Jensen v. Thornell
ADCRR Health Care Staffing Analysis and Plan
April 16, 2024

CV-12-00601-PHX-ROS

Contents

Introduction

This report is in response to the United States District Court for the District of Arizona ORDER AND PERMANENT INJUNCTION ("Injunction") regarding the Arizona Department of Correction, Rehabilitation and Reentry (ADCRR), Section 1.17 which states *"To determine the number of staff necessary to care for patients, the Court will appoint an expert to conduct a staffing analysis and plan of health care positions at each location."* (Doc. 4410)

This staffing analysis and plan ("plan") addresses direct patient care positions for medical and mental health care including treatment of substance use disorder with MOUD. The absence of staffing numbers for other clinical and administrative positions involved in health care does not alter requirements for such positions under the Injunction or under ADCRR's contract with NaphCare.

The plan was informed by extensive collaboration and coordination with the Monitoring team to assure that it was consistent with the letter and spirit of the Injunction, site visits to three complexes, consultation with Plaintiffs and Defendants including extensive consultation with the ADCRR Health Services Division, and conversations with NaphCare Facility Health Administrators (FHAs), providers, mental health leads, and others. In combination, these enabled an understanding of operations and enhanced the feasibility of recommendations.

The Injunction calls for the following elements:

- *Empaneling patients to primary care physicians (PCPs) and Advance Practice Providers APPs) based on their clinical complexity*. We developed a methodology to estimate patient assignments and required staffing levels using the diagnoses in the medical record. ADCRR may use this methodology for initial assignment of patients at the start-up of the pilot sites or may use a different methodology. In either case, we will use the results of the pilot to make any needed refinements of the methodology before system-wide use.
- *Patient self-scheduling of non-urgent primary care, with PCPs assessing and triaging care rather than nurses.* We have developed assumptions on the impact of this new process on health care utilization and therefore staffing, but the assumptions need to be tested over the course of the pilot and modified before applying staffing assumptions system wide.
- *Primary Therapist model for outpatient mental health.* We have developed assumptions on the impact of this model on health care utilization and therefore staffing, but the assumptions need to be tested over the course of the pilot and modified before applying staffing assumptions system wide.

In addition, ADCRR has determined that the Injunction requirements, in total, are best addressed through a wholesale shift in the model of care and has subsequently developed the *Patient Centered Care Model*. This model of care, if properly and fully implemented, has the potential to support almost health care-related elements of the injunction, improve and expedite patient care, and reduce staffing needs over time. However, implementation requires a great deal of training and guidance in the new clinical roles, team-based processes and relationships, and outcomes measurement. Many of the elements and new roles are detailed below.

The staffing plan presented herein is built on staffing assumptions based on the Injunction requirements and new models of care applied to every complex within ADCRR. However, we believe it would be unwise to expect ADCRR to adopt a plan to hire all the positions in the plan right away. Rather, we

believe that the patients, defendants and plaintiffs would be best served by a pilot that tests the proposed staffing and allows an opportunity to revise the final staffing based on experience with it. The pilot we suggest would be robust and time-limited, would create direct experience with staffing of all services that can be applied as modifications to the plan herein, and would become the final staffing plan.

The pilot has the following elements:

- Pilots at two complexes, with the entire model of care, all new care processes, and the proposed staffing fully in place in one entire unit within each complex. Based on input from ADCRR, we recommend San Carlos Unit at the Perryville Complex and Dakota Unit at the Yuma Complex as the pilot sites.
- Staffing of the pilots shown in Appendix 1: Pilot Project, Sites, Staffing, and Implementation Plan and is based on the percentage of the total complex population that each unit represents extrapolated from the recommended staffing of the full complex.
- Staff assigned to these two units may not be assigned to any other unit during the course of the pilot. Staff must be half-time or greater employees of NaphCare and may not be, temporary, or PRN personnel. Registry personnel may be used if they have worked at ADCRR at least half-time for at least six months; the registry parameters in the Order do not apply to the pilot.
- The site medical director and FHA must commit to full participation in the pilots and will likely need some back up to cover a portion of their other duties.
- The Health Services Division (HSD) will provide structure; training; and assistance with testing of processes, brainstorming and problem solving. There must be a dedicated team for the duration of the pilot and it must include a physician, an APP, an RN, and a psych associate, in addition to others determined by the HSD.
- HSD must make use of outside expertise in patient centered care. Our team has offered to provide this assistance but the choice is ADCRR's.
- The pilots must be robust and occur over not more than six months, in accordance with the basic schedule below.
- If the Court enters an order supporting this plan, the six-month pilot begins on the day the Court issues the order.

We have made every effort to create a plan that is as up to date as possible. However, we recognize that circumstances change. For example, the use of emergency medical technicians (EMT) at the complexes is relatively new, and the optimal role for and number of EMTs is in evolution. Thus we have invited Defendants to inform the Monitors and Court in their formal response to this plan, as envisioned by the Injunction, Paragraph 1.17, of any suggested adjustments. Additionally, though this plan recommends staffing levels based on the assumption of 1.0 FTE = 40-hour work-week, Defendants may use shift of any length to achieve the number of work hours described in the plan.

In summary, we recommend that the Court order that a pilot project be conducted immediately at San Carlos Unit at the Perryville Complex and Dakota Unit at the Yuma Complex with the staffing levels shown in Appendix 1. Once the data from the pilot project is reviewed, the Court should order the Monitors to determine whether any modifications should be made to the analysis and submit the final analysis and plan to the Court. The Plaintiffs concur with the plan. The Defendants do not and may provide the Court further detail in their response.

Section I: Medical – Outpatient (Patient-Centered Care Model)

1. Background

1A. Elements of the Injunction that inform Outpatient Medical Staffing Plan

- All residents will be assigned to specific PCPs based upon the complexity of their health care conditions. Patients with complex health care needs are deemed to need physician level of care and will be empaneled to physicians which may be MDs or DOs. Patients whose conditions are not complex will be empaneled to APPs which may be nurse practitioners or physician assistants.
- The assigned PCP will manage the patient's acute, chronic, preventive, and non-urgent primary care needs.
    - Patients will seek non-urgent care through a new mechanism for self-scheduling with their assigned PCP, placing themselves into open slots in the PCP schedule designated for this purpose.
    - The self-scheduling mechanism will replace submission of Health Need Requests (HNRs) for non-urgent health care needs. HNRs will still be used by patients for non-clinical requests, and will be sorted and redirected as needed by nursing. Also, an alternative mechanism for self-scheduling will be available to patients who cannot or may not use a tablet.
    - Initial care will be provided by a medical practitioner, or another health professional as directed by a medical practitioner.
- The staffing plan places limits on the number of patients on physician and APP panels based on the complexity of patient clinical conditions.
- All APPs are expected to collaborate with physicians on patient clinical management when necessary. Physicians are assigned APPs with whom they collaborate; an up-to-date list of the assignments is kept by the Facility Medical Director. No physician may be assigned to collaborate with more than three APPs.
- Facility Medical Directors at Douglas, Winslow, Safford (currently designated as low-intensity facilities) will see patients needing physician level of care and provide clinical collaboration to APPs. Facility Medical Directors at other complexes are limited to 100 patients on their panel, will not be scheduled as the provider for inpatient or special needs units (SNUs), and will not provide clinical collaboration to APPs.
- RNs must immediately assess urgent medical and mental health (MH) requests, consult with a medical practitioner (physician, nurse practitioner, or physician assistant) or MH professional (psych associate, psychologist, or psychiatric prescriber), respectively, and obtain a disposition within four hours.
- RNs must assess all patients returning from the hospital or ED upon return, prior to return to their living unit.
- Informed refusals for provider-initiated visits are done face-to-face with an RN or medical practitioner for medical visits and MH professional for MH visits. Patients canceling self-initiated visits do so with any health care professional, but may be done face-to-face or virtually.
- Medication administration must occur within defined windows of time; shifting many more medications from direct observed therapy ("pill line") to keep-on-person is strongly encouraged.

- Assessment and treatment for substance use disorder is required. ADCRR must continue Medications for Opioid Use Disorder (MOUD) that the patient received prior to incarceration at ADCRR and must develop capacity to initiate MOUD and medications for alcohol treatment to persons with OUD and alcohol use disorder, respectively, throughout the system.
- At prison intake sites, an RN must complete intake screening within four hours, a mental health clinician must complete a mental health assessment within one day, and a provider must complete a medical health assessment and physical exam by the end of the second day.

1B. Elements of a Patient-Centered Care Model that Inform Outpatient Medical Staffing Plan

ADCRR recognized that the Injunction requirements, in total, are best addressed through a wholesale shift in the model of care and has subsequently developed the *Patient Centered Care Model.* Based on communications put forth by ADCRR and through discussions with ADCRR and NaphCare, this staffing plan is premised on the following assumptions:

- All outpatient medical and mental health care is patient-centered rather than task-centered. Care is planned and delivered in the context of the Primary Care and/or Mental Health Team and a comprehensive integrated care plan rather than by individual personnel assigned to one component of a patient's needs. For example, LPNs are not assigned to only complete hepatitis C (HCV)-related care for all patients in a complex. Rather, an LPN on a specific care team completes HCV and other tasks related to the patients on that team.
- Primary care is team based. A permanent primary care team of providers, nursing and ancillary staff cares for a specified panel of patients. During a daily morning team huddle, the team reviews scheduled care for that day, overnight events, and high-risk situations. There is increased focus on patient engagement and self-management of chronic conditions. RNs become more involved in supporting patient engagement in self-care for chronic conditions, managing care for the day's high-risk patients, and assessing future scheduled visits and tasks that can be combined into that day's provider scheduled visits. PCPs evaluate all presenting non-urgent complaints for their empaneled patients.
- Patient panel assignments for medical and mental health care are aligned to cover the same housing units and patients as much as possible to enable better integration of medical and mental health care across teams and through huddles.
- Patients have a single, integrated care plan that addresses their medical, mental health, and SUD conditions.
- The role of RNs in managing chronic conditions changes markedly. For unstable or poorly managed patients, the RN conducts frequent check-ins with the patient in collaboration with the practitioners, to closely monitor response and adherence to treatment plan changes, thus closely managing the high-risk state. For stable patients in good control, the RN conducts visits with the patient in lieu of, but in collaboration with, the practitioner.

