions.

The nursing protocols have been adapted from those of the Georgia Department of Corrections, and are assessment protocols, which appropriately do not call for the use of prescription drugs. Each protocol defines the criteria for immediate or urgent or routine referral to a physician.

Pharmacy protocols are thorough and comprehensive. They allow for self-carry medications, a five-day supply of medications for transfers, and a 14-day supply on release. They establish an institutional pharmacy and therapeutics (P&T) committee to meet quarterly and an ODRC P&T committee to meet every two months. I did not look into compliance with these meeting mandates.

Dental protocols were also reviewed. They are appropriate and in keeping with generally accepted standards of correctional dental care.

Review of the medical operations protocols and clinical guidelines indicates a need for updating of the chronic illness guidelines and a revision of those flow sheets. For example, peak flow measurements should be done on patients with asthma and COPD, rather than only pulse oximetry. The hypertension protocol should reference
the latest JNC guidelines, and should require an ACE inhibitor for diabetics. (There are no drug recommendations in the guidelines.) The misuse of flow sheets will be commented on in a later section of this report.

**Telemedicine**

The telemedicine program is well established and seems to be running reasonably smoothly. Each facility had one person assigned to the scheduling of patients for telemedicine clinics. The telemedicine manual describes carefully the needs for each specialty clinic, the scheduling instructions, suggested items to be provided to the consultant, equipment commonly used, and general guidelines for referral to the clinic. For the 12 month period of September 2002 through August 2003 there was a total of 4722 telemedicine encounters at 14 different clinics. The most commonly used clinics were psychiatry (1092), general medicine (718), dialysis (469), infectious disease (452), dietary (402), surgery (279), pulmonary (273), cardiology (265), and neurosurgery (247). This program which connects widespread patients with OSU specialists is a valuable contribution to the continuity of patient care. It also enables important decisions in special clinical areas to be made by the most qualified people in those areas. Therefore, for example, the care of HIV infected patients is overseen by an infectious disease specialist, and the management of hepatitis C patients is overseen by gastroenterologists who are experienced in this area.

**Intake Screening and Initial Health Assessment**

The intake procedures and their documentation were reviewed at ORW and CRC. They seem to be performed in a timely fashion. However, logs of the several steps involved are lacking. A good QA program should regularly monitor the high volume and high risk aspects of care. Rather than reviewing a random sample of records for compliance with the time frame criteria for these intake procedures, it would be preferable if a log or spreadsheet provided this information on all new arrivals, for easy review of compliance. This is another example of the need for a uniform computerized information system.

Dental screening is done by a dentist, within a few days of arrival, and a panoramic radiograph is done just prior to that examination. A dental treatment plan is developed at that time.

**Hospital and Emergency Care**

Most of the hospital care is provided at the OSU Medical Center, usually by referral from CMC. Emergency care is provided by the nearest hospital to the institution concerned. These arrangements seem to be well thought out and developed.
Care of Female Inmates

The care of women inmates presents special issues and is deserving of separate attention in this report. The inadequacy of the physical facilities at the ORW medical unit has already been cited. However, the program for pregnant women is exemplary. Women in labor are evaluated at the local emergency room. If ready to deliver, they are sent to OSU Medical Center. After delivery, if the mother has 18 months or less to serve on her sentence, mother and baby are housed at a special unit of ORW. Here there is a nursery with cribs. Babysitting arrangements are made with other inmates to enable the mothers to attend educational programs. What I saw in evidence of a caring program for these mothers and their babies, and the constructive involvement of other inmates was very impressive. A pediatrician visits weekly.

On the other hand, attention to gynecologic care is problematic. Patients are scheduled for GYN clinic at CMC, which is held only once a week. Sometimes the patients, approximately 15 each week, are transported to CMC only to find the GYN clinic has been canceled because the gynecologist was unable to attend. This is a source of dissatisfaction on the part of patients and ORW staff. A caseload of this size, 15 patients per week, would seem to warrant an on site GYN clinic.

Sick Call

In most institutions requests for sick call are submitted confidentially, in a locked box. Health care staff retrieves them, prepares the nurse sick call list, and issues sick call passes for the inmates. At PCI inmates sign up for sick call. Some institutions are still using the "kites" that were designed for all kinds of inmate communications with institutional staff. Others are using the newer health services request forms. If the sick call list seems too long for the next day, the triaging nurse makes decisions about the urgency and schedules accordingly.

