

EXHIBIT 1

JEFFREY L. METZNER, M.D., P.C.
1777 SOUTH HARRISON STREET
SUITE 1500
DENVER, COLORADO 80210

TELEPHONE (303) 355-6842
FACSIMILE (303) 322-2155
TAX ID #84-0848664

April 29, 2022

Laura Mullally, Esq.
Assistant Attorney General
300 East Joppa Road, Suite 1000
Towson, Maryland 21286

Corene Kendrick, Esq.
Deputy Director
ACLU National Prison Project
39 Drumm St.
San Francisco, CA 94111

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Twelfth Report by the Mental Health Monitor

Dear Ms. Mullaly and Ms. Kendrick:

Introduction

This Twelfth Report by the Mental Health Monitor on compliance with the provisions of the Settlement Agreement in the above referenced matter is based on my site visit during April 6-8, 2022, review of documents prior to and during the scheduled visit, and the Commissioner's Semi-Annual Compliance Report dated April 1, 2022. The Commissioner's Report and related documents cover the time period from July 1, 2021 thru December 31, 2021.

Sources of Information

During this site visit, I was able to attend treatment team meetings on the IMHU and SNU. In addition to discussions with staff regarding the SA provisions and QI activities, I attended the morning huddle conducted by Centurion to review sick call and outstanding referrals to mental health. A presentation was provided by information technology staff from both ICDT (information technology communication department) and NextGen regarding upgrade in the specific context of the mental health treatment plan. I also interviewed 3 detainees in the IMHU and 5 SNU detainees. In addition, during the three-day site visit I reviewed with staff 5 healthcare records of various inmates receiving mental health treatment.

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 2 of 21

Prior to and during the site visit I was provided the following documents and quality management reports:

1. the April 1, 2022 Commissioner's Semi-Annual Report,
2. Centurion's Duvall Bi-Annual Submission covering July 2021-December 2021,
3. Corizon Health's Duvall Settlement Agreement Semi-Annual Compliance Report covering July 2021-December 2021, and supporting documents,
4. Centurion Organizational Chart for the Baltimore region,
5. Centurion Maryland - Vacancy Rate - Baltimore Region (July - December 2021),
6. listing of Centurion staff by discipline,
7. listing of mental health caseload numbers by providers,
8. BCBIC FTE summary, including vacancies and coverage,
9. BCBIC State Psychology Organizational Chart,
10. QI reports, which included the following topics:
 - a. Timeliness of Intake Urgent Referral Follow-Up,
 - b. Timeliness of Non-Intake Urgent Referral Follow-Up,
 - c. Sick Call Protocol and Timeliness Compliance,
 - d. Psychiatry Follow Up of Detainees on the Mental Health Caseload,
 - e. Clinician Follow-up for Suicide Precautions,
 - f. Mental Health Detainees Returning from Outside Institution,
 - g. Intake Treatment Plans,
 - h. Non-intake Treatment Plans,
11. listing of SNU and IMHU group therapies,
12. Suicide Prevention Committee meeting minutes (July - December 2021),
13. relevant inpatient statistics,
14. multivendor meeting minutes (July - December 2021),
15. listing of total bookings and commitments (January 2021 - December 2021),
16. SNU roster and average census, and
17. slides relevant to IMHU training by Centurion.

The percentage of detainees on the mental health caseload has remained significant as demonstrated by the following statistics:

For November 2021, the ADP for pretrial was 977

Total ADP by gender

Men= 842

Women=135

Mental health caseload for November 2021

Men= 451(39 men seen 2xs within the month) = 412

Women=116 (17 women seen 2xs within the month) = 99

Men= $412/842= 50\%$ of the total male population

Women= $99/135= 73\%$ of the total female population

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 3 of 21

Total unique mental health patients: $511/977 = 52\%$

It is my understanding that the Settlement Agreement re: a finding of “substantial compliance” should be assessed as follows:

Thus, “substantial compliance” is to be assessed with regard to a “substantive provision” (entire numbered paragraph), not each “component” (lettered subparagraph). The Settlement Agreement does not contemplate separate determinations of substantial compliance with regard to medical and mental health care.

Therefore, unless otherwise noted in the report, substantial compliance findings are specific to the component(s) (lettered subparagraph(s)) in contrast to the entire specific provision. All components of the specific provisions will continue to be monitored until all components of a specific provision have been found to be in substantial compliance.

