Justice Services Advisory Board Meeting

February 28, 2020

Good morning we like to call order the Justice Services Advisory Board meeting for February 28 2020. Roll Call.

Reverend Duvall - present,

Ms. Taylor - here,

Dr. Garza - here

Dr. McBride -

Mr. Smith - here

Ms. Lee -

Ms. Schmidt - here

Rev. Duvall: It should be noted that Dr. Mc Bride did notify us and had a previous engagement in that he could not break. And also we received an e-mail early this morning at 5:02 from Ms. Lee saying she would be absent as well.

I would like to put the motion to approve the minutes, understandably, we do have some questions that... have we had the time to review the minutes?

Ms. Taylor: I have - I don't know how much I should use but I do have just some corrections nothing tremendously substantive but before we improve them. Some. Um,

I knew I need to ask for a motion to amend and wonder how you want to do this. They're, they're really attributions who said what mostly, and so I could do them as a group and make a motion or one by one whichever you.

Ms. Frank: I would do that I would recommend we do it as a group they just kind of that that's the piece that we can move that accept the minutes with those amendments.

Ms. Taylor: So I don't know if you, if you all have them in front of you or if you even read them, but I'm assuming you have, but on paper on paper. First one, first one I want to raise to your attention is page two, in the bottom under patient safety updates the last line just say it's really something that Valerie said Miss Nelson has had conversations with Miss Taylor on additional structuring for improving communication. I don't think that's what we were talking about I think we were talking about two things one was event reporting and one was the work they're doing with between medicine people and corrections people. So, I think. Additional structuring for patient safety would be fine for me. That's, that's my suggestion just something

general because I you know I don't want to put words into Valerie's mouth that I think that's more specific. On the next page first paragraph. Last one says on the whole there needs to be a total strategic plan. This is attributed to me - I wish I had thought of it but I felt that Dr Garza should be involved in the discussion. The last part is true that it is should be a separate paragraph that says Dr Garza added that it would be appropriate for patient safety to have a strategic plan and. And I asked that he be certainly involved in that. However you want to say that.

And the next paragraph Ms. Taylor stated the committee needs to be more communicative with each other. I really, I didn't say that. I thought the issue was communication between the committee and Justice Services was adequate. And I felt that there should be more communication between Justice Services and the committee. I think that was part of the problem the committee was being a little bit too communicative with each other.

Further down that page in this second last paragraph that starts Reverend Duval. And then it says Taylor said that moving forward and timeline is needed on the total event. I was referring to the Mr. Mitchell death. She felt that this has been reported that she felt that was has been recorded I'm sure I’m sure you meant to say what has been reported so far has been through the eyes, has been through a review of negligence in the process needs to be reviewed changed what I really said was, I was concerned from the comments that I've heard from the county executive spokesperson and other people that they were viewing this death through a negligence lens instead of a process improvement process analysis lens which is not looking at, at the process of the review but process improvement is a term that describes a really thorough root cause analysis and looking at processes rather than individual people to blame that was my intention. So I would suggest just make a change, through the eyes, through your negligence lens and that and that and that the events need to be reviewed through a process improvement analysis. That would be, I think that is my... on last one. Last page under community process for communication.

In the first paragraph. It says it was discussed that Tashonda Troupe had to send Miss Taylor, a message that that then was forwarded to Dr. Doucette and Director Banasco, a communication system needs to be implemented so concerns are addressed.

That was part of what I brought up but I thought, actually I thought I didn't know what the communication system had been but I had certainly forwarded my concerns on, they had both told me that they were addressing the concerns. The big deficit here was the looping back the closed loop communication with the family, the source of the complaint the people who actually called and were concerned about the inmates in inside. No one called them and said, ‘We heard you”. This is what we did,

or this is what we can't do or we can't talk about it because of privacy or anything. And that's the closed loop communication is what needs to occur and then we went into a conversation about office events and things like that. That is the sum total of my amendments is anybody have any questions or objections to the amendments that I proposed or have a different memory of what I said I tried not to speak for others but just for me.

Rev. Duval: was that a total of 5?

Ms. Taylor: 1 2 3 4, they're yellow so I can see them, yep 5. Anyway I make a motion that these commitments be approved with these amendments,

Dr. Doucette: So I would second that motion but I would also make sure that you see how they're represented back before we finalize

Ms. Taylor: okay yeah I didn't yeah I know I couldn't have given very specific language that I wanted to be changed to make it easier but I didn't do that. Yeah, that would be great, thanks. Ms. Frank: You couldn't move to approve the minutes, and then table final approval till next. You know defer final approval till next meeting again.

Ms. Taylor: Okay, so that I second that with that. What was this Taylor was that you're most every mistake for you.

Mr. Smith: So let's be clear with what your motion was.

Ms. Taylor: Um, you know, I really don't want to approve the minutes. So, except if you're going to,

Mr. Smith: So I think we make the motion to accept your edits. And then, and then table approval until next meeting.

Ms. Taylor: see the language that was used to know so we can, there's no reason why we can't do two minutes next time. Right. As long as we get them, I get them posted and sent to us so that we can review them ahead of time, that'd be great. And I, and I only. And I'm also want to make a comment that I think I remember when we first met, I asked what how the minutes were put together and I thought someone said it was a verbatim record of the minutes but it's clearly not a verbatim record and I understand if that's not the. If that's not the case if you don't want to verbatim record but I just want to point that out to that was during our first meeting or second meeting.um, that was offered to us, that these were verbatim records.

Ms. Frank: I don't remember a conversation about verbatim that would be incredibly unusual for us, to have a verbatim record.

Ms. Taylor: Are they recorded?

Ms. Frank: And I think that's a, I think. Nancy and I are discussing that they are being recorded today for the first time we've never tried it, but it's technology, it's an, so she. Okay. She doesn't know how well the technology is going to work at this point it's kind of a test run today.

Ms. Taylor: Well that would be helpful for the board members to know that they're being recorded as well. So I believe that.

I think we're, I think we were going to start approval of the minutes for our following meeting so that we can see the changes and.