Each primary care team will have the following members who manage a specific panel of patients:

- Physician with an assigned patient panel. Each patient's health record will indicate the name of their physician PCP;
- APP with an assigned patient panel. Each patient's health record will indicate the name of their APP PCP;

- Temporarily, additional APP(s) who will assist in seeing self-scheduled care patients as assigned by the team PCP(s). This capacity will be needed while self-scheduling is introduced and until the model has matured such that visits are effectively collapsed, nursing is fully engaged in new roles, and patients have acclimated to the team approach. This is expected to require 9-12 months.
- RNs with a variety of roles which may be combined in different ways depending on the facility or complex:
    - Assessment, provider consultation, and disposition of urgent requests in collaboration with the PCP;
    - Collection and disposition of HNRs that are not for clinical issues;
    - Managing daily high-risk situations in collaboration with PCPs (disposition to, or return from, hospital/ED, issues that arose overnight, abnormal labs, etc.);
    - Chronic care management: carrying out chronic care visits for stable patients with practitioner supervision, patient teaching in groups, 1:1 patient consultations, teaching patients self-management and adherence to medications and other disease-specific care;
    - Addressing treatment non-adherence: face-to-face review of refused visits and medications, KOP adherence;
    - Patient schedule management (review of daily scheduled visits; recommending to collapse other scheduled visits and treatments into that day's visit);
    - Specialty medication administration such as intravenous medications.
- LPNs for medication administration, KOP preparation and distribution, patient treatments, HCV treatment; facilitation of telehealth visits. The most recent amendment to ADCRR's contract with NaphCare includes one new FTE LPN position at each complex dedicated to lab draws and facilitation of telehealth visits related to HCV treatment. Under our staffing plan, those LPNs will be integrated into primary care teams rather than operate outside of them.
- Medical assistants (MAs): one assigned to each primary care provider during visits to review visit plan with patient, obtain vital signs, draw blood, and carry out other non-license-requiring tasks. The model presumes that providers see patients 75% of their scheduled day, so .75 FTE MA is assigned to each provider. Their hours can be staggered at clinics to match the times providers see patients, thereby alleviating some of the crowding of limited physical space.

In addition, high-acuity complexes will include EMTs and/or paramedics assigned to each shift to provide emergency responses, urgent treatments, and manage unanticipated events that might interfere with scheduled visits. In most cases, basic EMTs can suffice. However, if, in the opinion of ADCRR, based on the complexity of patient emergencies at a given complex as well as the typical time frame between the emergency and arrival in a community hospital, paramedics are necessary, it would be appropriate to replace basic EMTs with paramedics. This concept applies to anywhere in this staffing plan where the term EMT or paramedic is used.

Licensed staff all work at the top of their licenses. Tasks such as vital signs or tracking down test results that can be performed by a lesser trained/credentialed person are moved down as far as they can legally and safely be moved, resulting in higher level staff only performing those tasks that no one else can.

1C. Efficiencies of a Patient-Centered Care Model

Under the model, important efficiencies will result including:

- Scheduled care proceeds smoothly every day, uninterrupted by urgent and emergent situations for which there will be dedicated personnel.
- "Bumping" of patients from daily schedule decreases because scheduled care can proceed uninterrupted. This reduces delays in scheduled care and also reduces unnecessary patient movement.
- The number of clinical visits and the accompanying resident movement and custody escorting decreases by collapsing multiple visits into a single visit making each visit as comprehensive as possible (preliminary evidence suggests 15% reduction in total primary care patient encounters).
- The number of PCP visits for chronic conditions decrease because RNs become involved in managing stable patients under PCP direction.

2. Staffing Plan

2A. Base Model

We developed the staffing plan based on a literature review of primary care staffing in governmental and community-based health care, interviews with prison staffing thought leaders, and our own extensive experience with patient-centered community practice and prison health care. The model assumes that patients with complex medical problems are cared for by physicians and drive higher staffing levels of nurses and other ancillary staff. Conversely, patients with less complex medical problems can be cared for by APPs and drive lower staffing levels for other ancillary staff. In this section we describe how we determined complexity and then how we applied patient complexity to staffing.

To construct the staffing plan, we established a proxy for estimating the medical complexity of patients residing in each prison complex. We reviewed the medical diagnoses of each ADCRR patient as found in the Master Problem List in the patient's electronic health record, which ADCRR produced 12/11/23. We identified a specific list of single diagnoses that automatically required physician-level care and several additional combinations of diagnoses that require physician-level care.[1]

We then placed patients into categories of medical complexity and defined PCP empanelment by level of medical complexity, as seen in the table below.

[1] Refer to Appendix 2 "Patient Panel Assignments by Diagnosis" for the diagnoses and assignments

PRIMARY CARE EMPANELMENT			
Patient Diagnoses	Medical Complexity		PCP Empanelment
	Number	Description	
No diagnoses in Master Problem List	1	Very Low	APP
One diagnosis approved for APP	2	Low	APP
Two or three diagnoses approved for APP	3	Medium	APP
One or two diagnoses, one or both requiring physician	4	Medium	Physician
Three diagnoses and at least one requires physician	5	High	Physician
Four or more diagnoses of any type	6	Very high	Physician

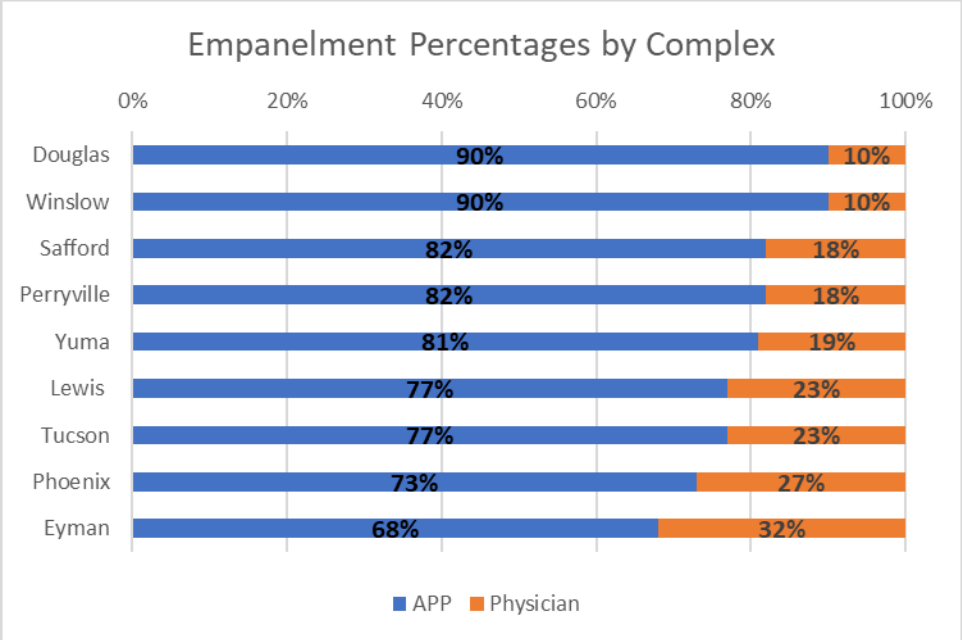
Finally, we established baseline panel sizes for medical primary care staff, based on level of patient complexity.

BASELINE PRIMARY CARE PANEL SIZE PER FTE								
Medical Complexity	Physician	APP	RN	LPN	MA	EMT	MOUD LPN	Other
1. Very low	0	900	400	500	1 per practitioner	1 per unit (high intensity complex)	1 FTE per 150 MOUD patients	Temporary APP FTEs during model transition
2. Low	0	750	300	400				
3., 4. Medium	400	400	150	200				
5., 6. High and Very High	175	0	75	100				

We use these panel sizes and FTE assignments to calculate baseline staffing needed for all complexes for primary care delivered in eight-hour shifts Monday through Friday. The panel size determinations also include the following:

- Second and third shift coverage and weekend coverage for RNs and LPNs are the same for all complexes, with afternoon shifts at 50% of the day shift and night shift at 20% of the day shift. RN coverage is reduced further by half on weekends and LPN coverage stays the same. The pilots will test the accuracy of this calculation in actual practice.
- No primary care is staffed evenings, nights, or weekends.
- EMT coverage is based on the assumption in place earlier this year that high intensity complexes need one EMT per unit, 24/7. We understand that HSD is currently working with NaphCare on a possible alternative involving RN/EMT code teams and provider coverage on site 24/7. We will consider this during the pilots and adjust the final numbers accordingly. If new RN and provider positions result, they will be in addition to the positions in this staffing plan.

The figure below illustrates the percentage of patient population assigned to APPs and physicians at each complex, using the methodology described above.