In the context of Settlement Agreement (SA) provisions relevant to the mental health system, the Commissioner has declared Substantial Compliance for provisions 17 b- c, 23 a-d, 25 e & g of the SA. My assessment of those these provisions was consistent with substantial compliance now being present except for 17c (which was extremely close to achieving substantial compliance) and 23d. Provision 25c and 25-fii were also now in substantial compliance. All of these assessments were being made in the context of the preceding paragraph.

Additional information was provided by either DPSCS, Centurion and/or Corizon regarding other provisions relevant to mental health services via the pre-site information packets. The following “Findings” section will summarize my findings, which will use the definition of substantial compliance as defined in the Settlement Agreement. Similar to Dr. Puisis’ report, I will define noncompliance as being significantly remote from substantial compliance with considerable work needed to attain substantial compliance. Partial compliance will be defined as between noncompliance and substantial compliance with reasonable efforts ongoing to achieve compliance. The Settlement Agreement does not use the term “partial compliance”. Unless either party objects, I will continue to use this term in order to acknowledge that the state has made some progress towards achieving compliance but has not yet done so. Some of the provisions that follow include mental health issues but are primarily traditional medical issues that are being monitored by Dr. Puisis.

Findings

17. Intake and initiation of medication.

17a: The Commissioner shall promulgate and implement policy and procedure to provide adequate medical and mental health intake screening to all plaintiffs accepted for admission at BCBIC. Such policy shall provide that initial medical and mental health screening, including rejection or acceptance for admission of the plaintiff, is performed by a RN within

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 4 of 21

four hours of arrival at BCBIC, provided the plaintiff is present for all four of those hours. If the plaintiff is rejected for admission and later returns to BCBIC, a new four-hour period within which the initial medical and mental health screening must be performed shall commence.

April 2022 Assessment: Partial compliance

December 2021 findings: See November 2021 report by Dr. Puisis, which included the following:

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

December 2021 recommendations: Dr. Puisis recommended that a QI be developed, which includes a method to review the quality of nurse IMMS performance that gives feedback to nurses. Such a QI process should include process to assess the quality of the mental health component of the intake healthcare screening (i.e., the IMMS form).

April 2022 BCDC status update: Per the medical monitor's recommendation, an intake quality evaluation tool was developed and piloted during this reporting period. The pilot confirmed discrepancies between nursing history and provider history, which can be attributed to the provider use of CRISP (Chesapeake Regional Information System for Patients), unlike the nurses whose evaluations were solely based on patient disclosure.

Duvall's leadership team has been collaborating with statewide leaders to implement a standardized intake process. Future plans involve integrating the Corizon Core process to streamline the intake process.

April 2022 findings: This provision is primarily one to be monitored by Dr. Puisis except for my December 2021 recommendation, which stated the following:

Dr. Puisis recommended that a QI be developed, which includes a method to review the quality of nurse IMMS performance that gives feedback to nurses. Such a QI process should include a process to assess the quality of the mental health component of the intake healthcare screening.

Centurion has provided training to nursing staff re: mental health intake screening.

April 2022 recommendations: Perform the recommended quality improvement study.

17b: The Commissioner shall ensure that any plaintiff who reports during intake screening that he or she is currently prescribed medication for a medical condition, or who presents with an urgent medical need, shall receive a physical assessment by a Clinician within 24

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 5 of 21

hours of the intake screening, or sooner if clinically indicated.

April 2022 Assessment: Defer to Dr. Puisis' assessment.

December 2021 BCDC status update: The Corizon semi-annual report included the following:

There is documentation of the same arrestee's name as an urgent referral on the IMMS Referral Log, the same date as IMMS

This indicator has remained 98% or better for the reporting period and the past 24 months. Medical Provider encounters for urgent referral completed within 24 hours of intake screening, or sooner if clinically indicated. (To validate this provision, the auditor uses the time of the IMMS and the time on provider's Sallyport encounter)

Medical Provider encounters for urgent referral completed within 24 hours of intake screening, or sooner if clinically indicated.

This indicator has averaged 97% for this reporting period and the last 18 months.

December 2021 findings: As per status update section.

April 2022 findings: I will no longer monitor this provision since provision 17c is the mental health system's equivalent of provision 17b.