Sick call requests and kites are not filed in the patient's medical record at any of the institutions I visited, and I gather this is statewide policy. They are retained, filed away by the month, but this makes it virtually impossible to document the timeliness of sick call response, something that may loom important in individual complaints or law suits. Furthermore, sick call logs tracking the dates of request, response, encounters and referrals are not kept. Therefore monitoring of this high volume activity is done on a record sampling basis rather than by the monthly review of the timeliness of all sick call encounters that would be easily done with the use of logs.

Chronic Illness Care

The chronic care protocols are several years old, and need updating. The flow sheets also need redesigning. At one facility I visited they are not used. They do not allow adequate space for the physician to enter the required information. As a result, an
entry on the flow sheet to cover several items may state "see progress notes." In one
institution, however, where such a note is customary, the progress note for that date
states "see flow sheet." Obviously no clinical information is conveyed in this
situation, which illustrates the need for a peer review activity. Quite a few of the
records I reviewed did not contain the indicated chronic care forms.

Policy requires that patients with chronic illnesses be seen at least quarterly.
Compliance with this is not regularly monitored. At Chillicothe, however, a model
system has been developed for tracking the care of these patients. A computer
database spread sheet enables the secretary to view lists by diagnosis, to view the
schedule of visits for any one patient, and to print a list of patients to be seen each
week. A nurse then takes this list and divides the patients among the five days of the
week, scheduling them to be seen by the physician. This computer program has been
shared with two other institutions at their request. It should be replicated
throughout the ODRC, to replace manual systems. A similar computer program is
in use at PCI and at Frazier Health Center.

At Hocking, a facility for older men, 406 of the 460 inmates are registered in chronic
care clinics. A computerized scheduling system is also used here. At this facility a
nurse prepares for the chronic care visit by ordering the indicated laboratory tests
in advance. When the physician sees the patient, the laboratory results are in the
chart. I do not know whether this procedure is followed elsewhere, but it should be.
This facility, unlike the others I visited, has a few peak expiratory flow meters, for
monitoring patients with asthma or COPD. Hocking also has 7 negative pressure air
flow cells. Twenty of the Hocking residents are using oxygen concentrators.

Specialty Care

Some specialty care is typically provided on site at the institutions, such as
optometry and podiatry. The rest is either by telemedicine or actual attendance at a
specialty clinic at CMC, staffed by OSU specialists. Each institution has one person
assigned to the scheduling task. Satisfaction with the CMC scheduling is variable.
Problems with gynecology clinic have been noted above. Some specialty clinics have
a long waiting period. There have been complaints about the less than caring
attitude of some of the OSU physicians, and that sometimes residents conduct the
clinics without the presence of their faculty supervisor, who sometimes fails to show
up. I visited an orthopedic clinic at CMC, spoke with the senior orthopedist and
observed the work of his residents. That clinic clearly was running smoothly and
with a professional and caring attitude.

A computerized "Medical Operations Scheduling System" is reportedly in use at all
institutions. I did not attempt to confirm this, but I did discover that at Chillicothe
some improvements have been made in that system, such that the spreadsheet also
shows the date of the request for referral. A standardized system would enable a
better statewide analysis of the timeliness of specialty care.
Infirmary Care

Except for PCI, each institution I visited has a few infirmary beds, located in proximity to the medical unit, used for short-term observation and low level care. Frazier Health Center, on the other hand, has a highly developed infirmary care system. The wards are staffed full time by registered nurses, who make frequent bedside visits and record vital signs daily. The physician makes rounds weekly. The analogous arrangement for women at ORW is not a ward, but 8 cells containing 11 beds. ORW has 2 negative pressure respiratory isolation rooms, and 2 crisis observation rooms with good visibility. ORW also has a housing unit for the medical fragile, and Frazier has long-term care wards for similar male patients. (Frazier also has a 15 chair outpatient dialysis unit serving men and women.)

Higher level infirmary care for men and women is provided at CMC.