It is important to emphasize that we used current patient diagnoses data as a proxy for estimating the current complexity of ADCRR's patients for the purpose of this staffing analysis. We strongly recommend (but do not require) that FMDs begin patient empanelment using the same methodology we used in this plan in order to expedite the transition and to create a uniform approach to rapid empanelment of more than 25,000 patients across all complexes. FMDs should then confer with FHAs and make further adjustments to assignments that account for other complexities. These might include frequent ED or inpatient care for chronic conditions, medications, co-occurring mental health conditions, age, clinical stability regardless of diagnoses, and other factors. While our methodology may be informative, actual patient assignments to physician and APP panels should be made by ADCRR's facility medical directors (FMDs) based on individual patient complexity and need. New patients would be empaneled as part of their intake process.

Of note, ADCRR's Health Services Division (HSD) objects to several of the diagnostic conditions used in our model and suggests alternative methods of empanelment. We intend to test empanelment options during the pilots and use the findings in the calculating the final staffing numbers.

This staffing plan provides a single plan for each complex that covers all its units. It is up to each complex's FHA and medical director to determine how to allocate the staff across the units, shifts, days of the week, and posts.

2B. Complex-Specific Adjustments to the Model

This primary care staffing model is built on baseline panel sizes for all health care staff that are weighted at each complex based on its diagnosis-based patient complexity. There are other factors to consider in adjusting and customizing staffing to each complex. Accordingly, we developed "complex profile factors" that *may* merit consideration of adjustments from baseline staffing. These include:

- Selected data points from the monthly Health Services Report provided by NaphCare, adjusted to per 1,000 residents and comparing high intensity and low intensity complexes separately.[2] Where outliers were found that had not been addressed in the complexity analysis, adjustments were made.
    - Population on prescription medication
    - Medication orders
    - Population with chronic illness
    - Medical Provider visits
    - Chronic care provider visits
    - Nurse HNR visits
    - Suicide watch
- Close custody/detention housing and max custody housing. This is due to the extra time required to escort patients to and from health care, even when there are exam rooms in the housing units. Additional provider staffing is allocated based on the portion of the population that resides in close or max custody.
- Number and proximity of buildings/units
- Nursing nights and weekend coverage by complex/unit
- Ratio of physicians to APPs for clinical consultation
    - Physician FTEs are increased by 5% (2 hours per week) for collaboration/supervision of every APP employed in the complex, including those who are seeing self-scheduled patients for episodic non-urgent care during the transition period
    - No primary care physician may be assigned to clinically support/supervise more than three APPs

2C. Future Modifications to the Model

Several aspects of the current staffing model are based on current conditions at ADCRR that we expect to change over time. When those conditions change, the staffing model will need to be adjusted.

- At the current time, LPN documentation requirements for perpetual inventory management of buprenorphine requires at least three minutes per patient. Until this is remedied, an additional full-time LPN is required every day of the week for every 150 MAT patients.
- Implementation of the Patient Centered Care Model and self-scheduling for non-urgent clinical needs will create workflow and role changes for practitioners and RNs. At the end of a transition period of 9-12 months, we expect that patients will have acclimated, nursing roles will have evolved, visits will routinely be collapsed for efficiency, and the PCPs will be able to manage the self-scheduled visits of their panels. However, in the interim, additional APPs are included in the

[2] Data in this analysis averages what is reported by NaphCare monthly for January – November 2023.

staffing plans to cover the anticipated large volume non-urgent provider visits. There will be at least one APP at each unit, and more if the historic number of HNRs warrants.

- ADCRR is in the midst of a system-wide program to diagnose and treat Hepatitis C (HCV). Currently, physicians with expertise in HCV treatment are centralized and are diagnosing and treating a very large number of patients in all the complexes via telemedicine. As HCV treatment is time-limited and the number of existing patients needing treatment is known, ADCRR expects that treatment with centralized specialized providers will continue until October 2027, after which the volume of this work will be reduced to a steady state of patients diagnosed through the reception process and a small number of new/recurrent cases across the system. At that point HCV treatment will be managed by PCPs with consultation from a small cadre of centrally located experts for complex cases. This aligns with ADCRR's Patient Centered Care Model and provides integrated, patient-focused care rather than task-based care. As such, the centralized FTE assigned to HCV care will eventually be removed from the staffing model.
- ADCRR is also in the midst of implementing a system-wide program to continue new patients on Medications for Opioid Use Disorder (MOUD) they received before arriving at ADCRR, on diagnosing OUD and initiating MOUD in a large number of currently incarcerated patients, and on continuing or inducting patients onto treatment for Alcohol Use Disorder (AUD). Medical management of MOUD and AUD is currently carried out by addiction treatment providers who are centrally located and see patients via telemedicine. The current protocol for MOUD includes frequent urine drug screens and mandatory monthly provider visits. Many of ADCRR's MOUD and AUD patients will remain on medication for several years and maybe longer.

  As OUD and alcohol use disorder are chronic conditions, and as any practitioner with a DEA license can prescribe buprenorphine, OUD and AUD treatment should eventually be integrated into primary care. ADCRR estimates that the initial process of assessing and initiating MOUD and AUD treatment in the system's population will be complete by fall 2024. At that time, the work will shift to:

  - Continuation of MOUD and alcohol use disorder treatment identified at intake;
  - Transition from non-prescribed opioid to MOUD for OUD treatment, and withdrawal management and subsequent induction of medications for alcohol use disorder, also at intake;
  - Occasional clinical response to acute overdose or evidence of use in housing units;
  - Long-term maintenance of persons on MOUD, which includes random urine drug screening, integration with SUD counselors and peer counselors to help people who wish to wean from MOUD to do so safely, and long-term maintenance of persons on medications for alcohol use disorder. Recognizing that the current standard of care does *not* require monthly provider visits once a person is stable on MOUD for approximately six months, the staffing plan assumes that average follow-up intervals are no more often than bi-monthly and are tailored to the patient's needs and unique circumstances.
  - A cadre of patients readying for reentry who wish to either initiate or wean from MOUD.

  When this shift occurs, management of OUD treatment should become integrated into the care delivered by PCPs. As with Hep C, a small cadre of addiction medicine specialists should be

centralized and made available to PCPs to consult on and/or co-manage complex cases. This also aligns with ADCRR's Patient Centered Care Model.

Four FTE physicians on the NaphCare staffing plan are currently assigned to Perryville, Eyman, Lewis and Tucson. ADCRR has advised that these providers are in fact centrally located and providing MOUD statewide. As such, our staffing plan does not propose specific MOUD providers at complexes, and it also disregards these four physician FTEs in the NaphCare comparison.

The table below illustrates the number of patients at each complex receiving buprenorphine or methadone as of 1/2/24. Note that this number is in rapid flux and staffing with extra LPNs to accommodate actual numbers is essential. Likewise, if the administrative burden of documenting MOUD administration is effectively reduced, corresponding staffing reductions are called for.

Patients Receiving Buprenorphine or Methadone by Complex as of 1/2/24									
	Douglas	Eyman	Lewis	Perryville	Phoenix	Safford	Tucson	Winslow	Yuma
Buprenorphine HCl-Naloxone HCl Sublingual	381	109	959	348	51	141	761	129	403
Methadone Oral	0	0	0	7	2	0	9	0	0
TOTAL	**381**	**109**	**959**	**355**	**53**	**141**	**770**	**129**	**403**

Other SUD Treatment Considerations

Counseling and a recovery community are essential components of effective addiction treatment. Both are vital to maintaining recovery following release. At ADCRR, counseling is currently provided by persons outside of health care. Historically, especially prior to recent increases in use of medications for OUD and AUD, this has been the default approach in most correctional settings. Many, though, especially those with large MOUD treatment programs like ADCRR's, are re-thinking this approach and integrating SUD counseling into the health care team. We are not proposing this in the staffing plan, but are compelled to recommend that ADCRR consider this approach in the near future. To fully integrate addiction treatment into mental health and primary care, SUD counselors must be considered part of the health care team.

3. Patient-Centered Care Model Implementation

Patient Complexity and Empanelment

The crucial element of patient empanelment, regardless of the methodology used, is that the same criteria be used at each complex to empanel patients to PCPs. This will ensure compliance with the injunction's requirement that patients be empaneled to PCPs based on their clinical needs, with all those who need physician level care receiving it.

Empanelment is the responsibility of the Facility Medical Director (FMD) in consultation with the Facility Health Administrator (FHA). The initial empanelment must use a statewide database and set of definitions for patients assigned to the complex. Upon arrival of new patients through reception centers, FMDs will review diagnoses and assign clinical complexity levels and empanel to PCPs. Where patients transfer within complex units or across complexes, their complexity levels will remain intact and they only need to be appropriately empaneled by the FMD. Changes to complexity levels and panel

assignments can be made at the request of providers and reviewed by the Medical Director and FHA at any time.

Empanelment must also consider the number of units in the complex and their proximity. To the extent possible, panels should align with units to facilitate quick morning huddles and to allow alignment with mental health primary therapist assignments. Where a practitioner has panel members in more than one unit, the units should ideally be near one another, and some huddles may need to accommodate virtual participation.

Patient Training

Patients must understand the new model of care and how to properly use it. Patients in every complex must receive clear training and reference materials on primary care teams, proper use of self-scheduling, and how to request and access emergent and urgent care medical and mental health care. ADCRR and NaphCare must collaborate on this training. Also, ADCRR should engage prisoner ombudsmen, liaisons, or other resident-led communication channels to regularly reinforce the model and means for accessing correct levels of care. This will be an ongoing function. There also needs to be an orientation to accessing health care for new prisoners coming through reception centers.