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

April 2022 Assessment: Partial compliance

April 2022 BCDC status update: A comprehensive audit by Centurion specific to this provision was reviewed. During the July - December 2021 data period, the average compliance rate for men and women at BCBIC was 88% (75/85) and 87% (39/45), respectively. The combined six-month compliance rate for this audit period was 88% (114/130). Further analysis of various compliance included the following:

1. Custody Issue
2. Referral Sent Late by MHP
3. Scheduling Issue
4. Technical Issue
5. Staffing Issue
6. No Clinic Appointment Slots

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 6 of 21

7. Provider Issue MHP & Scheduling Issue
8. Clinic Interruption and Escort Challenges

An “MHP Issue” accounted for 7/16 of the reasons for non-compliance during this reporting period (July - December 2021).

April 2022 findings: As per status update section. Appropriate corrective action plans have been initiated by Centurion as summarized in the Centurion generated Duvall Report binder provided to the parties. This provision is very close to being compliant.

Of note, the Corizon generated Duvall settlement agreement report provided an audit specific to this provision, which was consistent with the audit results reported by Centurion.

April 2022 recommendations: As per the corrective action plans.

17d: To address the needs of plaintiffs who, prior to being taken into custody, were prescribed medication that, if interrupted, would pose a risk of adversely affecting health, the Commissioner shall promulgate and implement policy and procedure to ensure that such plaintiffs receive such medications within 24 hours of the intake screening or subsequent encounter at which the plaintiff first reports such medications to a Medical Professional or Mental Health Professional, or sooner if clinically indicated, unless:

- (i) a Clinician determines that such continuation is not medically appropriate, including without limitation a determination that continuation is not medically appropriate pending verification of the reported prescription, provided that appropriate verification efforts shall be promptly undertaken; or
- (ii) despite reasonable efforts consistent with the gravity of the need for the medication, DPDS is unable to timely obtain the medication. The Commissioner shall promulgate and implement policy and procedure requiring reasonable efforts, consistent with the gravity of the need for the medication, to ensure that such plaintiffs are timely provided with the medication or a pharmaceutical equivalent.

April 2022 Assessment: As per Dr. Puisis assessment.

April 2022 BCDC status update: The Corizon Duvall settlement agreement report summarizing audit relevant to this provision. Findings included the following:

For this audit period, this audit indicator averaged 69%, which is up from 66% in the last reporting period

First dose medication reported at IMMS or alternative medication ordered were administered within 24 hrs. of the IMMS in OCMS

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 7 of 21

For this audit period, this audit indicator averaged 62%, which is up from 51% in the previous reporting period

April 2022 findings: As per my December 2021 findings, it is my understanding that the lack of the planned new EMR is directly related to the lack of substantial compliance.

Since this provision primarily involves the medication administration process (i.e., Corizon Health services) I will defer to Dr. Puisis in the context of his assessment and recommendations. I will continue to track progress because this provision directly impacts mental health care services.

April 2022 recommendations: As above.

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

April 2022 Assessment: As per Dr. Puisis assessment.

December 2021 findings: Dr. Puisis' report included the following:

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

This provision is very similar to provision 17d.

December 2021 recommendations: See report by Dr. Puisis.

April 2022 findings: I am deferring to Dr. Puisis for assessment of this provision. I will continue

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 8 of 21

to track this provision.

23. Sick Call

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

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

April 2022 Assessment: Substantial compliance has now been maintained for at least 18 months in the context of mental health sick call slips that have been received by the mental health staff.

April 2022 BCDC status update: Refer to the Centurion and generated Duvall report, which included the following findings:

The six-month aggregate compliance rate, from July – December of 2021, was 100% for women and men for picking up sick calls from medical nurses daily, to include weekends. Similar compliance was demonstrated by audit results for sick call requests being triaged by a mental health registered nurse within 24 hours of receipt.

However, the above results were applicable to only mental health sick call slips received by the mental health nurses from the medical nurses. A Corizon audit indicated compliance issues with sick call slips being received and triaged by medical nurses in a timely manner. This issue is being monitored by Dr. Puisis. For this element of this provision to be in compliance, compliance will be required by both the medical and mental health nurses.

April 2022 findings: As per status update.

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

April 2022 Assessment: Substantial compliance has now been maintained for at least 18 months in the context of the mental health care services.

April 2022 BCDC status update: Refer to the Centurion generated Duvall report, which included the following findings:

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 9 of 21

Almost 100% of routine triage decisions resulted in a face-to-face encounter with the detainee by a R.N. Urgent and emergent referrals received by a registered nurse resulted in a face-to-face encounter within the required timelines.