Corrections Medical Center and OSU

CMC is a hive of medical activity. It houses short-term (about 100) and long-term (about 50) inmate patients, men and women. The long-term patients are those whose needs exceed the care capabilities of the institutions. The long-term facilities include an exemplary hospice program and an attractive chemotherapy room. Short-term patients are frequently post-operative or convalescing patients who have been discharged from OSU Medical Center (OSUMC) but are not yet ready for a return to their assigned institutions. In addition to the inmate patients residing at CMC, there is an inmate work force cadre of 58.

The physician staffing consists of a full time medical director, one other full time and one part time physician. In addition, there is psychiatry and other mental health staffing. Ancillary services include physical therapy, radiology, a pharmacy and a full service laboratory.

CMC also serves as the center for outpatient specialty clinics, patients being sent in from the many institutions. Scheduling of clinic visits and of admissions to OSUMC for surgery is a major undertaking, involving several employees of CMC and OSU. This is a computerized procedure, and the monitoring of the activity is printed out in graphic form. Most specialty clinics have no significant backlog of appointments, cardiology and neurosurgery being exceptions in the September report with 46 and 86 appointments pending respectively. Surgical admissions are another matter, the greatest delays being in general surgery, perhaps reflecting the issue of hernia repair.
Policy 68-MED-14 Specialty Health Care Services designates four levels of care:

Level 1 - Care that is medically mandatory.
Level 2 - Care that is presently medically necessary: Care without which the inmate could not be maintained without significant risk of either further serious deterioration of the condition or significant reduction of the chance of possible repair after release, or without significant pain or discomfort.
Level 3 - Care that is medically acceptable, but not medically necessary, and is considered to be elective.
Level 4 - Cosmetic or other care that is not considered medically necessary.

The policy does not provide any time frame for carrying out the procedures that qualify as level 2, which would include most hernias.

A number of surgical procedures require pre-authorization, or approval, by the ODRC Medical Director. This is normal procedure in state corrections departments, or in any managed care system. Most of the procedures on the pre-authorization list are not controversial, such as cosmetic surgery, scar revision, tattoo removal, and sex change operations. It only makes sense that the need for these procedures is carefully considered before approval or denial. However, the problematic procedure is hernia repair. There is a lack of consensus among ODRC physicians as to which hernias should be repaired, and the OSU surgeons apparently favor repair of all of them. This presents a difficult decision problem for the ODRC Medical Director. It illustrates the need for a consensus among those directly involved in the referral and selection process, to avoid wasteful and destructive conflicts. Criteria for selection for repair, developed in concert with institutional medical directors and the OSU surgeons, would be extremely helpful.

I visited the OSUMC, following the route for hospital admissions of ODRC inmates from the holding areas to the locked ward and other special care units. At the time of my visit there were 14 patients in the locked ward and 8 more in other areas, such as surgical ICU, medical ICU, coronary care unit, and OB/GYN. As mentioned earlier in this report, the only utilization review on these patients is conducted by an OSU nurse, none by a CMC employee. Furthermore, it is my understanding that ODRC is billed for these admissions in accordance with Medicare approved length of stay for the diagnosis, regardless of the actual length of stay. This is not unusual, but may warrant a cost-benefit analysis on the part of the ODRC.

I also visited the CMC long term and short term units and reviewed a number of medical charts. Patients in the long-term units are apparently visited by the CMC physician monthly or less often, according to the information in their charts. Additionally, the OSU infectious disease physician visits his patients, with his resident, managing the care of patients with chronic infectious diseases.
While these patients are obviously on different levels of care, their charts do not clearly reflect such level, and there are no protocols, to my knowledge, prescribing the frequency of physician visits and progress notes. Problem lists, required by policy, are conspicuously absent in these charts.

Interdisciplinary attention to care is in evidence here, with mental health treatment team charting in the medical record, and a weekly meeting of a treatment team comprised of about 10 people, including representation from medical, mental health, physical therapy, and the chaplain. This group sees long-term patients one at a time, scheduling them such as to review each patient every three months, and updating the multidisciplinary treatment plan. Another multidisciplinary committee meets weekly focusing on program matters, with representation from medical, mental health, dietary, laboratory, the chaplain, nurse supervisors, and quality assurance. This meeting is chaired by the CMC medical director, and minutes are recorded.