Section II: Medical – Special Needs Units (SNUs) and Inpatient Care Units (IPCs)

The Injunction requires ADCRR to build or modify housing for no less than 200 patients needing assisted living in SNUs by February 1, 2024. The beds will be concentrated in the Tucson complex; its new Catalina SNU will operate 200 beds and its 46 beds in the Manzanita SNU unit will remain in use, so the total male SNU beds in the state will be 246. It is expected that male patients who need SNU level of care and are housed at Eyman (currently living in Cook and Meadows which are not SNUs) will also be moved to Catalina, but this has not yet occurred, and the staffing plan leaves those patients at Eyman.

Once the SNU population is permanently housed and the unit is staffed, a period of about 60 days should elapse before the staffing is evaluated and codified. Accordingly, a staffing plan for Tucson's SNU beds is not included in this staffing plan. It should be expected as part of the next iteration of a staffing plan as described in the introduction.

The Injunction also lays out requirements for clinical services delivered to patients in IPCs. The primary new male IPC is housed at Tucson's Catalina unit and has 100 new beds. It is not yet fully populated or staffed. Tucson Rincon also has 66 IPC beds that will remain in use. Lewis currently operates 13 IPC beds and Phoenix Baker Unit operates a 49-bed IPC. Patients from both units will eventually move to the Tucson IPC beds, but this staffing plan leaves IPC patients in both complexes where they are.

Once the Tucson IPC beds are fully operational and staffed, a period of about 30-45 days should elapse before staffing is evaluated and codified. A staffing plan for IPC beds is not included in this plan. It should be expected as part of the next iteration of a staffing plan as described in the introduction.

Note that while staffing SNUs and especially IPCs is labor-intensive and expensive, there are significant cost offsets to be realized in reducing the use of community hospital beds that have been serving ADCRR as SNU and IPC overflow.

Section III: Mental Health –Outpatient (Primary Therapist Model)

1. Background

1A. Elements of the Injunction that inform Outpatient Mental Health Staffing Plan

- All patients categorized by their clinical conditions as MH levels 3 – 5 will be assigned to a Primary Therapist (PT) who may be a psych associate or psychologist.[3]
- Patients in a crisis stabilization bed must be seen on the first day by a psychiatric practitioner and seen daily by their PT.
- Patients on the MH caseload (MH Levels 3 -5) will submit HNRs to MH. The PT or (other therapist if the PT is not available) will triage the HNR for response.
- Patients not on the MH caseload (MH Levels 1-2) will submit requests for care to medical through the procedures for seeking medical care.
- Mental health visits are carried out in a treatment room with privacy. Cell-side MH care is not acceptable except in cases where the patient's medical or mental health condition precludes movement to a treatment room.
- Patients designated as MH3 (outpatient) and on psychotropic medications will be seen by a psychiatric practitioner at least every three months.
- Psychiatric NPs are expected to consult with psychiatrists on case complexities, treatment objectives, and care. Psychiatrists are assigned psychiatric NPs with whom they consult, and an up-to-date list of the assignments is kept by the Facility Medical Director. No psychiatrist may be assigned to collaborate with more than three psychiatric NPs.
- Outpatient psychologists shall supervise no more than eight psych associates, and inpatient psychologists shall supervise no more than six psych associates.
- A Mental Health Duty Officer must be available at all times when facility MH staff are not available. The Duty Officer may be a PA, psychologist, or psychiatric provider.

1B. Elements of a Primary Therapist Model that inform General Population and Outpatient Mental Health Staffing Plan

- ADCRR uses a scoring system to assign clinical MH acuity to each resident. Scores are assigned at intake and revised by clinicians as appropriate. MH Levels 1 and 2 are not considered part of the MH caseload, though they must receive crisis assessment, suicide prevention and stabilization services as needed. All five divisions of Level 3 are considered as outpatient level of care.
- Each complex has a Mental Health Watch unit where patients who are under suicide watch or crisis stabilization receive care by MH clinicians during daytime hours seven days a week at high intensity complexes, and weekdays at low intensity complexes. MH watch is carried out by PAs. Where the number of patients in these beds is low and the beds are located in proximity to the patient's original living unit, many of the daily care visits can be completed by the patient's PT. Otherwise, the daily care visits are completed by PAs assigned to the MH Watch Unit.

[3] See Appendix 3 for a description of MH levels utilized by ADCRR and the calculations used to determine caseloads by MH Level

- Patients are seen in a private MH exam room in the unit, unless the patient's medical or mental health condition prohibits this. Custody escorting is carried out in accordance with the patient's security level. This is a significant departure from the current practice of watch rounds carried out cell-side, which is not acceptable under the Injunction. To accomplish this, the staffing plan assumes patients will be brought to the MH exam room by custody staff in accordance with an "opt-out" model. In an opt-out model, the custody staff – not the MH staff – go to the patient's cell at the time of the appointment, informing the patient that they have come to escort them to their health care appointment.
- All units within high intensity complexes have a Lead Psychologist who is not assigned a patient caseload. This position:
    - Oversees administration of mental health services, level of care changes, and overall quality of clinical mental health care, and provides input into custody decisions on housing changes for patients with serious mental illness.
    - Assigns patient caseloads to PTs based on the patient MH levels and caseload limits described below.
    - Supervises psych associates
    - Assigns one PT to be the daily "rover" for each unit.
    - Monitors the daily status of and assures adequate interventions for all patients on a wait list for residential treatment.
    - The Lead Psychologist duties as described above are calculated to account for about 2.5 hours per day or .3 FTE per unit. Other duties must be assigned to allow for this time commitment.
    - A psychologist may serve as Lead Psychologist in more than one unit in a complex. Where more than one psychologist is assigned to a unit, the FHA must identify one to serve in the role of Lead Psychologist. This assignment can rotate.
- Additional psychologists will also be employed in high and low intensity complexes to fulfill the requirements for supervision of psych associates as specified in the injunction: no more than 8 outpatient PAs and no more than 6 inpatient PAs. Psychologists will also conduct necessary testing and evaluation of patients as part of their general duties. They will typically not carry specific patient caseloads.
- Patients designated as MH Levels 1 and 2, regardless of complex, receive crisis assessment and stabilization which includes MH watch.
    - Services are provided by Psychology Associates seven days a week.
    - For the low intensity complexes, one psych associate is required for each complex seven days a week, regardless of whether the patient population meets the 2,500 patient caseload for patients in MH Levels 1 and 2.
    - A psychologist is assigned to remotely supervise the PAs at all three low intensity complexes, with occasional site visits as needed.
    - A psychiatric provider is assigned to remotely assess all patients within one day of placement on suicide watch.

- The MH Outpatient staffing plan is rooted in the Primary Therapist Model. In this model, every patient with a designation of MH 3-5 is assigned a Primary Therapist (PT). The PT is a licensed masters level therapist (or, if unlicensed, works under the supervision of a licensed therapist). The PT assignment is maintained constant as long as the patient remains in the housing unit(s) covered by that PT. This model helps ensure that patients' care is managed by the same professional as much as possible. This clinical continuity improves patient outcomes.
- One psych associate covers each high intensity complex for weekend day shift.
- PTs provide assessment and treatment at a frequency and intensity that addresses the patient's needs. *Note this differs from current policy.* PTs are not held to scheduling patients at pre-determined visit intervals (i.e., 30-60-90 days). Rather, patients are seen as often as is clinically indicated. Patients who have recently changed MH settings – moved from general population or inpatient care to outpatient and those who have moved within the outpatient levels – should be considered at higher risk by the PT and seen as often as necessary until stability is achieved. Conversely, PTs may, using clinical judgement, set longer intervals for care of stable patients. This model of care provides for a higher intensity level of care from Primary Therapists than the current ADCRR approach.
- The MH Outpatient staffing plan is based on ADCRR's current classification of patients to MH levels. We have learned that some patients classified as MH-3A are not seriously ill enough to meet ADCRR's stated definition of that level, but are assigned that level for administrative reasons, most notably, because they were labeled as SMI at some point in the community. If ADCRR were to reclassify these patients to the clinically appropriate (lower intensity) MH level, this would result in a decrease in staffing requirements. Also, patients in all three low intensity complexes are designated MH 1 or 2 yet, according to the NaphCare monthly Health Services Report, more than 300 routinely receive psychotropic medications. We do not propose staffing these facilities with psychiatric prescribers to address these prescriptions because we have assumed that these patients are either receiving psychotropic medications for non-MH reasons, or their MH needs are minimal and are being managed by their medical provider. Rather, we recommend that ADCRR investigate the patients and medications to determine if psychiatry services are indicated.
- The Primary Therapist model will greatly improve the continuity of mental health outpatient care and will subsequently result in better management of patient risk and instability and address patients faster and with fewer gaps in care. The net effect will be fewer crises and higher patient and staff satisfaction.

Mental health team members for all Level 3 sublevels include:

- Psychology Associates are assigned as Primary Therapists (PTs) for all patients. Each patient's health record indicates the name of their assigned PT. PTs are responsible to:
    - Provide assessment and treatment at a frequency and intensity that addresses the patient's needs.
    - Triage HNRs each weekday, in consultation with other members of the MH or Patient-Centered Medical team, as needed, and assure appropriate clinical response.
    - Develop and update treatment plans with input from other team members.
    - Integrate care with primary care and addiction providers.

- Serve as a "rover" for the Outpatient Population in the building in a rotation developed by the MH Lead, not more than one day per week, to provide crisis intervention and assure that scheduled visits for non-rovers are not interrupted by unexpected clinical events.
- Monitor patient status and increase treatment intervals for patients who are on a wait list for residential or inpatient MH services.