Ms. Taylor: Yeah I was withdrew my motion to amend and approved today, do you want to second that?

Mr. Smith: Yes

So do you want to officially, do you want a second that? Yes?

Okay. Good morning. We need to take a vote"

Aye, aye, aye aye

Rev. Duval: Morning, Mr. Director Banasco are you there

sir. Yeah. Can you hear me well?

Director Banasco: Morning this report on the services as of today, we are 855, and he came into the jail of that 782 and into our males are103tor females, the racial breakdown and 500. Black 286 white, one Asian, 81%. Pre-trial, we have today 5845 on some form of probation and community corrections. And in addition to the municipal mental health, we have 150 on their caseload, 231 on pretrial police services and 24 through the MacArthur program there on pretrial out the program. To move forward I would like to go ahead and also, there was a question that was asked the last time, the last one maybe close to the number of inmates we have on probation violation. We have approximately, we have 79 custodies, and 2% of those have been there less than, between one and 30 days. So there seems to be a very good turnaround time, so they don't seem to sit in our jail very long so that's a good thing we'll get them out of the system within the good period of time. Next, let's share a few other things our next elections graduation is coming up March 6th at the Justice Center, 2pm, and other information and it's important that they will mail it out to the board as well. We have 27 correction officer vacancies, nine to start on our next Academy, that's going to take place March second. So sure, I would like to see a few more people know we have mostly almost everyone's schedule to come out for facility tour. I know the first individual came out with Jeff Smith and thank you for coming and I think we were able to give him a good tour or you can give a little oversight on positive education so I we are a little progress here we're looking at bridging some opportunities with workforce, vocational

programs. Mr. Smith shared with us some opportunities about community dialogue with the larger services because we do have the women working on the services and the vocational training and hopefully going to have some job opportunities with some big companies that are looking for that workforce skill set. So, that's a good thing that came out of that tour and Dr. McBride came out as well. And we're looking because universities have many students who are in criminal justice fields are wanting into a connected field. So we're looking at developing some form of part time Academy for corrections and so that's because we do have part time position available, and that will give the opportunity to some of the criminal justice students to have part time employment while they still studying and feel and it's sort of Midway into some practical experience and in their field is certainly an area that could be really using their skill set. So, very good outcomes from those two tours and for that reason, so thank you for that, and we look forward to the next few meetings on the other board members. That's all I have to report today.

Rev. Duval: This is a bit awkward but if you don't mind, can you go ahead and introduce the deputy who's in our presence.

Director Banasco: Darby Howard, he's been as a very strong member of Justice Center doing this over 31 years. He started his career as a corrections officer worked his way up the ranks and his last position was a superintendent security and gave him the opportunity to establish Deputy Director position and now be able to fill that role, and, and we're happy to have him in that role, and doing even more great things in the future.

Mr. Howard: So, nice to meet everybody. Good morning.

Rev. Duval: Any questions for the director?

Dr. Garza: No questions but just a comment just so yeah.

Good morning doing well. So, just a comment, really. I had asked at the last meeting whether we could get some, some reporting sort of standardized reporting. And so you went through a lot of data together there which I appreciate you pulling all this data together but what would be really helpful for me and I think for the, for the other board members is if we can develop a scorecard or some sort of some sort of routine data presentation so that we can just get a quick glance on this is just everything that you just reported there but in one succinct document that would really be helpful for us and I know the health department probably going to go over that a little bit later. So you guys have done a great job, pulling that together. So something along those lines, and that way we can we can take a quick glance and get an understanding of what the current operation looks like.

Director Banasco: Actually, we're in the process, said that in the challenge we're having and we're going to get through this we have this assistant that gather information, until we get very antiquated so we're in the process and I know is something at different levels but we're working on that and I hope by the next meeting we will have something in place.

Dr. Garza: Okay, that would be great. Thank you very much, and a couple of other things if I could just to get a couple more minutes here, Mr. Chair. So, and this is really sort of around some strategy at, at, Justice Services. It would I think it'd be helpful for me as well. If, if I understood, you know, what are your two or three sort of key priority areas for the justice or so you've been here for a little while you've been able to kick the tires things like that and I'm sure you've noticed some things that you want to improve. And so, maybe just, hey these are two or three of my priorities for the next year this what we're really going to focus on, this how we're going to measure success, that would be helpful as well. And I know you know there's a ton of things you can work on. But, but I think part of having a good strategic plan is also saying these are our priorities and so that would be helpful for me.

Mr. Banasco: In the process of scheduling. The 97 days I've been here we have achieved a lot of games overseas so you will come to us and, and I know that you're a collaborative. Of all the six months permits but we would go out working on strategic planning we sort of have that in place, but you'll be able to have the opportunity to give an enormous oversight so hopefully, you get to come with us, you'll get a good understanding of some of the things already, because we have a presentation but okay but we can go ahead and share the long term six months one. But that's, I'll take that under advisement but yeah, you'll see some other things.

Dr. Garza: Okay, so it sounds like you've got a strategic plan in process in place now. Okay, great. Thank you. Yes.

Ms. Taylor: I just have to add on to that I think the value of the plan ahead of time, lets us know what you're worrying about. Let's just know where you think the deficits are, instead of. I know that there are gaps in, in, in your, in terms of what you want to do and what's existing today. And that is more helpful for me as a board member, than hearing a litany of all the good things, because I know there are a lot of good things going on over there because I'm over there quite a bit. So, and that is, and I'm not saying we shouldn't congratulate ourselves and cheer ourselves on. But the point of the strategic plan I think in this, in this situation is to look at the gaps between where we are and where we want to be. And then, and then some kind of discussion about how you intend to get there so what are you worried about, what keeps you up at night to echo Dr Garza saying you know the top five things that need to be done in order for people who work there and

people who live there to feel safe and secure. So, thank you.

Mr. Banasco: Thank you.

Reverend Duval: Mr. Banasco, so on the vacancies how many graduates did we have in January?