There is a monthly meeting at OSU involving key staff of both OSU and ODRC, a monthly CMC clinical staff meeting at the central office and a monthly clinical and administrative staff meeting at CMC. The interface between ODRC and OSUMC presents a number of challenging aspects, and warrants constant attention and problem solving. It is apparent that this is a recognized issue and that it is being addressed, through clinical and administrative meetings and with the assistance of an OSU liaison employee, who is not a clinician.

The Mental Health Care-Medical Care Interface

Except for the interdisciplinary activity cited in the previous section, there is not much evidence of patient care communication between mental health and medical providers at the institutions. The initial mental health screening done at intake is copied in the medical record. The more comprehensive mental health assessment is not, remaining in the separate mental health record. Apparently the usual procedure is for the medical record to be brought to the psychiatrist along with the mental health record, but the reverse does not occur. The psychiatrist orders medication on the medical record order sheet, but does not make notes in the progress notes.

This method of record communication, or lack thereof, between medical and mental health is not unique to ODRC. Mental health records require a higher level of confidentiality by statute in most states than medical records, and therefore are maintained separately from the medical record. From the standpoint of optimal overall patient care, the important issue is the communication of needed information. This can be achieved by copying some information, such as the psychiatrist's note, into the medical record, and by a faithful use of the problem list in the medical chart. It was my observation that problem lists are usually lacking the indicated mental health diagnosis.
Dental Care

Dental staffing may be sufficient, but the waiting period for non-urgent dental care varies greatly from one institution to another. For example, at Frazier there was a two week wait for extractions, a two month wait for fillings, and a 6-8 month wait for dentures. At Chillicothe the waiting period is 2-5 days for extractions, 2 months for fillings, and 5 months for dentures and partials.

At PCI the dentist only screens patients who have signed up for dental sick call, and sends those needing care to Frazier Health Center. The computerized scheduling system developed at CRC is also used at Frazier, and a different program is utilized at Chillicothe. The CRC program is a commendable one, providing not only an appointment schedule, but also a spreadsheet showing the date a request or referral is received, the date it is answered, the inmate name and number, and the date of the scheduled appointment. This is another example of a model system that deserves replication throughout the ODRC.

The Dental Director visits each institution twice a year. He audits each facility annually. I reviewed many of his reports, which are narrative, problem-focused, and informative. The monthly statistical reports from the institutions report the number of dental visits, but not the number of various dental procedures. The Dental Director would welcome a more detailed dental service report, and I think that would be useful for purposes of program analysis.

Medical Records

I reviewed 56 medical records, sampling a few at each institution from the list of chronically ill. The records are divided into sections, and material is generally located in the appropriate section. As previously noted, mental health records are separate. Dental records are also separate, not a usual arrangement in my experience. A frequent deficiency in the medical records is the absence or incompleteness of the master problem list. This is a list of medical diagnoses or problems, located by policy as the top page in the first section of the record, to provide any health care staff with the immediate knowledge of what is wrong with the patient. An admission history and physical examination were missing on several CMC records. Physician illegibility and excessive brevity is an issue in many records. Noteworthy are physical examination documents that are inadequately informative.

Record availability is an issue for some institutions. Medical records do not always accompany inter-facility transfers. The standard procedure for re-admissions, parole violators for example, is to obtain the old medical record from the institution where they were last housed. In the case of re-admissions of those whose previous sentence has expired (EDS or expired definite sentence), and are now in on a new sentence, the old record has been archived at a central location, and a new
identification number is assigned them. The old record is retrieved only if the physician requests it. There are complaints that the retrieval process is too slow, whether from the previous institution or central archives. This would be a good QA study, as would be the matters of record deficiency cited in the previous paragraph.

Some of the problems with medical records are attributed to insufficient clerical staff and the abolition of relevant positions.

Pharmacy and Medication Distribution

The institutions visited had either a full pharmacy or a satellite drug room. Drug orders are dispensed in blister packs, and pill pass occurs three times a day for general population. A correctional officer is present at each pill pass window to observe the ingestion of the medication, to be sure it is not pocketed or cheeked. Segregation units are visited by a nurse three times a day for medication distribution. Emergency (stat) drug orders are either filled from pharmacy stock supplies, or are filled by a local commercial pharmacy.