- Behavioral Health Technicians work within their capabilities and legal limits and under the supervision of a PT to manage the caseload. They may not assess patients but may observe and hold discussions with patients and report findings to the PT as members of the patient's MH care team. Duties include:
  - See patients face-to-face who are refusing MH appointments, if delegated by the PT. Report findings to PT who will determine appropriate action;
  - As assigned by the PT, connect with and observe patients who are moving between levels of care and report status to PT;
- Psychologists provide clinical supervision of up to eight outpatient PAs, allocating approximately two hours per week per PA supervised, which includes documentation.

The following team members are also required for patients in MH-3 sublevels A, B, C, and D:

- Psychiatrists or Psychiatric NPs prescribe and manage psychotropic medications, coordinate with PTs on treatment plans, and engage PTs in medication adherence issues.
- Psych RNs conduct individualized and group teaching and support for medication adherence, symptom management, treatment plan adherence.

1.C. Efficiencies of the Primary Therapist Model

Under the model, important efficiencies will result including:

- Reduction in HNRs and patient visits due to better continuity of care and case management
- Fewer "mandated" visits that are not clinically indicated
- More timely response to increases in clinical risk
- Reduction in MH crises and the need for crisis stabilization services

2. Staffing Plan

2A. Base Model

BASELINE OUTPATIENT MENTAL HEALTH CASELOAD PER MH FTE				
	Levels 1 and 2	OP 3-A	OP 3-B	OP 3 C-D-E
Psychiatrist/Psych NP		300		
Psychologist	1 per 8 Psych Associates			

Psych Associate	2,500	40	65	200
BHT		150		
Psych RN		300		

We use these panel sizes and FTE assignments to calculate baseline staffing needed for all complexes for MH care delivered in eight-hour shifts Monday through Friday.

In outpatient settings, psychiatry and psychiatric NPs are interchangeable, but the model calls for at least one psychiatrist in each complex. The total "psychiatrist or NP" is converted to assign at least one psychiatrist once the total FTEs has been identified.

Second and third shift coverage and weekend coverage for all positions mirror each complex's current staffing with modifications where indicated.

The requirement for a MH Duty Officer available whenever clinicians are not on site is currently being met by NaphCare's contract with STATCare and is sufficient at this time.

Of note, HSD does not agree with the percentage of primary therapist time we allocate to patient visits or to the number of visits we estimate each outpatient patient type should receive as determined by our experts. We will test the sensitivity of our assumptions in actual practices, and use them to calculate the numbers in the final staffing plan.

2B. Facility-Specific Adjustments to the Model

The Outpatient mental health staffing model is built on baseline caseload sizes for all health care staff that are used to weight staffing of each complex based on the MH patient acuity levels assigned to its patients. There are other factors to consider in adjusting and customizing staffing to each complex. Accordingly, we developed a "facility profile" that identifies factors that merit consideration of adjustments from baseline staffing. These include:

Average Daily Patients on MH Watch by Complex July-December 23								
Douglas	Eyman	Perryville	Phoenix	Lewis	Safford	Tucson	Winslow	Yuma
0	20	10	13	15	0	44	0	9

- Average daily number of patients in MH watch. As seen in the table above (based on the count on the last day of each month from July to December 2023), this varies considerably from complex to complex. Complexes with a daily average of 10 or more patients on MH watch will be assigned an additional 1.0 FTE PA per 12 patients on watch. This ratio assumes approximately 30 minutes per visit, allowing time for the custody officer to bring each patient to and from the PA in the MH exam room and time for the PA to document in the patient's health record. This supports compliance with the Injunction requirement that MH patients receive care in a room with privacy. This position is filled seven days a week (in contrast to most other positions in the plan which are staffed 5 days a week, i.e., 40% greater) which equates to 1.4 FTEs for every 12 patients on watch. Psychiatric time will be increased by 1.0 FTE for every 100 average daily patients placed on watch.

- Close custody/detention housing and max custody housing. The same assumption of a 30% reduction in provider productivity used in the medical staffing plan is also applied to outpatient MH. This is due to the extra time required to escort patients to and from mental health care. Additional provider and PA staffing is allocated based on the portion of the population that resides in close or max custody. Where there are patient interview rooms in the housing units, this additional calculation can be greatly reduced because escort time is not required in most cases.
- Number and proximity of buildings/units
- Number of Psychiatric NPs and psychiatrists
- Number of PAs needing supervision by psychologist
- Ratio psychiatrists to psychiatric NPs for clinical consultation
    - Psychiatric FTEs are increased by 5% (2 hours per week) for clinical collaboration with every psychiatric NP employed in the complex.
    - No psychiatrist may be assigned to clinically collaborate with more than three psychiatric NPs.

Also, we created MH acuity profiles for each complex and its units, which MH Leads can use to spread the allocated staff across units within the complex in accordance with the MH acuity of its outpatient populations.

2C. Future Modifications to the Model

As the Primary Therapist staffing model matures, we expect that HNRs and crises will decrease. This may lead to changes in the caseloads that PTs and other staff can cover. The staffing plan may need to be adjusted accordingly.

Section IV: Mental Health Residential/Inpatient Care

1. Background

1A. Elements of the Injunction that inform Residential/Inpatient Care MH Staffing Plan

Residential Care

ADCRR currently operates residential mental health programming (MH Level 4) at four complexes with the capacity and patient population seen in the table.[4]

ADCRR Residential Mental Health Units			
Complex	Number of units	Total Capacity	Census
Eyman	3	79	79
Perryville	2	54	25
Phoenix	1	150	144
Tucson	1	428	374

- Primary Therapist (PT) must evaluate patients whenever there is a significant change in the course of treatment, e.g., new type of treatment including medication, significant decompensation; and at least annually, documenting the prisoner's need for residential level of care.
- PT must have face-to-face encounters with patients in accordance with treatment plans.

[4] Capacity and census data provided by ADCRR for 12/18/23.

- Treatment plans will be reviewed and updated as clinically indicated but no less often than every three months.
- A full team meeting shall be conducted at least every three months to include: primary therapist, psychologist, psychiatrist, any other staff as necessary, and patients as required by the Injunction. The meeting will consider treatment, efficacy of interventions, level of care needs, rationale for the need for residential care, diagnostic impressions, progress to date in treatment, and steps taken toward moving to a less restrictive environment.
- Patients shall have an appropriate clinical encounter with a psychiatric practitioner as often as indicated, but no less than every fourteen days.

Transitional Mental Health Unit

There are three Transitional Mental Health Units in ADCRR – one at Tucson and two at Lewis. Their total capacity is 107 and their census on 12/18/23 was 54 patients. These are staffed at the same level and with the same team members as Residential Mental Health care.

Inpatient Care

Inpatient mental health care (MH Level 5) is currently provided at Perryville and at Phoenix in 4 units with a capacity of 125 and census of 111. A large new inpatient mental health unit is being built at Lewis in its Eagle Point unit. It will house all the Phoenix patients and the Phoenix inpatient units will close. Eagle Point capacity will be 126 and it is expected to be fully occupied. Eagle Point is scheduled to open June 2024. At the request of ADCRR, the staffing plan for Lewis will include the Eagle Point unit and the staffing plan for Phoenix will not include its inpatient psychiatric beds.

- At least annually, the PT must conduct a comprehensive mental health evaluation reflecting rationale for inpatient placement including but not limited to current symptoms and functional impairment, timing and pattern of decompensation, interventions attempted, diagnostic impressions (including potential substance-related impacts), progress in treatment to date, goals for treatment in the inpatient setting, anticipated length of stay, and criteria for discharge.
- Upon discharge from inpatient care, the PT must prepare a discharge summary.
- The PT must conduct daily face-to-face encounters with patients unless clinically contraindicated. Patient participation in weekly treatment progress meetings may be counted as a face-to-face encounter with the PT.
- The PT must evaluate patient treatment progress daily.
- Treatment teams meet at least weekly with all providers (e.g., nursing, psychiatry, mental health, social work, custody/unit staff, behavioral health technicians), patients as required by the Injunction, and providers from the prisoner's previously assigned unit whenever possible. At a minimum, teams shall provide updates on progress, the type and efficacy of interventions used, treatment adherence, potential obstacles to recovery, and rationale for continued placement in the inpatient unit.
- A psychiatrist conducts a clinical encounter with all patients as often as clinically appropriate, but no less than once per week.

1B. Elements of Care Model that Inform Residential/Inpatient Mental Health Staffing Plan

Team members for residential and inpatient levels of care are more clinically specialized and include:

- Psychiatrist, for diagnosis, medication management, integration with medical and SUD providers, and participation in interdisciplinary team care planning. Note that the staffing plan does not utilize APPs in these high acuity settings.
- Psychologist to provide clinical leadership and supervision of PAs, conduct diagnostic testing and evaluation for patients, and participation in interdisciplinary team care planning. Psychologists do not have patient caseloads for these settings.
- Psych Associates to provide assessment and counseling, develop and update treatment plans, supervise BHTs, and participate in interdisciplinary team care planning.
- Psychiatric Nurse to administer all patient medications, provide psychiatric nursing through individual and group interactions, integrate with medical and SUD providers, and participate in interdisciplinary team care planning.
- Behavioral Health Technicians to interact with patients throughout the day in social and therapeutic encounters, report pertinent observations to PA, and participate in interdisciplinary team care planning.

Note that for staffing purposes, patients who are deemed in need of residential or inpatient care but are on a waiting list must be overseen by the Mental Health Lead and must receive increased services deemed necessary until residential care is available.

Psychologists provide clinical supervision to up to eight PAs in residential units and up to six PAs in inpatient units, allocating approximately two hours per week per PA supervised, which includes documentation.