April 2022 findings: As per status update section.

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

April 2022 Assessment: Partial compliance

April 2022 BCDC status update: Audit results demonstrated the following:

Summary of data reflects an 89% (56/63) compliance rate for Urgent Referred patients.

The Routine referrals six month aggregate total compliance rate for this period was 80% (208/261).

In the sample, there was 1 (one) emergent referral in September 2021 which reflected a 0% (0/1) compliance rate for this period.

This emergent encounter was noncompliant due to the Mental Health Professional sending the notification later than the 2 hour time frame per contract.

During the focus period, there were a total of 91 Outliers categorized into 7 categories. Scheduling Issue/s (45) and Custody Issue/s (28) accounted for 80% of the overall outliers during this focus period.

Appropriate corrective action plans were formulated.

April 2022 findings: As per status update section.

April 2022 recommendations: Implement the corrective action plans.

24. Medical Records

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

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 10 of 21

April 2022 Assessment: As per Dr. Puisis' assessment.

April 2022 BCDC status update: The Corizon settlement agreement report included the following audit:

The eligible audit population included all patients that were scheduled for chronic care (CCC), nursing and mid-level provider sick call clinics, mental health, onsite specialty, and dental clinics. The purpose of this audit is to determine medical records compliance with providing the hard copy record for review for all scheduled provider visits. In addition, the audit reviews that providers are documenting a review of the hard copy record for patient encounters. For this reporting period, the provision monthly sample size was set at 65 based on a 95% confidence level, with a 5% confidence interval as indicated on the sample size calculator on www.omnicalculator.com/stastics/sample-size.

This audit indicator averaged 85% for the past two reporting periods.

There is documentation of the encounter in the EPHR, noting that the hard copy records were available and were reviewed during the specific healthcare encounter

This audit indicator has trended up slightly to 58% in this reporting period

April 2022 findings: As per my December 2021 findings, it is my understanding that the absence of the planned new EMR is directly related to the noncompliance.

Since this provision primarily involves the medical records system (i.e., staffed by Corizon Health services) I will defer to Dr. Puisis in the context of his assessment and recommendations. I will continue to track progress because this provision directly impacts mental health care services.

April 2022 recommendations: As above.

25. Mental Health Care

25a: The Commissioner shall promulgate and implement policy and procedure to ensure that appropriate Mental Health Professionals are provided to ensure timely and appropriate evaluations for medications and suicide risks.

April 2022 Assessment: Partial compliance

December 2021 BCDC status update: Data was not provided specific to this provision although data provided in the context of other provisions was relevant to this provision.

December 2021 findings: Findings specific to this provision will be based, in large part, on compliance or partial compliance with other provisions, especially if partial compliance is

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 11 of 21

determined to be directly related to staffing issues. Additionally, the contract with Centurion requires includes the following provisions:

3.6.4 At least fifteen (15) Business Days before the start of each Contract Period beginning with the second Contract Period, the Contractor shall submit a staffing plan which reflects its then current staffing arrangement for approval by the DPSCS Contract Manager and the DPSCS Director of Mental Health... .

Centurion will be submitting their adjustment in January and DPSCS will send me the needs assessment at that time.

December 2021 recommendations: As above.

April 2022 BCDC status update: As per my December 2021 findings

April 2022 findings: I was not provided with the required needs assessment as summarized in my December 2021 findings. It is my understanding is such an assessment is almost completed and will be submitted through the proper channels in the near future.

April 2022 recommendations: Please include the above referenced needs assessment in the pre-site package prior to the next site visit.

25b: When a request for a bridge order for psychotropic medications is made for a plaintiff, and the bridge order is approved, the plaintiff shall be seen within 14 days, or sooner if clinically indicated, for an in-person evaluation by a licensed psychiatrist or psychiatric registered nurse practitioner. In the event that a bridge order is denied, the plaintiff shall be seen for an in-person evaluation by a licensed psychiatrist or psychiatric registered nurse practitioner within 24 hours of denial of medication.

April 2022 Assessment: Partial compliance

December 2021 BCDC status update: See below.

December 2021 findings: It is my understanding that bridge orders are no longer being used due to implementation of a primary care model, which includes medical providers writing the initial psychotropic medication orders based on the initial healthcare screening process. However, this process has not been specifically reviewed via a QI process that focusses on the initial prescription of psychotropic medications.