Director Banasco: We had nine in January the first round and seven coming up for that for how long about several retirements and promotions, captains have retired so it's some of a moving target but we actually I do strategic planning my guess today is to make our apply to job fairs in the last few weeks, and going ahead and trying to take several back to back academies.

Rev. Duval: So this way we can sort of sharing some of the seven in January, has there been a follower, keeping track on how they're doing. Have we retained all seven?

Director Banasco: Out of the nine that we were graduated, two separated, one because of job and actually one because of family, family challenges. So, but we still here still there I saw quite a few the other day on decisions, but at the 9, 7 are still with us.

Rev. Duval: Okay. Thank you. Yes.

Mr. Smith: Thank you very much. Director for the tour and for getting so many different people. Such a great cross section of correctional staff to, to kind of give me their perspectives on all the different units and on all the different floors, so thank you and thank you, Deputy Director as well

Rev. Duval: Discussion of procedures, regarding external questions and reports.

Dr. Doucette: Before we do that, do, do that update from medical we don't have it as a formal agenda items like as a secondary agenda item to update the medical reports to.

Dr. Doucette: So, wanted to share with the board today our performance management dashboard. So as you're well aware of at the end of this there's net at the end of last year. To start to talk about performance management and data reporting out of the corrections medicine practice. This is a product of that direction and discussion that we have been working through with the Department of Public Health. I am going to pass it over to Valerie to talk in a little bit of detail about, about the January numbers that we are presenting today. But first want to just provide a little bit of context and caveat to this initial report. The first and for those of you who have been involved in this process you're well aware that we are certainly hearing, doing this system, we are hearing our system towards the cellular data reporting. We, we have built a system to do this specifically. We're proud of the, the product that we've been able to report but we definitely recognize continued opportunities to improve the accuracy of it moving forward so. the other piece that I want to kind of explicitly lay out is that this data is specific to care that is provided and visits with medical providers, which include our physicians, nurse practitioners, physician's

assistants. And so that, that is, is an important, important and important and kind of a core part of the medical care that is provided, but does not necessarily reflect some of the other scope of the nursing care, Social Work care and other things that are happening in the system, hope to be able to gear towards collecting that eventually. And then the last thing that I think is a really key caveat with this work is, obviously, to get to percentages when we're looking at visits as well as population characteristics and diagnoses. We have to look at the group of patients for whom could receive care but they're not going to hurt right and the process that we have gone through and that's actually been one of our biggest challenges is trying to, in, in our system in which there is a lot of flow of people in and out of the system pretty quickly, trying to get to what is an accurate representation for that group of people who, who should be in that denominator in the first place and so that that has been a challenge I would say that it certainly is representative but that piece is an approximation, essentially of the people who could who could see care.

So, so that's kind of the caveat I will pass it over to Valerie to speak a little bit to some of the details and we really look forward to ensure your advice and suggestions for this and keep rolling this process.

Ms. Nelson: First, before we look at the actual dashboard I'll just call your attention to that second document that was attached to it to glossary. So this serves really as that dictionary for each of these metrics that we could be explicit in relating what you see here in the dashboard back to the way that we capture the data to internally, so we have called out that in certain pieces of data are included versus excluded or certain categories classifications and so forth. So I hope that that will serve to be a good tool. Please do look at that and offer feedback if it's not communicating that in the most beneficial way though. So, then coming over to the actual dashboard I'll take your direction as we start into this my thought was maybe we talked mostly about what fed into how these metrics are compiled and start, start with that. Does that sound like a good plan? All right, so looking at that safety section on the first page, we are looking at parameters around folks that need to leave the building for a variety of types of care and then also looking at the information that picture around when we're reviewing patient safety reported that this. Starting with the transfers that first metric will capture everything that goes every time that a person needs to leave the building, whether it's for a scheduled specialist consult or for a more urgent needs to the emergency department. The subcategory of that is looking at those transfers specifically for acute care. So this is when need to transfer someone to the ED, whether that person then returns back to the Justice Center after care provided in the ED or needs to be admitted into the hospital for further care. The safety events reported is through the new structured programming that we have to specifically to log

all events related to safety recording so this is a, this is the total of any event that has come to our awareness and then that's broken down into greater detail around acuity with Sentinel events, and if those events any of the reported events led to a morbidity and mortality review.

Mr. Smith: So with that review, can I ask something real quick. So, with this so first of all thank you for putting all this together. So, with the, the number of transfers for medical care as well as Chances for acute care. And I recognize it's difficult to come up with a denominator, but it would be helpful to have a range, if you know what I mean. So, if it's 53 out of 5000, that's one thing it's 53 out of 54, it's another thing. So, and you can figure out how to come up with that denominator and recognize it's going to be directionally correct and precisely wrong. Right? Yeah so, which is fine. So I think if you if you come up with this was our average daily census, which is, I mean we do that in healthcare all the time, and use that as your denominator, it would be totally fine.

Ms. Nelson: So that's a good question and this denominator space. So, average daily census is one that we could use in that space. We also explored and I think for some of what we have here is we used bookings. And so we really did debate like the wisdom of both in terms of what's the…

Mr. Smith: What is the difference between those two denominators numbers that we can use?

Dr. Doucette: It is use quite significant.

Mr. Smith: Actually, I guess my question is what the definition of booking versus average sales is.

Ms. Nelson: So the booking, and I we relied on Tricia's data, who is the expert for the Justice Services information on the booking count is anyone who comes into the building and officially gets booked, now a subset of those folks will then be admitted into the, into the center.

Mr. Smith: Some of those will be released right exactly every book, never be processed, exactly what percentage of the, of those never you never become population of about

Ms. Nelson: 40%, it's about 40%,

Mr. Smith: And then what percentage of those are required, medical care to be transferred, do you know, and if you don't know that's fine.

Ms. Nelson: Just don't know off the top, we have the data here but can I follow up with you on that... Mr. Smith: Yeah. So I think there's some way that we could come to an agreement on hey this is. Ms. Nelson: Let's explore both rates potentially for like the next so we can take, see if we can add a rate number to this based on booking and rate number based on average daily census and then we can kind of talk about, like, which one represents to us, was like the most, like the information that we're looking for well

Mr. Smith: And the other thing is, sorry, going down a rabbit hole here but then tell you what let's take this offline.