2. Staffing Plan Methodology

2A. Base Model

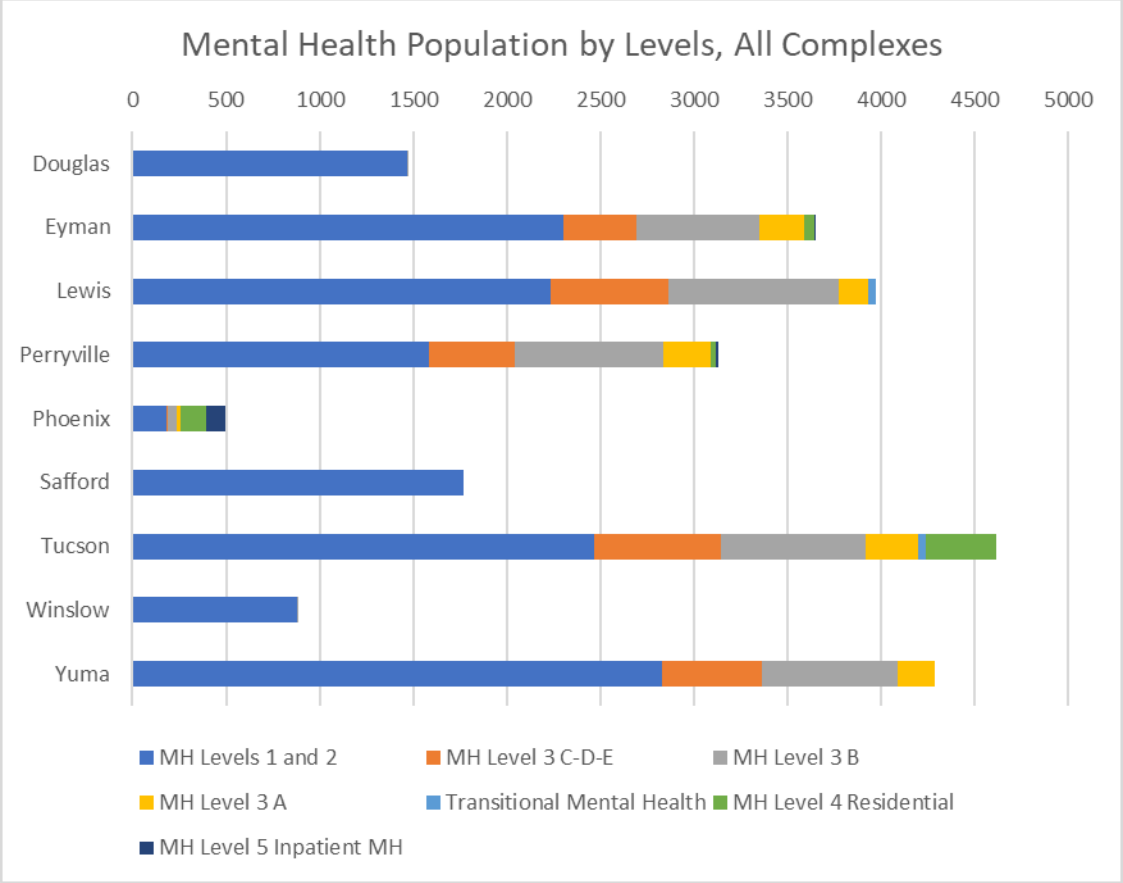
Based on our extensive experience with community mental health practice and prison health care and review of the injunction requirements and ADCRR's draft Mental Health Treatment Manual, we propose the following baseline calculations to use in establishing baseline mental health staffing across ADCRR. It applies to an 8-hour day shift, Monday through Friday. Additional staffing for weekend coverage will be facility specific. Also, this staffing is for direct patient care and does not include facilitation of telepsychiatry visits, which is addressed separately.

We use these caseload sizes to calculate day shift, week-day mental health staffing needed for each complex. We largely defer decisions to FHAs, in consultation with their MH leaders, on which facilities within complexes to assign the FTEs.

BASELINE RESIDENTIAL AND INPATIENT MH CASELOAD PER MH FTE					
	Psychiatrist	Psychologist	Primary Therapist	Behavioral Health Tech	Psych RN
Transitional MH Program	100	1 per 6 PAs	25	15	40
Residential MH	100	1 per 6 PAs	25	15	40
Inpatient MH	30	1 per 6 PAs	15	8	25

To determine second and third shift coverage and weekend coverage for all shifts, we used the current ratios of Monday-Friday day shift to other shifts and the weekend coverage ratios for each specific complex, with modifications where indicated.

For informational purposes, the graphic below illustrates the number of patients in each Mental Health level by complex.



Section V: Staffing for Telehealth Facilitation

The use of telehealth for medical and mental health care varies widely and changes frequently at each complex and in each unit. Telehealth visits require that a facilitator be present for the encounter. For medical care, this can be an LPN, medical assistant, nursing assistant, or clerk. For mental health care, this can be a behavioral health technician or clerk. We cannot quantify the staffing needs for telehealth facilitation by complex because of its fluid nature and the flexibility afforded to staffing it. However, it is essential that this function be staffed to meet the medical and mental health demand at each unit of a complex. Accordingly, we are adding a line in the staffing for each complex to allocate a minimum of one FTE facilitator to each unit of each complex. The position can be allocated to medical and mental health by the FHA and can be filled with the staff of the FHA's designation.

Section VI: Provider After Hours Coverage

ADCRR must provide physician coverage for after-hours medical and psychiatric needs across the system. On-call coverage must be available such that a response is provided within 15 minutes and is available 5:00 p.m. – 6:00 a.m. weekdays and 24 hours on weekends and holidays.

Currently, ADCRR's contract with NaphCare includes immediate on-call medical and separate psychiatric coverage for all complexes through a contract with STATCare. That is sufficient and acceptable. The psychiatric coverage meets the Order's requirements for a mental health Duty Officer. In the event that this arrangement changes, options for on-call coverage include:

- Centralized coverage through dedicated physician and psychiatric teams. Hours required for a regular week call for 2.8 FTEs for medical and another 2.8 FTEs for psychiatry, if single physician and psychiatrist take call with no back up.
- Complex-specific or regional coverage: The same coverage hours would be required and could be provided with separately hired/contracted physicians and psychiatrists or by staff physicians and psychiatrists who are paid an hourly or shift-based on-call fee in addition to their regular compensation. This can be voluntary or part of a position description.

Section VII: Relief Factors

Relief coverage for permanent staff positions is an essential component of a staffing plan to account for staff absences. This plan includes a relief factor based on coverage of 2 weeks of vacation and 2 weeks of sick time for each direct care FTE in the staffing plan. This equates to 7.7% (4 weeks leave/52 weeks per year) added to each FTE in the staffing plan.

Section VIII: Staffing Plan Summary

The total staffing for each complex is shown in their individual narratives below. A comprehensive table of staffing by position for all complexes is also included as Appendix 4.

For each complex and in the summary, we have also compared this staffing plan with the positions that appear in ADCRR's contract with NaphCare, including all amendments through #12 and its positions to be provided through March 2024. Data came from a document provided by ADCRR on 3/4/24 "Staffing Matrix Amendment # 12 Mar 1st," which we were advised was comprehensive and complete. Of note, many of the positions, especially those required by Amendment #12, have not yet been filled.

Section IX: Complex Staffing Plans

These complex-specific staffing plans provide a single plan for each complex that covers all its units. It is up to each complex's FHA and medical director to determine how to allocate the staff across the units, shifts, days of the week, and posts.

DOUGLAS COMPLEX

Douglas Complex is a low intensity complex housing only residents designated minimum or medium custody. Douglas' ADP was 1,416 as of December 31, 2023. No staffing adjustments are necessary for close or max custody. There are no residential or inpatient mental health units, and patients needing mental health watch are rare, with a monthly average of less than one. Ninety percent of patients are empaneled to APPs and 10 percent are empaneled to physicians.

DOUGLAS Health Care Utilization Compared to Average for Low Intensity Complexes			
Indicator	Douglas Complex	Low Intensity Complex Average	Douglas Variance
Patients on any medication per 1,000 inmates	652	663	-2%
Patients on MH meds	87	NA	NA
Average weekly HSRs per 1,000 inmates	87	98	-11%
Monthly medical provider visits per 1,000 inmates	211	243	-13%
Patients with any chronic care condition per 1,000 inmates	521	529	-2%
Monthly chronic care provider visits per 1,000 inmates	175	133	32%

Key health care data shows that on most measures, Douglas patients use fewer services than the average for all the low intensity complexes (Douglas Safford, and Winslow). The exception is that there are nearly one third more chronic care visits per 1,000 patients, though the portion of patients with chronic conditions is about average. This may be due to differences in provider documentation, and rather than make an adjustment to staffing, we recommend that ADCRR track whether there is a backlog for chronic care and address this issue as needed in future staffing revisions.

Also note that data shows an average of 87 patients per month on psychotropic medications, though all are MH levels 1 or 2.

The table below summarizes the staffing plan for Douglas and compares it to the current contracted staffing. Relevant notes follow.

Douglas Staffing Plan Summary (FTEs)													
	Physician	APP	Transition APP	RN	LPN	MA	EMT/ Paramedic	Psychiatrist	Psych NP	Psycholo-gist	Psych Associate	Behavioral Hlth Tech	Psych RN
Staffing Plan by Model	0.7	2.0	0.0	15.1	22.4	2.1	0.0	0	0	0.1	0.7	0	0
Staffing Plan with Adjustments	1.0	2.0	0.0	15.1	22.4	2.1	0.0	0	0	Combine	1	0	0
Contract Requirements with All Amendments	1	3	0	8.8	5.1	1	0	0	0	0	1	0	0

- The staffing plan calls for .7 physician FTE. The complex has a full-time Facility Medical Director who sees patients and can provide clinical consultation to AAPs. The physician panel size is 154, which is manageable. The physician FTE was amended to 1.0 FTE and is covered by the FMD position.
- Given the low volume of HSRs in low intensity complexes, additional APPs are not needed to cover the transition to self-scheduling.
- Supervision requirements call for .1 psychologist to supervise the PA. ADCRR should combine this FTE with that of other psychologists in the system who can absorb this supervision via remote interaction with the PA.
- Per the model, all low intensity complexes need 1 FTE PA regardless of the patient census. The PA FTE was amended from .7 to 1.0.