There is a keep-on-person, or self-carry policy, which allows inmates in general population to keep certain medications in their room. These include medications for chronic conditions, antibiotics, topical medications, eye and ear drops, inhalers, vitamins and over-the-counter medicine. Psychotropic and mood-altering drugs and drugs of potential abuse are excluded from this policy. A 5-day supply of a patient's medication is to accompany inmates transferring to another ODRC institution or to a county jail, and a 14 day supply is given to inmates on release from custody.

The pharmacy protocols are extensive, comprehensive and specific. Computerized drug profiles are maintained for all inmates receiving medication. The formulary is reasonably comprehensive, and is appended with a list of non-formulary drugs for which an equivalent formulary substitution will be made. If a physician insists on prescribing a non-formulary drug, approval of the ODRC Medical Director is required. That is standard policy in correctional health care systems. Apparently, however, the approval is usually post hoc, occurring after the drug has been started.

The pharmacies and drug rooms I visited were well maintained, and with proper security safeguards.

Conclusions and Recommendations

The Bureau of Medical Services is fortunate to have some high quality employees on its staff, very capable, hard working, and conscientious. However, some are objectively critical of the obstacles to the achievement of their goals. Unfortunately discouragement is not uncommon, and recruitment and retention are a daunting challenge. In an effort to identify significant problem areas and to suggest remedial measures, the following comments are offered. These comments are not presented in any order of priority.
1. There are serious space problems at ORW and PCI which make work conditions less than rewarding and pleasant. There is perhaps a resolution to this, pending new construction, by some interior remodeling with a more efficient use of space. This seems particularly possible at PCI, where there is adjacent space that is not adequately incorporated into the clinic area. I suggest an architect be consulted on this matter.

2. Peak expiratory flow meters should be available at each clinic. This is an inexpensive equipment item, important in following patients with obstructive airway disease. Pulse oximetry is not an adequate substitute, although it is useful for additional evaluation of patients whose breathing is compromised. The peak expiratory flow is a more sensitive indication for determining the need for referral to the hospital.

3. The connection between the central office bureau staff and the field staff is far from optimal. Communication is inadequate and lacking in personal contact. There are five health care professionals in the central office, one physician and four registered nurses. The division of labor deserves reassessment.

The work load of the Medical Director is excessive for one individual. In that position it is always difficult to strike a balance between the administrative demands of the central office and the need to maintain contact with staff in the field, particularly physician staff. Governance of a physician staff is a challenging task, and is best achieved through consensus. When directives or protocols have had prior input from the physicians involved, they are much more likely to be followed. This implies meeting together for discussion of important matters, and that is difficult to achieve with a medical staff as large and scattered as exists in Ohio. Apparently such meetings were held in the recent past, but have been discontinued. That is unfortunate. An effort should be made to resume them bimonthly or quarterly, ideally on a statewide basis, at least on a regional basis.

The Medical Director needs to visit all the institutions regularly, meeting with the physicians, health care administrators and nurses, establishing collegial relationships, evaluating physician performance, addressing complaints and problems. The fairly recent physician contract arrangement, requiring physicians to incorporate and bid competitively, rather than selectively contracting with physicians at a previously established compensation rate, has presented new challenges for the Medical Director. He is minimally involved in the selection process in the first place. Secondly, he may have another physician interposed between him and the site physicians, complicating his relationship as a monitor of physician performance.

Therefore, in reassessing the work load and division of labor in the central office I recommend establishing a full time position of Assistant Medical Director, to be filled by another physician. This person could perform some of the peer review that
is now not getting done, reviewing physicians' charts for legibility, and for compliance with chronic care protocols, for example, as well as for appropriateness of care. I also recommend considering the establishment of regional medical directors who would be half time administrative and half time clinical, as another organizational step in improving communication and direction within the Bureau of Medical Services.

Consideration should also be given to establishing a Nursing Director. This position could relate to the institutional health care administrators, most or all of whom are registered nurses. Here too, regional nursing directors or health care administrators might improve operational efficiency and communication.

Additionally, in the central office, consolidation of the quality assurance and infectious disease coordinator roles might be considered. I feel strongly that there is a need to examine the roles and responsibilities of the central office staff, and its working relationship to the field staff, with an eye to crafting a more effective and efficient organizational structure.