Ms. Nelson: To be sure, that's exactly where we were centering around though.

Ms. Nelson: Yes, we appreciate the feedback on, on what that how that can best be shaped. But that yeah and the way you break those statistical methodology like questions so slightly changes the way it represents the depth

Dr. Garza: and as long as everybody's consistent, comparing apples to apples. That's right. Just one other question for you and I probably asked you this before. Do we have electronic health record or is it paper based it's just electronic. One other questions, sorry. And I think I asked you this before. Can we get this in like a rolling 12 months, or? And the reason is, this doesn't give me context right now it's like 53 in January, and what was it in December?

Ms. Nelson: That's what these are will be like. So this is the first time it's had this full calculation based on these particular characteristics, yeah and so it will be a rolling number as it moves forward.

Dr. Garza: Right so maybe for the next month, could we add maybe December and November from 2019 or is that sort of impossible to do so, so,

Dr. Doucette: So we changed the way we recorded into the system to be able to pull this data.

Dr. Garza: So go when any chance. Okay, thank you.

Ms. Taylor: I think I asked you this before about your EMR but maybe specifically not when we were talking about triggers and embedding things in the EMRs. To what extent are you able to write a program around your EMR and, I mean, you know, so I know some of it is really difficult but some of these… Some of the issues, as you know, are, and are easier to embed in an EMR. NORCAN or like medication administration or anything. Anything else I'm just wondering to what extent. I know you're not happy, necessarily with your EMR as it as it is, but it is not paper. So this is good we're making progress, but I wonder how flexible it is and how much can you rewrite and program so that we can get some of this stuff without relying on people to report it.

Dr. Doucette: So, some others yeah so I think that that's a complicated question also we're certainly making progress in that space the ability to embed clinical decision support tools is somewhat limited. We're working really closely with our vendor right now and all kinds of spaces to do that. But it is a product that for those of you who are more used to working with hospital based systems. There are quite a few

more implementations, and…

Ms. Taylor: They don't do it either. Yeah, I mean I'm not really talking about clinical decision support which guides the provider right into algorithms, essentially, or prompts and asks questions of the provider in order to, when you're standing alone, which is a real thing for you guys. You know what do I do I'm really talking about embedding trigger tools for that reporting for adverse events or things like that, that nobody does that particularly well on the hospital side, either, but you can do it for some discrete things and I was just wondering if, if you were thinking about going forward and getting a new EMR at some point, this might be something we want and now I don't have a wish list. And I appreciate it I appreciate the number of safety events in our appreciate what you're doing with that because I don't want to eliminate the people, because that goes to culture, right, that goes to transparency and when people feel free to report and, and we don't want to go robotic on everything.

Dr. Doucette: But I don't know if we've checked for Allscripts specifically but many of the EMRs that we've looked at have been in have like some modules, so it's more difficult to customize something for something that they tried to build modules for yeah so the upgrades don't do it for you. Yeah, yeah.

Ms. Taylor: Well yeah the one we did for Wash U. side of BJC system, just let us go have at it. so we can talk about this more going forward, but I just, that could be a subset of, you know, four or five events that are automatically recorded,

Dr. Doucette: I think that, as we get to, but this is also that combination back towards some of the cultural things that we have to do with some capturing system and then how as we process improve our way through it, we can identify where the processes can be more automated. And so, I think, as we're building the structures, it takes that practice of culture and then that gives us the opportunity to sort of look at that and then find out the best ways to automate.

Ms. Taylor: That's how I feel too, you got to do both, and then. So what are the range of dates? Are you guys creating this system? Are is this a system software that already exists?

Ms. Nelson: Yes, yes. We have a little bit of customization ability, but not very much like it's, it's packaged in this sort of intensity me, what we control is how we enter into it. And so what Dr. Doucette was talking about building out for January, is when we sat last year and went through what we wanted to know, we then retrained all of our procedures and what we could report to get to these numbers.

Rev. Duvall: And, and how new is the system.

Ms. Nelson: Oh, it's 14 years old, the electronic medical records As far as this kind of software package goes,

it's particularly old, but they are

Dr. Garza: I'm assuming the versions are refreshed every so often.

Ms. Taylor: Yes. And I will say that the EMR for 14 years at one point you were ahead of the curve.

Ms. Nelson: That is true. Yes.

Ms. Taylor: For 14 years ago there were not a lot of people having EMRs, even in hospitals.

Yes.

Rev. Duval: Any other questions?

Ms. Nelson: If you like I can go through the rest of the metrics or if you prefer. If you'd like to ask about specific pieces of it,

Rev. Duval: I would like to go through it all.

Ms. Taylor: At one point, is it, is it possible to get these ahead of time I don't know if we asked that before. But is it possible for the board to get ahead of time just so we have a chance to review it before we come in. I mean I know we're not using certain, I don't know how you will communicate with this, and I'll leave that up to you. But it will be helpful for me to have some time to look at it.

Ms. Nelson: So moving on to the next page around delivery metrics, as Dr. Doucette said, explained the information that we see here is based entirely on the visits with our medical providers. So, again, it goes back to also what we were saying that these are, this would be based on anyone who was booked into the system. So that changes the perspective of a little bit of what we're looking at here, and it's broken down by location of that visit whether it's in the clinic or the infirmary and also the type of the visit if it's focused on medical care or psychiatric care.

Mr. Smith: Yes, just so if I understand correctly, what you're trying to save your memory so persons who presented persons with medical visit, type in clinic is that all covers then. Okay. And then it's broken out by medical versus psychiatric. Okay. And so, and this is a data question as well so when you receive to visit caps are those unique individuals or those encountered

Ms. Nelson: Very good question we cycled around trying to determine the best way to represent all of us too. So we tried to make combination here. So what we see here and then what will become the trended information is unique individuals. Okay, the compliment to that is what you see on the right hand column with the visit count so of that for example the first the first metric the percentage of persons with medical visits in the clinic, we saw, nearly 11% of the individuals that were booked into the Justice Center had that visit in the clinic, but that led to nearly 400 visits in January, okay.