EYMAN COMPLEX

Eyman complex currently operates 5 units housing 3,711 residents as of December 31, 2023. Medically, the complex does not operate a SNU or IPC. However, many patients in the Cook and Meadows units are older, need significant assistance with ADLs, and have chronic illness. Patients at Cook need overnight care for mobility and incontinence, which is provided by CNAs. Eventually, ADCRR expects that many patients in these units will be moved to Catalina SNU beds. When that occurs, staffing at Eyman will need to be revisited. At Eyman, 68 percent of patients are empaneled to APPs and 32 % are empaneled to physicians.

The complex houses 557 close custody patients and 276 max custody patients, for a total of 833 patients or 22% of the population. Because of the high level of close custody, Eymen also has a high number of frequent and violent incidents that require clinical intervention. Browning, in particular, needs around-the-clock EMT support for ICS in order to allow nursing duties to proceed smoothly.

As seen in the table below, medically, 9% more of Eyman's patients have at least one chronic illness compared to other high intensity complexes. However, their medication usage is equal and their rates of medical and chronic care provider visits are far below their peer complexes. This comports with reporting from Eyman that they have provider shortages and that provider productivity is hampered by the escorting and movement requirements of the high numbers of patients in close and max custody.

Eyman has one FTE Facility Medical Director who, under the Injunction, may be assigned as PCP up to 100 patients. The FMD may not be scheduled as the provider for inpatient or special needs units, and

will not provide clinical collaboration to APPs. If the Eyman FMD is assigned a primary care caseload, it should be limited to patients who are of medium clinical complexity and exclude patients of high or very high complexity.

EYMAN Health Care Utilization Compared to Average for High Intensity Complexes			
Indicator	Eyman	High Intensity Complex Average	Eyman Variance
Patients on any meds per 1,000 inmates	818	806	1%
Patients on MH meds per 1,000 inmates	370	390	-5%
Patients with any CC diagnosis per 1,000 inmates	656	602	9%
Average weekly HSR per 1,000 inmates	52	117	-56%
Medical visits per 1,000 inmates	150	213	-30%
Provider CC visits per 1,000 inmates	78	102	-23%

Regarding mental health needs and services, Eyman has about 900 patients who are MH Level 3A-B and is one of four complexes that operates a residential mental health unit. It houses between 50 – 80 patients. The complex averages 20 patients per day on Mental Health Watch, which is the second highest volume in the state. Adjustments are made to staffing at Eyman using the factors built into the model for these circumstances.

The table below summarizes the staffing plan for Eyman Complex and compares it to the current contracted staffing. Relevant notes follow.

Eyman Staffing Plan Summary (FTE)													
	Physician	APP	Transition APP	RN	LPN	MA	EMT/ Paramedic	Psychiatrist	Psych NP	Psycholo-gist	Psych Associate	Behavioral Hlth Tech	Psych RN
Staffing Plan by Model	7.0	5.1	5.7	58.4	57.9	13.2	22.6	2.8	5.7	4.5	27.2	13.0	6.0
Contract Requirements with All Amendments	3	15.5	0	27.3	42.8	1	8.4	2.2	9	8	17	8	5

- The FMD may see up to 100 patients of medium complexity. This equates to .25 FTE. Accordingly, the total physician number may be reduced by .25 FTE if 100 patients are empaneled to the FMD.

LEWIS COMPLEX

The Lewis complex currently operates six adult custody units housing 3,745 residents as of December 31, 2023. Eagle Point is planned to open June 2024 and at ADCRR's request, is included in the staffing plan. This brings the total number of Lewis units to seven. The Sunrise youth facility is also within Lewis and houses 32 youth. The Sunrise facility is included in the staffing plan but diagnostic and utilization data for the youth are not included in the analyses, nor are the youth closed custody numbers included. The juveniles housed at Sunrise are typically not medically complex, and their primary care needs are met by primary care providers who travel to Sunrise for episodic and other care as needed, usually at

the end of the day. At Lewis, 77% of patients are empaneled to APPs and 23% are empaneled to physicians.

Lewis operates a 13-bed IPC which is always full. It is slated to be closed when the Catalina IPC is fully staffed and operational but remains in the Lewis plan at this time. As noted, staffing of IPCs is not included in this plan. Therefore, the Lewis staffing plan for physicians and nurses is understated.

Morey, Rast, and Buckley units house primarily close custody and max custody prisoners. The total number is 1,818 patients which is 47% of the population. The high population of close custody patients also results in a high number of ICS. Medical and mental health staffing are adjusted using the factors built into the model for these circumstances.

LEWIS Health Care Utilization Compared to Average for High Complexity			
Indicator	Lewis Complex	Corridor Complex	Lewis Variance
Patients on any meds per 1,000 inmates	834	806	3%
Patients on MH meds per 1,000 inmates	416	390	7%
Patients with any CC diagnosis per 1,000 inmates	739	602	23%
Average weekly HSR per 1,000 inmates	133	117	14%
Medical visits per 1,000 inmates	346	213	63%
Provider CC visits per 1,000 inmates	195	102	91%

Key health care data shows that 23% more Lewis patients have at least one chronic care condition than patients in other high intensity complexes per 1,000 residents. This is addressed in the staffing plan methodology. However, the variance between Lewis and other corridor complexes in medical provider visits and chronic care visits per 1,000 residents far exceeds the increased prevalence of chronic conditions in its population. Lewis patients, at this time, use far more provider resources than patients in comparable complexes. Accordingly, provider staffing is adjusted with an increase of 10% in the staffing plan.

Lewis has one FTE Facility Medical Director who, under the Injunction, may be assigned as PCP up to 100 patients. The FMD may not be scheduled as the provider for inpatient or special needs units, and will not provide clinical collaboration to APPs. If the Lewis FMD is assigned a primary care caseload, it should be limited to patients who are of medium clinical complexity and exclude patients of high or very high complexity.

Lewis operates two transitional MH units with a total of 36 patients. The staffing for these units is the same as for residential mental health care.

The Lewis population averages 15 patients per day on Mental Health Watch, which is the third highest volume in the state. Adjustments are made to staffing at Lewis using the factors built into the model for these circumstances.

The new Eagle Point Unit will house 126 MH-4 level and mental health watch patients and is expected to be at full capacity. The mental health watch section which will be staffed as inpatient level of care. The

new unit will require additional medical primary care staffing as it is large and separately located. This is accounted for in the staffing analysis.

The table below summarizes the staffing plan for Lewis Complex and compares it to the current contracted staffing. Relevant notes follow.

Lewis Staffing Plan Summary (FTEs)													
	Physician	APP	Transition APP	RN	LPN	MA	EMT/ Paramedic	Psychiatrist	Psych NP	Psycholo-gist	Psych Associate	Behavioral Hlth Tech	Psych RN
Staffing Plan	5.6	6.8	8.5	57.0	74.2	14.9	31.7	10.5	7.7	5.7	45.3	38.3	14.6
Contract Requirements with All Amendments	3	15.5	0	30	38.9	1	12.6	3	8	8	10	9	4

- Staffing for the 13 bed IPC is not included, so medical/nursing staffing is understated.
- The FMD may see up to 100 patients of medium complexity. This equates to .25 FTE. Accordingly, the total physician number may be reduced by .25 FTE if 100 patients are empaneled to the FMD.
- Physician staffing will need to be allocated across all seven units.
- Mental health staffing is based on Eagle point being fully operational with 125 MH Level 5 Inpatients. Treated 7 days a week. These patients and staffing for their care are deleted from the Phoenix Complex Flamenco units.

PERRYVILLE COMPLEX

As the state's only women's facility, Perryville houses 3,164 patients with every category of health care need found in all the other complexes plus the addition of OB/GYN issues. Perryville operates intake and intake housing; minimum, medium and close custody (though no max custody); infirmary care; SNU and IPC units; mental health watch; and outpatient, residential and inpatient mental health care. Close custody patients make up 11% of the population. At Perryville, 82% of patients are empaneled to APPs and 18% are empaneled to physicians.

Perryville operates 5 units.

FEMALE HEALTH CARE DEMAND

It is widely understood that female patients utilize much higher levels of health care than male patients, and that they generally avoid placement in residential care setting such as SNUs that separate them from their social contacts. The data confirms this for Perryville. Its population of 3,164 women generally includes just 4 patients in SNU beds and 1-2 in IPC beds. The table below shows that while Perryville patients include one third fewer patients with any chronic care diagnosis than male counterparts and use one third fewer chronic care visits, their volume of HSRs is more than triple, their use of psychotropic drugs is 45% higher, and they use 27% more medical visits than males .

PERRYVILLE Health Care Utilization Compared to Average for all Men's Complexes			
Indicator	Perryville	Men's Complexes Average	Perryville Variance
Patients on any meds per 1,000 inmates	895	759	18%
Patients on MH meds per 1,000 inmates	458	317	45%
Total meds per 1,000 patients	2,624	1,193	120%
Patients with any CC diagnosis per 1,000 inmates	410	622	-34%
Average weekly HSR per 1,000 inmates	265	81	227%
Medical visits per 1,000 inmates	258	203	27%
Provider CC visits per 1,000 inmates	71	110	-36%

These factors must be considered in the Perryville staffing plan, and adjustments have been made to baseline calculations. Medical panel size for all positions is reduced by 15% and outpatient mental health caseload size is reduced by 10%.