4. A very significant inefficiency results from the lack of a uniform interconnected computerized information system. Some institutions collect and report necessary data manually, while others use their own computer system to prepare a report, but transmit it by mail. Likewise, the appointment systems, tracking systems or logs, are handled in different ways at different institutions. An exemplary computerized dental appointment schedule and tracking system exists at CRC, and deserves replication. A model computerized system for tracking the care of chronically ill patients has been developed, and deserves replication.

5. The quality assurance program is weak. There is some good work taking place at some of the institutions largely as a result of the initiative of some experienced and knowledgeable nurses, but there is not a widespread understanding of the importance of QA or continuous quality improvement (QI). QA or QI is the keystone in the arch of correctional health care. There is not a high level of organizational commitment to it, dedicated staff time is inadequate, tasks are often performed perfunctorily, and pursuit of remedial activity is insufficient. I recommend that the ODRC consider technical assistance for its quality improvement program.

6. Staffing apparently is a problem at all institutions, a number of positions having been abolished in the past two years in an effort at fiscal restraint. I did not carry out a staffing analysis, but the current vacancy rate of 16% is about 6% higher than is generally acceptable and explainable by normal attrition. It suggests a problem with employee morale, retention and recruitment, and indeed many of the key staff I interviewed had been in place only a relatively short period of time and some were considering leaving because of dissatisfaction with workloads and inefficiencies.
It is my understanding that there used to be a position of QA coordinator at each institution, and that these positions were abolished a year or so ago. As noted in the previous paragraph, this is an essential activity that is receiving inadequate attention. It is my suggestion that each institution have one nurse whose full-time responsibility is Coordinator of QA/QI, Infectious Disease, and Chronic Illness Care. I believe that this is a manageable clinical package for one registered nurse, and that none of these assignments should be added to the responsibilities of the Health Care Administrator.

7. Utilization review for patients admitted to OSU Medical Center is conducted only on the OSU side. Therefore ODRC does not participate in the evaluation of cost effectiveness of continued inpatient care. I recommend that there be an ODRC counterpart for this activity.

8. The medical grievance procedure is responsive but slow in reaching its final formal stage. I recommend that medical grievances be separated from other grievances early in the process, and that they be routed through health services paths to the central office, bypassing the Chief Inspector's office.

9. There is no systematic physician peer review activity. This need should be addressed by the Medical Director, and the comments in paragraph 3 above are relevant to this problem.

10. The infection control program has a beneficial connection with the Ohio Department of Health (DOH). The tuberculosis surveillance activity reports some confusing and inconsistent data. I recommend that the reporting of patients taking INH be clarified, that PPD converters be identified as a category separate from reactors, and that the possibility of two stage PPD testing at intake be explored with the DOH. I also suggest that the relative efficiencies of annual mass PPD testing versus testing in the birthday month or confinement anniversary month be examined. The latter system would coincide with the annual health assessment, and might be less burdensome on staff.

11. A meaningful mortality review is not taking place in many instances. Such a review should include the staff directly involved in the patient's care both prior to and during hospitalization, and should have available the essential information, including medical record, death summary and autopsy report. Apparently OSU has not been forthcoming in providing this information. As a result, mortality reviews by ODRC are greatly handicapped. I recommend that this matter be addressed and resolved in the CMC-OSU meetings.

12. Guidelines for the management of the common chronic illnesses are in need of updating to comply with current national recommendations. There are several sources available for information in this area.
13. The flow sheets used in the chronic illness care program are also in need of revision. They are too crowded and invite the kind of misuse that is occurring. They should call for less information and be supplemented with further clinical information placed either in the progress notes or on a specially designed chronic illness encounter form.

14. The telemedicine program seems to be running smoothly, the only problem being scheduling in a timely fashion, a matter to be addressed as mentioned in paragraph 18 below.

15. There is a need to track the several components of the intake procedure. In other words, a log giving the dates of the various procedures is necessary for purposes of completeness and quality assurance. Rather than monitoring the timeliness of this high volume activity by means of a small sampling of records, it is preferable to review all new intakes for compliance with requirements, which can easily be done if computerized spreadsheets are used. This is another example of the need for a uniform computerized information system.