So the year to date yet so the percentage would be based off, patients and the visit counts based off the

counters. Yes.

Because it's not clearly a one to one ratio between the individual and numbers of visits a year may maybe use.

Dr. Garza: The let me be really precise about this. So really it's the percentage of encounters that not percentage of persons with the percentage that we see is of individuals.

Ms. Nelson: Okay, so all of the folks that were plugged into the Justice Center in January. We saw nearly 11% of those in the clinic for a medical provider visit.

Mr. Smith: Regardless of how many encounters.

Ms. Nelson: Right, the number of encounters for that 11% is 384, welcome your feedback to if there's a better way to represent that so that it's again trying to balance what that ratio is right. Dr. Doucette: Let's talk a little bit about how we I think we could add a little bit to clarify that in the way that it's expressed.

Ms. Nelson: The next set of metrics is focused on describing the conditions and healthcare needs that the people coming into the Justice Center, that we see me as we engage with them. Then, starting with the top looking at mental health disorders and then broken out below that, in some categories and a few different views. And likewise with substance use disorders. And this is a good example this set of metrics is a good example of what Dr. Doucette was explaining and Spring too. We took the approach with this. An industry standard epidemiology review, based on the conversations that we had with the subcommittee early on. There, that's one way to view and interpret the information, and we can evolve and mature this as, as we start to see this and understand what makes what's most meaningful for you all to understand what's happening inside the building.

So, for the way that this is characterized the 54% of provider visits, so is that of the total number of provider visits. So that would be back to either, so one of these visit counts off the first page. So the second page.

Ms. Nelson: So we're looking at the population characteristics, we can think of that denominator as it's the total of all provider visits. So if we tie that back to the delivery, it would be the sum of all of these visit counts Yes, 54% of all of those were related to mental health Yes, regardless of functional area, clinic or infirmary, four types of provide the type. Yes.

Mr. Smith: So again, the challenge is how many people those that represent so is that one person that had 517 visits, or is that 517 people everyone there. So, however we want to clarify that number. Maybe just like his

account and then unique individual. So this is a great first draft so please don't take our comments as criticism it's like this is awesome. Yeah.

Let's make it, let's make it better.

Ms. Nelson: Any questions on population.

Mr. Smith: Just a comment really 54% of provider visits for mental health disorders is that's alarming. Okay, sorry, keep going.

Ms. Nelson: The last page is more of an organizational perspective I have a couple of key views again looking at staffing, we are continuously trying to increase that pipeline and working with operations or to recognize that we do have those openings. And the last piece that I would point out around the budget is that we are this number this calculation comes from a cash accounting process. So it's there is, we're looking at information in arrears we don't receive all the bills or can't

Mr. Smith: Can we go back. Just very quickly. One thing that I would be curious about I don't know if there's a way to quantify, you know if there's a way to, to show this every month but I would be interested to know of those. You have a demonstrated, you know, mental health problem that requires provider visit, what percentage of those upon intake had a diagnosis. Right, because, I mean, my concern for the direction like our job is like, if a low percentage of those came in, saying, I've experienced schizophrenia in the past have experienced, you know I've been diagnosed with bipolar, but now they're having, you know, this frequent number of visits. Then there's something going on in the jail but they really need to attend to. If. Conversely, it's more like a symptom of broader dysfunction, which my hunch is that it probably is, just a lack of, you know, appropriate treatment in the community which is leading people to be in meshed in the justice system we probably shouldn't be, you know, I would be more comforted from the perspective of our job. Sure. So just so I guess, curious way of saying I'd like to know how many of the people. Once we get the number of individuals. What, what number of those individuals had, you know, had no versus established exactly yeah I think

Dr. Doucette: So I think we that yeah I, there are many, many opportunities for us as we continue to mature this and our I think our, our challenge right now is that the data that we're accessing is essentially diagnostic data that comes from a physician. And so our ability then to answer that question and many other questions goes back to being able to use the system to gather information that is not necessarily diagnostic information but other self- supported. Exactly. And so that's the gist.

Ms. Taylor: But I think our original concern, which I think you are, have been working on which is the, which is whether or not there's a delay in diagnosis, as well how quickly you get to people when they when

they come in, and I know you have standards for that but you know some of it might be recognizing it some of it maybe it takes a while to diagnose some of these conditions.

Ms. Nelson: So I think we can talk about that in terms of. And we've talked before about looking at the overall pathways of care and so at what point does the diagnostic process, begin for different types of issues that you may experience that are better or particularly some of these psychological so there are standard points of care that happen in which standard diagnostic tools are deployed. There are triggers that then escalate a level of care to a next aid or series of diagnosis or medical visit or something along those lines. So, if someone's self- reports they have a psychological issue or a pre-existing condition that automatically sort of sets the mind, confirming those diagnostic pathways or medical visits and those things like that. If someone doesn't, then it takes some additional trigger or something that could show up on a standard diagnosis. Before we would begin to so like if someone doesn't self- report that on the front end, it would take an observation of something that would trigger additional diagnostic things right.

Ms. Taylor: And in communication between the people who are actually who are observing it to get it to the medical people. I'm not so concerned of a second part but you know concerned about the complaints that we've heard in the past of people coming in knowing they're on meds, being here and being without their meds for a while and delays in initial. I mean, you can tell me anecdotally if you think that that initial assessment of people with mental health issues who do say, hey, I've got meds and I don't have them with me and I'm gonna go with maybe they already you know, displaying symptoms. So, that is that initial gap that I that I, you know, that I hear about when I sit with people. And I don't know if that is not, if that's not as much of a concern for you now because I don't see a look of recognition like your faces, then maybe that's an improvement. Maybe that's an improvement or maybe, and that's, that's one of my concerns.

Ms. Nelson: So I think this is where some qualitative work would come in handy. I think the system is set to not have that happen, right, but that doesn't mean that there couldn't be an experiential component that someone else has is their perception or their perspective. And I think that it would take some qualitative survey workers.