The QI should assess the following:

1. Whether the PCPs are writing orders when clinically indicated in a timely manner.
2. Whether such detainees are followed up a psychiatric prescriber within 14 days, or sooner when clinically indicated, of the PCP's medication order.

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 12 of 21

3. If the verified psychotropic medication is not prescribed by the PCP, is the detainee evaluated within 24 hours of such a denial by a psychiatric provider?

December 2021 recommendations: As above.

April 2022 BCDC status update: Data was not provided specific to this provision.

April 2022 findings: The requested QI has not been performed. However, detainees interviewed indicated that they had received timely bridge orders.

April 2022 recommendations: Perform the recommended QI study.

25c: The Commissioner shall promulgate and implement policy and procedure to ensure that plaintiffs are evaluated by an appropriate Mental Health Practitioner within 24 hours of an urgent referral.

April 2022 Assessment: Substantial compliance (April 2022)

April 2022 BCDC status update: The Centurion Duvall report described relevant audit results as follows:

During the July-December 2021 data period, the average compliance rate for men and women BCBIC was 97% (38/39) and 90% (18/20) respectively. The overall compliance rate for the July-December 2021 data was 95% (56/59).

April 2022 findings: This provision is distinguished from provision 17c because it addresses timeliness of urgent referrals generated outside of the intake process.

April 2022 recommendations: Continue to monitor.

25d: Plaintiffs who are prescribed psychotropic medications shall be seen face-to-face by a licensed psychiatrist or psychiatric registered nurse practitioner at least every 90 days, or more frequently if clinically indicated.

April 2022 Assessment: Partial compliance

April 2022 BCDC status update: The Centurion Duvall report described relevant audit results as follows:

During the July - December 2021 data period, the average compliance rate for men and women at BCBIC was 99.7% (598/600) and 100% (314/314) respectively.

The combined six-month compliance rate for this audit period was 99.8% (912/914).

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 13 of 21

When the patient was scheduled and seen sooner than the standard 90-day period, audit results were as follows:

During the July - December 2021 Data Period, the average compliance rate for men and women at BCBIC was 88% (526/600) and 97% (306/314) respectively. The combined six-month compliance rate for this audit period was 91% (832/914).

During this reporting period, 52.4% (43/82) of the outlier reasons were due to “No Clinic Appointment Slots.” This was due to an influx of Initial Psychiatric Evaluations. The remaining outliers were due to Scheduling Issues (30.5%, 25/82) and Custody Issues (17.1%, 14/82).

April 2022 findings: As per status update section.

April 2022 recommendations: Continue to review consistent with the above audit.

25e: Plaintiffs who are suicidal, self-injurious, or otherwise in need of close monitoring or treatment shall be seen by appropriate Mental Health Practitioners as often as clinically indicated, for evaluation and recommendations for the management of such behavior. Nothing in this Settlement Agreement is intended to restrict the ability of RNs, consistent with the scope of their training and licensure, to participate in and assist with the treatment, evaluation, and management of such behavior.

April 2022 Assessment: Substantial compliance has now been achieved in the context of daily clinical contacts with a mental health clinician. (April 2022)

December 2021 findings: See status update section. I discussed with leadership staff the need to see a QI that addresses whether detainees on suicide precautions are being observed on staggered 15 minutes intervals.

December 2021 recommendations: As above.

April 2022 BCDC status update: The Centurion report included relevant audit results as follows:

The July - December 2021 aggregate compliance rate was 100% (110/110).

17 out of the last 18 months (August 2020 – December 2021) are 100% compliant, with anticipation of continued compliance in the next six-month review period.

The 24-month overall aggregate of compliance rate for January 2020 through December 2021 was 98.2%.

April 2022 findings: As per status update section. The requested QI that addresses whether detainees on suicide precautions are being observed on staggered 15 minutes intervals was not done (see December 2021 findings and recommendations).