16. There is likewise a need to track the sick call responsiveness for the same reasons of monitoring timeliness. Again this speaks for the need of a uniform computerized information system. Additionally, the practice of filing sick call requests in monthly folders rather than in the inmate's medical record presents a problem if retrieval is needed for reply to grievances, for example. Most systems I am familiar with record the date and time of receipt of the request, and on the request form also record the disposition of the request, by a nurse. This then remains in the medical record, in a designated section. If the request form is a full page, it can also serve as an encounter form for the nurse sick call. I recommend that this or some other arrangement be considered, such that the inmate request for care remain in the medical record.

17. Availability of gynecologic care is a problem at ORW. It requires transportation to CMC, and scheduled clinics may be canceled at the last minute, resulting in a waste of transport resources and dissatisfaction on the part of patients and institutional health care staff. I recommend that an on-site gynecology clinic at ORW be initiated.

18. The relationship between ODRC/CMC and the OSU Medical Center, while very advantageous, is less than wholly satisfactory. It is apparently the focus of several committees and meetings. Satisfaction with scheduling for specialty clinics is variable, some specialty fields having a very long waiting period. There are also complaints that some OSU residency physicians regard inmate patients as second class citizens and do not treat them with proper respect and a caring attitude. I did not find that to be the case in the one clinic I observed, however. Nevertheless, it seems clear that there are problems in the ODRC-OSUMC interface that are not being successfully resolved by the current committee approach. I suggest that OSU designate one physician to deal directly with the ODRC Medical Director and the
CMC Medical Director, to meet regularly, even informally, to address mutual concerns. I think this trouble shooting approach may prove helpful, even if it doesn't replace existing committee meetings.

19. The CMC inpatient service should have tighter oversight in regard to medical record completeness and frequency of physician rounds. I recommend that levels of care be conspicuously indicated on the medical records, that requirements for minimal frequency of physician rounds be clearly stated, that problem lists or diagnostic reasons for admission be prominently located in the chart, and that compliance with these requirements be regularly monitored by clerical staff.

20. The issue of hernias is a bone of contention among the involved physicians and deserves resolution. Hernia repair is not an expensive operation, is often done as an outpatient procedure, and patient selection should not be the source of as much disagreement, nor consume as much time and energy as it currently does. The matter would be alleviated if there were selection criteria that were developed and agreed upon by the Medical Director and the OSU Department of Surgery, and endorsed by the institutional medical directors.

21. There is a need for more mental health information to be placed in the medical record. Although the different level of confidentiality may require separate mental health records, the mental health diagnosis should appear on the master problem list, and a copy of the initial mental health assessment should appear in the medical record. Consideration might also be given to using a NCR form for the psychiatrist's encounters, so that one copy can go in the medical record, thereby sharing information between physicians.

22. Dental waiting periods are extremely variable, a matter deserving the attention and analysis of the Dental Director. This may reflect a problem of staffing or efficiency. There is a need for a uniform computerized scheduling system, and the one in use at CRC is a model for statewide adoption.

23. Completeness and legibility of the medical record are problems that require attention, and additional medical records staff are needed in some institutions to monitor records for completeness. Illegible entries should be brought to the attention of the author, as should the absence of entries on the master problem list. Physician illegibility and excessive brevity also require the attention of and mentoring by the Medical Director.

24. Old medical records of new admissions are not routinely retrieved if the inmate is in on a new sentence. The need for retrieving the old record is decided by the physician. This is a mistake in my judgment, since the physician may not have sufficient information on which to base such a decision. I recommend that old medical records be retrieved from the archives on all new admissions.
25. The issue of non-formulary drug requests is a source of irritation for some. In my opinion the formulary is adequate, including the list of equivalent substitutions for non-formulary drugs. It is also appropriate that there is a provision for the prescribing of non-formulary drugs, if such prescriptions can be justified as clinically necessary. The system for these requests is slow and inefficient, however, and should be streamlined, using fax or e-mail communication.

26. Finally, there is a need for more participation by ODRC health professionals, both salaried and contract, in national correctional health care organizations and conferences. Inmates are the only segment of our population with a constitutional right to adequate health care. How to provide such care and how to avoid expensive litigation are the focus of national conferences and publications. Correctional health care is a field with unique challenges and aspects of care, and the sharing of information and cross-fertilization of ideas that occur at national conferences are an extremely valuable resource. ODRC physicians, nurses, and healthcare administrators, particularly those in key positions, should be urged to take advantage of these resources. The salaried staff need to be supported in this effort with educational leave, and perhaps with some financial support as well.

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