Ms. Taylor: I'm just interested in how many people fall through the cracks. Yeah, and if. And if you're doing something about what those cracks tell you about your process. Right, that's, that's where I'm getting a job.

Rev. Duval: Now I want to shift over directors and. So I want to shift over to your side of the wall, in terms of reporting are your correctional officers.

What type of training does it look like for them to identify the early signs and warning symptoms, are they trained to identify that and how's that passed on to the Medical Services.

Well we're crossing the street here,

Those who might be going through going withdrawals is part of the Academy. Finally Academy curriculum. And actually, there's also, like we did, we do regular trainings exploring the opiates and functions and all that so that's part of the curriculum, and it's also onboarding, a new service training as well. And we do have just to piggyback on the director CIT training crisis intervention and helps identify as someone's going through a crisis and we report that to the medical staff.

Mr. Smith: So if I could maybe expand on the chairman's comments, so I think, and correct me if I'm wrong, I think Where you at, what sort of training to the corrections officers have to identify a potential medical issue, and the process then to bring in medical personnel I see it is really de-escalation techniques for patients that are for people that are agitated, suicide prevention, totally get that. I think what we're for more, what we what we're waiting to get some information on is people with medical issues outside of because we accepted suicide and those you're going to be trained on, but it's more of the, the, sort of response

Mr. Banasco: Medical emergency preparedness, that's all part of that whole curriculum, we have a curriculum. Here we had medical emergencies go and try as a result of, all those aspects of what the protocol, this the contact us on can be also certified in first aid, the corrections officers contact Medical if we know that, yes, we have that as part of this information time at, as well as in house servicing. Okay.

Ms. Taylor: They're also talking about. I'm tired we've talked about that. Things something less than a medical emergency I mean if we think back to the people who have died. It was, were there signs and symptoms early on that were more that were more subtle that could have been yeah let me,

Rev. Duval: Let me, try and appreciate the hopefully you can. How do you separate a mood disorder from somebody who's just acting out that day? And then how does that at some point start to juggle into this inmate must have a problem to worry with required medical Hey, take a look at this guy, because his mood disorder, he’s not just acting a fool today he's acting a fool for a week. Okay, and I apologize, when I say acting a fool, but I think acting out, right, because you because on the front end, you're on the ground game, you see it on a more, and we just want to make sure I think that's been our concern that if it starts to escalate. And then we hear these stories and we hear stories that just says hey just blow us off or some was going on with that inmate, I’m just trying to get my head around the training aspect of. Okay, I need to escalate this, and

even if I told the lieutenant you need it. I need to get in touch with medical and say hey, you just need to take a look at this guy.

Mr. Banasco: I would like to answer that, conversation I think all of us who are in the question industry, because we all know the cost of this, can you hear me?

Okay, that we all know that in correctional settings we have a diverse type of population when we talk about acting out, and all those kinds of behaviors that we have to be sensitive to. So that's where this constant communication with officers, supervisor see something that quite is not in the norm for that individual that you're not testing read a constant communication with medical mental health has protocols in place. I mean, I can tell you part of the best to answer all these questions when you, when you visit with us so maybe I sit down to individually go over all the, the actual protocols like they were seeking and channeling what our systems are in place. So you can have a good understanding of, and we pretty solid at what we do and we deal with this every day. Those are the types of communications, whether they come into booking or when they go to the housing units which is the officers of super high This is something we documented we get the attention, we refer them to medical, mental health we make all those calls, ensure that the services on. So I mean we have some expensive. We'll be more than happy to share that with you, and the other board members. So you can see a look at it and they make some recommendations about an opportunity for improvement.

Rev. Duval: Thank you so get

Ms. Taylor: Can I say yeah can I recommend that. So we talked a little bit about training curriculum before and I know that things have been implemented and some things are standard and some things are going forward. Could we maybe dedicate a future meeting specifically to covering like the training protocols that are joint either between corrections and medicine and the Justice Services staff that are specific to these care pathway, like identification, action and referral? And we dedicate a meeting specifically to that topic where we're really diving in and you see some things in front of us about like the list, and then talk about how those are being presented culturally how that's being trained, how it's being reinforced that's been communicated in the last bit is how you know it's working. Yeah, as we know, I know you have lots of great protocols and I've seen a lot of the training stuff and it's really great. But there's clearly a gap between what we're training and what we're aspiring to and what's actually happening in the jail on some days with some people and I, and that's what I would like to know from the people from you guys. What. That's what honest talk is going to be, this is what this is what keeps me up at night. This is where our gap is between what we're aspiring to be and where we are and what and what you're planning to do

about it culturally is because it's the cultural stuff that's the rub. And that's, if we look at all the, if you look at all your problems I know we always talk about it in detail but if we look at all the deaths you know we there. They are replete with cultural issues. Not cultural in terms of, you know, white Caucasian African or African American but then whenever the culture is in the jail. And so that that gap between. I'd like to hear all the aspirational stuff but I really want to hear what we're doing about this stuff where we know we are falling. We are failing ourselves and we are work in what we are doing to bring ourselves up to our aspirations

Mr. Smith: So, I could just make one comment about that and so just to sort of encapsulate I think with the discussion and so I think it's that it's great that we have policies and procedures and protocols and I have no doubt that they're well written and that we're educating on them. The key though is in the performance part. And that's what I think we're really asking for is how well are we performing against the policies and procedures. So there's a really high risk for people to, to have some sort of bias within correction is not just here it's everywhere. Yeah. So, you know, experienced it as an emergency physician it happens in the emergency firm where people are deemed as malingering or their complaint is not taken seriously. And we have to try and minimize that bias as much as we can. There's not that you know it's not that we training bias or things like that. But, but the way that you address that is through performance improvement and making sure that you're closing the loop. So, again, I have no doubt that we have really great policies, procedures and education. It's the performance improvement piece that really, I think we need to be comfortable with.

Dr. Doucette: I think that could be a really robust conversation.

Rev. Duval: I have a discussion of procedures regarding external questions and reports regarding inmate medical concern.