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 14 of 21

April 2022 recommendations: Perform a QI that addresses whether detainees on suicide precautions are being observed on staggered 15 minutes intervals

25f-i: For purposes of this Settlement Agreement, a "Mental Health Plan of Care" is a combined summary, evidenced by psychiatrist, psychologist, or psychiatric registered nurse practitioner documentation in the medical record that includes:

- (a) a summary listing of major mental health problems; and**
- (b) a plan for treatment of such identified major mental health problems, including, as applicable, medications, testing, and records of past periodic chronic care appointments and access to orders for future periodic chronic care appointments. The Mental Health Plan of Care shall be documented in the EMR. In the EMR existing as of the Effective Date, the Mental Health Plan of Care shall be documented utilizing the Chart Summary template. See paragraph III.18.a. regarding the Medical Plan of Care.**

April 2022 Assessment: Partial compliance

December 2021 findings: The template for the mental health plan of care is in the process of being developed as part of the EMR process that is in the late stages of development. During the virtual site assessment, I discussed the following issues with leadership staff:

1. The need for separating the mental health problem list from the medical and dental problem lists although all of the problem lists should be accessible to clinicians who have access to the EMR.
2. The need for training of mental health staff in the context of developing a problem list. For example, diagnoses in general should not be listed as a problem although symptoms of diagnoses may be an appropriate problem to list (e.g., auditory hallucinations, high suicide risk, vegetative symptoms of depression, etc.). The problem list should be the driver of the treatment plan (i.e., the mental health plan of care).
3. The problem list should be able to easily distinguish between active problems and problems that are now inactive and/or resolved.
4. Staff will need training regarding developing a manageable problems list. For example, 20 problems will be very difficult to adequately address in contrast to 3-5 problems.
5. The mental health plan of care (a.k.a., the treatment plan) should address the active problem list and include the goal (e.g., expected outcome), specific interventions (which should include who is responsible for providing the intervention) and the how the outcome (i.e. accomplishment of the goal) will be measured.
6. The process of developing the treatment plan will depend on the level of mental health care being received. This should be clarified by policy and procedure. It is my understanding that such a P&P is in the process of development. Please send a draft to me when it is in a form ready for my input.

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 15 of 21

7. A best practice re: progress notes is to either use a SOAP (subjective, objective, assessment, plan) or a DAP (data (combines both subjective and objective components), assessment, plan) format. I recommend that either format be used and required by P&P although this is a best practice recommendation and not a settlement agreement requirement.

I think that this provision will be among the last provisions to be in substantial compliance due to the amount of training/supervision that will be required to successfully implement it. Unless the parties tell me differently, I also interpret this provision to require successful implementation of the treatment plan developed, which also means that the treatment plans need to be implementable.

December 2021 recommendations: As above.

April 2022 BCDC status update: No pre-site information was provided.

April 2022 findings: As per my December 2021 findings. During the site visit, a presentation was provided by information technology staff from both ICDT (information technology communication department) and NextGen regarding a planned upgrade to the electronic medical record (EMR) in the specific context of the mental health treatment plan. The discussion of the planned upgrade in this section is restricted to the mental health treatment plan only. The planned upgrade to the EMR is much broader than just the mental health treatment plan.

The treatment plan template used in the current EMR is a reflection of custom modifications made over the years, which has resulted in a very adequate treatment plan template. Unfortunately, it is my understanding that the planned upgrade, which is to be rolled out very soon, will not include any of these customized modifications although modifications will be possible after the rollout has been completed. It is my opinion that the planned upgrade will actually result in a “downgrade” in the specific context of the mental health treatment plan if the custom modifications that are present in the current treatment plan template are not eventually incorporated into the upgraded EMR. I discussed in detail with both information technology staff and leadership staff the differences in the treatment plan template that will be present in the upgraded EMR as compared to the current treatment plan template. IT staff appeared optimistic that the pertinent modifications in the treatment plan template will be made after the upgrade has been rolled out.

I discussed with both parties during an April 29, 2022 conference issues related to the mental health plan of care (i.e., the mental health treatment plan). It was clarified that the POC would include records of past periodic chronic care appointments and access to orders for future periodic chronic care appointments as applicable. Both of these data points are currently available in a manner that is assessable to both clinicians and mental health leadership staff. The history of periodic chronic care appointments is present in the section of the electronic medical record entitled “Adult Chart Summary” and future chronic care appointments are lists in the latest clinicians’ progress notes.

This treatment aspect of the mental health plan of care is documented utilizing the chart summary

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 16 of 21

template. It is my understanding that the “chart summary template” is the same as the “Homepage/Adult Chart Summary” section in the current EMR. IT staff indicated that a link on the homepage can be designed and implemented in the upgraded EMR to provide easy access to the mental health plan of care (i.e., the treatment plan).

April 2022 recommendations: Implement the above recommendations.