Dr. Doucette: So will we added this agenda item on the public health side and hoping to have a robust conversation around it so following up on, on, certainly discussions from last week and what Mary referenced earlier minutes. And in hearing, you know, communities, questions and concerns and concerns from the board, really wanted to follow up on kind of process and procedure around how we on the medical side are dealing with external questions from family members, from board members, from staff members about individuals. So those certainly have ranged, we are getting many more of those they have ranged from very non acute questions about you know what is going on with so and so, or this and the other, to someone having a significant concern about their loved one, and we're really kind of working to understand how we can best manage communication in that space so to kind of give you a sense when we hear those concerns. Every

single time we have a nurse go visit the patient, and that that you know that medical contact is initiated and then then from that point. Get the, the appropriate care pathway kind of gets initiated but the opportunity for communication back, and how we do that most effectively with kind of the channels that these things often come to us in can be kind of circuitous sometimes and so would love to get a thought about from board and community about the best ways that we can approach that and how we can kind of standardize that process for everyone in a way that is patient centered and Family Centered but recognizes some of the constraints in in sharing of information that is ethical nature. So in some of those containers are like just a conversation on how to reassure a community member or someone who has asked us about a concern. How do we be responsible for sort of replying back to that, without breaching the patient's rights to not have their health information sort of violated and so we talked about, you know, ideas around. Do we encourage the patient to connect to the person who is concerned about them? Because that they are entitled to disclose like having feeling and write those things but not everyone chooses to do that. How do we let everyone know that definitely initiated a medical contact we checked that we should have a contact, and that. What is the information that provides that closed loop back when we have an adult, who is who chooses entire entirely responsible for their information. We're not allowed to tell you what their, what their health condition is, I am allowed to, you know, certainly can tell you that we definitely talk to them.

But that feels like. You know, my feels insufficient to say, or does it. We want to provide that that sense of assurance and something back.

Ms. Taylor: I'm sure there. I'm sure there’s some really good comments here but as, as the go between two of them Yes. When I first because I like my first job in healthcare in 1974. I was ombudsmen at up at 1200 bed hospital in Chicago and all I did all day long was sit and listen people and we developed a system for doing this. So, like, the first thing I did when they when these folks contacted me, was say, I want you to know that I'm going to pass this on and you can be assured that I'm going to pass this on and I don't know exactly what the answer will be, but I want you to be prepared for the fact that the answer you get might be unsatisfactory because there's private information about this patient that that you don't have a right to have now I will say on the other side. I don't know if you guys do this but you know when I go into hospital they say, you know who else has access to your HIPAA stuff and I give permission to my son wisely or not to have access to my, my HIPPA stuff so I don't know, you know, if you can say to that. I think it's always good to go back to the inmate and say someone has, you know, we've been called by someone who has concerns about your about you here first of all we want to let you know that they're concerned about you, because it's always good to hear when you're in jail. And secondly, you know, you

know, we feel, you know that we cannot tell your private information to people who call unless you designated them as somebody who's okay to release that information I think what most people want. You know, you guys have you talked to people who have passed on concerns. They just want to know if they were heard and they want to know if it was followed up and they want somebody to call back and say, we heard you. You know, we went to the inmate, we talked to the, in your case I call always call it the patients, we did, yeah went to the patient we talked to them and. And we want you to know your we're following up on it, especially the patient didn't give you permission to give them information, but if there's somebody who has been designated as they can. But, I mean, I think your instincts are right, you just, but most these folks just, it goes down to a big black hole and that's when you get a lot of community anger, that's when the last couple situations

were just so much anger that really could have been prevented a lot of the angst could have been just prevented from the very beginning by somebody just calling and saying we heard you know, and that's a, so we want to in order to make sure that we can do that we want to get it to procedure, so that everyone can train.

And there was nothing on a website so I just also went and looked on the, the corrections website and on your section of the website the medical section, there's nothing in all the grievance policies are there for inmates, policy I get at your inside you can do, that's not what this is. There is nothing on the website that gives the community, any hint about if they have a concern. This is a number they can call, and I know we talked about this before and that and Director Banasco suggested everybody called him this is not a sustainable process, even though it's a generous offer. It is somebody who does this all the time for living it's like drawing blood, right, you know, you never let residents draw blood, you know, so have somebody who does this all the time and gets and gets a relationship with the community. I know that's a bunch of item. But I will be happy to work on that Director Banasco and format for an ombudsman position and help with the development of that before you have any money to do it, I will be happy to.

Mr. Banasco: Thank you Mary, but I want to make sure the importance of the chair, but for all the members to hear, just to bring everyone to let you know we have, I know myself and Mr. Darby, I called some non-family members, and we have circled back, and close the loop, and let them know we looked into it. And they even saw the call the family members. I started documenting that for my own journal, we have done that several occasions.

And sometimes that message doesn't get conveyed the way we actually happen but we have to do that just to rest assured, we have been circling back. One personally on Sunday when I came in to drop something

off and I circled back. And so, we are making every effort to share that with everyone.

Dr. Garza: Now, thank you for that. So am I hearing you correctly, there's not a process for that right now.

Mr. Banasco: So what I think we are talking about is that we have some individuals who are not immediate family, and we looked into it, and they want more information than that we were legally able to give, and that individual will contact their family member, so we have in fact so it wasn't like they called and nothing was done about this.

Mr. Smith: So, so, so I think that you guys need a process. So that's why we're so if the process is you go and talk to the inmates. This is, you know, you're aunt called and was concerned about you do we have permission to share your medical care with your aunt, that solves your problem, right. So, but, but there's got to be a process. Right, right, which is what are they again which is.

Dr. Doucette: So I think the visibility of the board, and many of the connectivity that you have both with patients and external like family members or others as well as some of the other community members who have been engaged and involved, have become proxy sometimes for family members as well and that has sort of escalated a change in this, and I will admit like you know everybody called me like I, you know, called, to make sure that, as you got to think back and didn't call you back.