25f-ii: The Commissioner shall promulgate and implement policy and procedure to ensure that all plaintiffs who are currently diagnosed in the BCDC medical record with mental health problems are enrolled in chronic care clinics. If clinically indicated, treatment plans shall be documented in the EMR within 14 days of the plaintiff's admission. If a mental health condition requiring treatment is identified after intake, treatment plans shall be documented in the EMR within 14 days of the identification of the condition.

April 2022 Assessment: Substantial compliance (April 2022)

December 2021 BCDC status update: No pre-site information was provided.

December 2021 findings: As I understand this provision, it specifically applies to detainees receiving an outpatient level of care. It awaits implementation of the new EMR prior to providing relevant QI data.

December 2021 recommendations: Make sure that the new EMR will be able to facilitate a QI process relevant to this provision with a specific focus on the 14-day timeframe requirement.

April 2022 BCDC status update: The Centurion Duvall report included relevant audit findings as follows:

The aggregate intake treatment plans compliance for July through December is 99% for Men and 98% for Women, respectively.

The aggregate non-intake treatment plans compliance for July through December is 100% for Men and Women.

April 2022 findings: See status update section.

April 2022 recommendations: Continue to QI and include a qI that assesses the quality of the treatment plans.

25f-iii: The Mental Health Plan of Care for a plaintiff with a major mental health problem, or who is prescribed medication for a mental illness, shall include scheduled follow-up with an appropriate Mental Health Practitioner as clinically indicated but no less frequently than every 90 days and shall be updated at each clinical encounter.

April 2022 Assessment: Partial compliance

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 17 of 21

April 2022 BCDC status update: See provision 25d

April 2022 findings: See provision 25d. I discussed with the parties issues related to the requirement that the Mental Health Plan of Care be updated at each clinical encounter. It is my opinion that the frequency of treatment plan updates should be based on their level of mental health care and be clarified via a written policy. In general, treatment plan reviews for an infirmary LOC should be weekly, residential LOC should be monthly (some systems the frequency is every 90 days) and an outpatient LOC update frequency should be 6-12 months. Treatment plan reviews should also occur whenever the person's mental health LOC changes (increased or decreased) and as clinically appropriate.

The parties will jointly discuss these recommendations.

25f-iv: The Mental Health Plan of Care shall be accessible to any Medical Professional or Mental Health Professional who is providing treatment, including diagnostic services, to a plaintiff, unless the need for emergency treatment precludes access at the plaintiff's location.

April 2022 Assessment: deferred until next site assessment

April 2022 BCDC status update: No update provided.

April 2022 findings: Will defer assessment until issues re: the definition of the mental health plan of care have been clarified/resolved.

April 2022 recommendations: As above.

25g: In those cases in which a plaintiff under treatment for mental health problems is returning to BCDC after having been confined in an outside institution and has been absent from BCDC for two weeks or more, the plaintiff will receive a new medical/mental health screening by a RN, and a new suicide risk assessment from a Mental Health Practitioner.

April 2022 Assessment: Substantial Compliance has been maintained.

April 2022 BCDC status update: The Centurion Duvall report included relevant audit findings as follows:

For the July 2021 – December 2021 reporting period, 24 detainees returned from MDH. No detainees returned during the month of September.

The 6-month data in the above charts demonstrates the continued effectiveness of the current process.

For all 24 detainees (100%), medical records, including COVID test results (when

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 18 of 21

available) and the most recent Medication Administration Record (MAR), was obtained prior to the detainee returning to DPSCS custody.

For this reporting period, 23 out of 24 detainees (96%) who returned from the state psychiatric hospitals received a full medical intake by the medical vendor before being admitted to the IMHU for continuity of care and medication reconciliation.

Similarly, 23 out of 24 detainees (96%) were monitored for stability and proper recommendations for housing were made.

Over the past reporting period, 22 out of 24 detainees (92%) received the Columbia-Suicide Severity Rating Scale (C-SSRS). The two detainees who were not admitted to the IMHU did not receive the C-SSRS. Despite this, both were followed by mental health.

As noted, 20 out of 24 (83%) of the detainees received a multi-disciplinary treatment plan.

Overall, the data for the reporting period reflects continued compliance with 96% of detainees receiving a full medical intake, and 92% of detainees receiving the Columbia Suicide Severity Rating Scale.

April 2022 findings: See status update section.

April 2022 recommendations: Continue to QI this provision.

25h: Nothing in this Settlement Agreement is intended to restrict the ability of any Mental Health Professional to place a plaintiff on suicide restrictions pending review of that status by an appropriate Mental Health Practitioner.