But some of that wraparound now as, and then gets escalated to multiple points and I think our visibility and all of that, like we do need to get it down to a person whose daylight job and responsibilities, has a procedure and a bit of the script of what we expect from that customer service standpoint and so part of our conversation is to kind of capture not too scripted, but not too customer service-y either, even though, so true compassion, but yet, so it comes from some expectation of what that language sounds like it's coaching around that there's some things that always work. When you say them and there's some things that always angry people when you direct when you do them as well. It's, it's an area of expertise that, lots of other states have offices of ombudsman, and they have them in their prisons and they have them, you know, in their jails and I know it's, it would be it would be a great thing for us to do the reason I brought it up, originally two months ago, was because was January right was one month ago. Wow, was that we were is, that I thought the pressure on Tashonda Troupe and some of the other mothers of inmates who have died, was just too much that people naturally reached out to them because they knew that they would be understood, and they knew that she that they knew her from the community, and frankly I thought that in my conversations with her I found that pressure was overwhelming and more than, more than she could really bear, I'm in the first anniversary of his death is Sunday. This Sunday. And I think that is, you know, that's my,

my reason for bringing up with it to take pressure off her but also, this is just something we could do this, I think relatively simple, and we like to talk about the ombudsman piece and so as we're putting those pieces in place, we wanted to really do get your advice and make sure that we are going to assemble a process that aligns with that.

Ms. Taylor: I'm happy to help with that part of that, that part of it.

Rev. Duval: Timeline?

When we come back to the report next month about what our next step. Oh yeah, like and what, the whole package with the website is going to say, because it doesn't do us any good if the community doesn't know about it.

Mr. Smith: Yeah, there's a couple of things process and communication. So conflict typically rises when expectations don't meet reality so you can establish an expectation early whether it's on the website with. Frequently Asked Questions or whatever, as long as you can establish an expectation, I think that would ratchet down some of the anxiety, that's not going to completely eliminated. Thank you.

Ms. Taylor: And we'll be meeting with you guys is going to be because I mean response will have to be coordinated with correction side, not just your side. Maybe somebody from Corrections?

I'll be there.

Rev. Duval: Jeff?

Mr. Smith: I haven't counted on one other piece is. I guess under new business. So, when you go to the next agenda item. I ready to go.

Rev. Duval: Ok, I'm ready to go to new items.

Mr. Smith: All right, thank you. I've asked for that information which you helpfully provided on the length of stay. And, yeah, I guess I'm just I'd love, I, I know it's not exactly under the jail's purview and I'm sure it requires some interaction with the county prosecutor's office but I remain curious about the fact that there's 16 people that, you know, in pretrial for more than, 60 people that have been pretrial for more than two years. And I'm wondering if anyone can illuminate if there are kind of exceptional circumstances around, particularly those 16 cases.

M. Banasco: I would have to defer to our attorney. That's really out of our scope and, of course, this might be more geared for the prosecutor's office.

Mr. Smith: Sure. I mean, so, and I guess this might be a question for you, Mr. Chairman. How would you advise, I'm happy to reach out to the county prosecutor's office I don't want to overstep the bounds of this board or, but that that troubles me that there are people you know 16 people that haven't gotten trial

yet after three years. Right, so can help me with the name of the Commission, there, there is a separate board. They have adapted the name Crime Commission although that's not for criminal justice Coordinating Council. Yes. And so that is people from corrections, from law enforcement, from the prosecuting attorney's office, from the community. From the outskirts and from the courts and from the county executive's office and that was that's a commission created by ordinance that had been, I think approached in a more informal matter for a long time that is now being, you know is meeting in a much more structured formal way and that that is essentially at the heart of what they're tasked with, doing is looking at those kind of things looking at how they can work together for judicial efficiency for, for, you know, a sort of decreasing lengths of stays in in jail all those kinds of issues they are looking at. And I know that administration, I don't want to speak for the administration. But I will say, I know that the administration is aware of the overlap between maybe what this body is interested in and what their body is looking at so there may be an opportunity for some, some dialogue there.

Rev. Duval: So that is going to be a suggestion I'm going to make, that we request to get on their agenda, and it's open to the public. We want to go on record as the Advisory board and ask them that questions, with all of them, that's my suggestions.

Mr. Smith: That's why you would prefer handling it formally, in that way as opposed to reaching out to coordinate some support.

Rev. Duval: For transparency, yeah, that I'd rather just cut to the chase, everybody we all get to talk about it the same time.

And we all get to hear the answers. Now as a private citizen.

And I believe they are meeting monthly. Yes.

I think it would behoove the County to address that county doesn't want to, you know, mass lawsuit. You know, people claiming violation of the right to it to a speedy trial.

Well, that that wouldn't be the county that was yesterday.

Right that I mean that the county has no control over that that's really a matter of that.

The courts and you know the criminal justice system as a whole.

Ms. Taylor: So we reach out to them and let the rest of us know in case we can attend. Thank you.

Rev. Duval: Any other new business.

Mr. Smith: Just a quick question, Mr. Banasco, bring us up to earlier but I recognize there was another meeting, while I was out of town. I'm assuming that that was a closed session meeting. But I was never in on that and

I would appreciate if I could get some information on what transpired at that meeting. So I don't know if we need to go into a closed session to discuss that, but you can certainly go into closed session.

Rev Duval: Well we can’t today, but at a future meeting to review the minutes of your closed session.

Because, because the minutes of that of that meeting of that closed session would be a closed record, so you wouldn't want to review that at an open meeting.

Dr. Garza: Right. Yes. Okay, so maybe at our next meeting.

Ms. Taylor: Do we do we get to see the minutes of those closed sessions because I know we have in the past but I haven't seen any recently.

Yes. Yes. Did you all get yet? Not yet. Okay, thank you.

Rev. Duvall: So this is there any new business anybody else. Mr. Banasco, director, do you have anything.

No, you can skip to the next one. So we've got to get to our visitors real quick.

Okay, get visitors that would like to speak today, So, we would like to set the next meeting right now my calendar would show March 27th for Friday, March 27. The fourth Friday at nine o’clock right 9am.

Like a motion to adjourn. Second.

All in favor. Aye