April 2022 Assessment: Substantial compliance

December 2021 BCDC status update: No pre-site information was provided.

December 2021 findings: I am not aware of the history that led to this provision being included in the settlement agreement. However, it is my understanding, based on information obtained from both leadership and line staff, that nothing in either settlement agreement or policies and procedures, restrict such an ability of any mental health professionals to place a detainee on suicide restrictions pending review of an appropriate MHP.

April 2022 findings: Unchanged from my December 2021 findings.

Additional Information

As summarized in my December 2021 report, the SNU serves the following function:

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 19 of 21

Due to the COVID-19 pandemic, the Special Needs Unit (SNU) incorporated the IMHU's stepdown program due to the physical plant of the IMHU interfering with proper social distancing. Since January 2021, the SNU has functioned as a subacute unit for detainees stepping down from the inpatient level of care and for those in general population who require additional supports.

SNU detainees confirmed that the programming on the SNU includes individual therapy with a SNU clinician on an as needed basis, treatment team once a month and one to two group therapies per week. Additionally, detainees are offered, at minimum, two to six hours of free recreation during the day and evening shifts depending on their privilege level. The physical plant of the SNU and the custody and mental health staffs have facilitated a therapeutic milieu within the SNU.

Related to the Covid-19 pandemic and the IMHU physical plant, the IMHU appears to function as a segregation level of confinement from the perspective of very limited out of cell time being offered to the IMHU detainees. The acuity level of the IMHU detainees remains high.

The detainees are offered showers three times per week, phone usage twice weekly, and movies several times a week. When feasible, psychiatrically unstable detainees are brought out of their cell to meet with the treatment team in the conference room. These interactions vary in length depending upon the detainee's ability to maintain safety.

There have been no reported completed suicides since March 2018.

Update re: Covid -19 issues

The Commissioner's Semi-Annual Compliance Report (July to December 2021) included the following:

I. Departmental Response to COVID-19

It has now been two years since the onset of the COVID-19 pandemic. At the onset of this event, the Department of Public Safety and Correctional Services ("department") moved swiftly to implement COVID-19 prevention, detection, and response measures as informed by Centers of Disease Control and Prevention, and worked closely with Maryland Department of Health (MDH), medical monitor Dr. Puisis, the department's Chief Medical Officer Dr. Baucom, and Corizon's infectious disease physicians and specialists to develop policies and procedures at Baltimore Central Booking and Intake Center (BCBIC). These measures have been thoroughly documented in previous reports. The department has continued to share policies and procedures related to COVID-19 with the court monitor and plaintiff's attorneys through phone conferences, declarations, email/written responses, and regular reporting of the following parameters to the Plaintiffs' counsel: cumulative

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 20 of 21

numbers of positive cases, recoveries, active cases for state and contractual staff and inmates, daily BCBIC census.

This section will highlight related updates during this reporting period. The following data is current as of 3/23/2022 unless otherwise noted.

558 inmate and 557 staff total COVID-19 cases have been recorded since March 2020

0 inmate and 0 staff active cases

Staff (all DPSCS): 4,134 first doses administered, 4,038 second doses administered, and 2,003 booster shots (ref. DPSCS COVID-19 Dashboard: <https://dpscs.maryland.gov/covid-19/>)

Inmates (BCBIC): 466 first doses administered, 282 second doses, and 90 booster shots administered (ref. DPSCS COVID-19 Dashboard: <https://dpscs.maryland.gov/covid-19/>)

Ongoing weekly staff testing this reporting period

Ongoing weekly randomized inmate testing this reporting period

There have been no changes with respect to **detection** measures outlined in the previous submission, including testing at intake and surveillance testing.

There have been no changes with respect to **prevention** measures outlined in the previous submission, including vaccine education, enrollment, and administration.

There have been no changes with respect to **response** measures outlined in the previous submission, including continued coordination with the Maryland Department of Health for all aspects of COVID-19 response.

. The next site, which will be a joint visit by Dr. Puisis and myself, will occur during September 21-23, 2022.

Please contact me if you have any questions.

Sincerely,



Jeffrey L. Metzner, M.D.

Psychiatric Assessment

Re: *Jerome Duvall et al v. Lawrence J. Hogan et al.*

Page 21 of 21

Clinical Professor of Psychiatry

University of Colorado School of Medicine

*This report was dictated via the use of voice software, which may explain the presence of any typographical errors.