INTAKE

Busses bring women to Perryville for intake three to four days a week. New residents always include individuals who have violated the terms of their parole, so intake must account for women who are experiencing substance withdrawal. Intake includes breast and pelvic exams and a PAP test as well as other standard labs. Staffing intake poses several challenges.

The Injunction requires that:

- An RN or higher credentialed professional conducts an intake screening within four hours of arrival.
- Alternatively, a rapid screening can be conducted immediately on arrival by an LPN or CNA and abnormal findings are immediately reported to an RN. All rapid screenings are followed by intake screening provided by an RN before the resident proceeds to housing.
- A medical practitioner completes a history and physical exam by the end of the resident's second full day.

This affords the complex some staffing flexibility when there are no buses or when RNs may not be available.

The current requirements for both practitioner and nursing duties in reception have created significant duplication of effort between the intake RN and intake medical practitioner at Perryville. Both review the transfer packet, take patient histories, and conduct other tasks. Such duplication should be minimized. Intake nurses, providers, and the FHA should conduct a detailed workflow analysis and identify the optimal efficient flow. The staffing plan is built on assumptions that these efficiencies have been achieved and that the ratio of RNs to medical providers is 0.75:1.

There are other inefficiencies that impact timeliness of care and use of other staffing resources. For example, all patients get standing intake blood tests drawn before seeing providers. Providers may order additional testing, which requires a second blood draw. Also, most intake providers do not order blood tests for routine chronic care but rather presume that the PCP will order these tests when seeing the patient in a week or two. It would be much more efficient for the intake provider to order routine, patient-specific, and chronic care bloodwork when evaluating the patient, and then having a single blood draw in the intake unit complete the full panel of testing. Intake would be more efficient, and chronic care labs would be in the chart when the PCP sees the patient. Any potential efficiencies from modifying this workflow have *not* been built into this staffing plan.

It is also unclear whether all the intake providers conduct the breast, pelvic and PAP exams, or whether this function is separate from the other intake clinical assessments. This should be optimized as well, and integrated into a single assessment and creation of a problem list.

OBGYN

Perryville must provide OBGYN services at intake and as a component of primary care and patient specialty needs. Staffing includes a women's health APP and an OB/GYN provider.

SNU/IPC

Perryville operates separate SNU and IPC units and both regularly have very low censuses. While staffing levels for these units are different, for efficiency, the patients should be combined into one unit that is staffed at the IPC level of care. Nursing will be required around the clock, but with the low census, a large portion of the provider staffing can be allocated elsewhere in the complex. As noted, this staffing plan excludes staffing of IPCs and SNUs, but staffing at Perryville should incorporate these recommendations.

MENTAL HEALTH

Perryville operates all levels of mental health care. As noted, the caseloads for outpatient MH care are reduced by 10% based on the high demand for services by female populations. Based on that adjustment and on the staffing in the base model for inpatient care being higher than current NaphCare staffing, the plan for mental health staffing at Perryville is notably higher than the contractual requirements.

The table below summarizes the staffing plan for Perryville Complex and compares it to the current contracted staffing. Relevant notes follow.

Perryville Staffing Summary (FTEs)															
	Physician	APP	Transition AP	RN	LPN	Medial Assistant	EMT/ Paramedic	OB/GYN	Women's Health NP	Psychiatrist	Psych NP	Psychol-ogist	Psych Associate	Behavioral Hlth Tech	Psych RN
Staffing Plan	3.8	5.9	6.4	42.6	47.1	11.9	22.6	0.4	1.1	3.3	7.3	5.0	30.0	15.6	7.3
Contractual Requirement	2.2	12		30	31.3	1	4.2	0.2	1	2	4	6	13	4	4

- Staffing for the SNU and IPC beds are not included, so medical/nursing staffing is understated.
- The FMD may see up to 100 patients of medium complexity. This equates to .25 FTE. Accordingly, the total physician number may be reduced by .25 FTE if 100 patients are empaneled to the FMD.

PHOENIX COMPLEX

Phoenix Complex is unique among the male complexes. It is the main male reception center and receives about 250 new prisoners and 25-30 individuals who have violated the terms of their parole per week. These residents complete intake and are moved to other complexes within 5-6 days, with outliers taking up to 10 days. This rapid flux of residents precludes the comparison of health care utilization data with other complexes. Also, intake is staffed separately from primary care. Phoenix also operates a resident worker dorm that houses residents with very low complexity health care issues. Phoenix operates Aspen, a large dorm-style Level 4 residential mental health unit. Finally, Phoenix operates five Level 5 inpatient mental health wings at Flamenco. These will be moving to the new Lewis Eagle Point unit in June 2024, and at ADCRR's request, these patients are not included in the Phoenix census for purposes of this staffing plan. Using 12/31/23 as an example, the Phoenix population is shown in the table. Note that just 205 patients need regular primary care. Of these, 147 are patients in the Aspen residential mental health unit and 58 are resident workers. These patients can all be empaneled to a single FTE physician. Psychiatric nurses will administer all the meds in Aspen. RNs from intake can cover the occasional needs of the 58 resident workers.

PHOENIX CENSUS ANALYSIS (12/21/23)	
Total population	528
Residents in reception	170
Patients in IPC	46
Patients in Flamenco	107
Remaining residents	205

For intake, the complex currently operates with 4 medical practitioners Monday-Thursday and 2.5 on Friday, so the FTE is 3.7. No adjustments are needed for close custody or other factors. Providers should be a mix of APPs and physicians.

Intake processes at Phoenix are almost identical to those at Perryville and contain the same inefficiencies. Phoenix should minimize the overlap between intake RNs and practitioners thereby reducing the ratio of RNs to providers to .75:1. Likewise, Phoenix should re-order the intake events so that all labs for intake, current clinical profile and chronic care are ordered and drawn at the end of the intake process.

For intake mental health assessments, the same number of psych associates are needed as medical practitioners, since both must do comprehensive assessment on each patient – 3.7 FTEs.

One FTE LPN should be on site all shifts, every day to address patient procedures and dressings and to pass medications when the psychiatric RNs are not present. One EMT should be on site each shift, each day as well.

The table below illustrates the staffing plan for intake, Aspen Level 4 MH, and resident workers. Staffing of the IPC is not included, as noted elsewhere. Staffing for Flamenco is deleted as those patients will be moving to Eagle Point. Given these considerations, it is not useful to compare contractual requirements for staffing.

Phoenix Staffing Plan Intake, Aspen and Inmate Workers (FTEs)										
Physician	APP	RN	LPN	EMT	Psychiatrist	Psych NP	Psychol-ogist	Psych Associate	Behavioral Hlth Tech	Psych RN
3.2	2.9	3	4.5	4.5	2.3	0	2.3	14.1	15.6	6.4

- Based on the high patient volume and patient complexity of Level 4 residential units and on the number of PAs that a psychologist can supervise in a residential setting, the staffing model was augmented with an additional .5 FTE psychologist.
- The residential units need coverage by PAs, BHTs and Psychiatric RNs, though at a reduced level, on day shift weekends. Two people of each profession were added for Saturday and Sunday.

SAFFORD COMPLEX

Safford Complex is a low intensity complex housing only residents designated minimum or medium custody. Safford's ADP was 1,769 as of December 31, 2023. No staffing adjustments are necessary for close or max custody. There are no residential or inpatient mental health units, and patients needing mental health watch are rare, with a monthly average of fewer than one. At Safford, 82% of patients are empaneled to APPs and 18% are empaneled to physicians.

Key health care data shows that on most measures, Safford patients use services at about the average rate for all the low intensity complexes. The exception is that Safford patients use 17% more medical provider visits and 13% fewer chronic care visits. This is essentially a "wash" for the use of physician services, and no adjustments in the staffing plan need to be made.

Also note that data shows an average of 161 patients per month on psychotropic medications, though all are MH levels 1 or 2.

Safford Health Care Utilization Compared to Average Low Inensity Complexes			
	Safford	Average	Variance
Patients on any meds per 1,000 inmates	647	663	-2%
Patients on MH meds	161	NA	NA
Patients with any CC diagnosis per 1,000 inmates	520	529	-2%
Average weekly HSR per 1,000 inmates	97	98	0%
Medical visits per 1,000 inmates	285	243	17%
Provider CC visits per 1,000 inmates	115	133	-13%

The table below summarizes the staffing plan for Safford and compares it to the current contracted staffing model. Relevant notes follow.

Safford Staffing Plan Summary (FTEs)													
	Physician	APP	Transition APP	RN	LPN	MA	EMT/ Paramedic	Psychiatrist	Psych NP	Psycholo-gist	Psych Associate	Behavioral Hlth Tech	Psych RN
Staffing Plan by Model	1.2	2.6	0	19.7	21.8	2.8	0	0	0	0.1	0.8	0	0
Staffing Plan with Adjustments	1.5	2.6	0	19.7	21.8	4.1	0	0	0	Combine	1	0	0
Contract Requirements with All Amendments	1	4	0	14.7	9.3	0	0	0	0	0	1	0	0

- The staffing plan calls for 1.2 physician FTE. The complex has a full-time Facility Medical Director who sees patients and can provide clinical consultation to AAPs. However, the physician panel size is 312 patients, which is a heavy load for an FMD who must also provide consultation to 2.5 APPs. The staffing plan has been adjusted to 1.5 physician FTEs, 1.0 of which is covered by the FMD position.
- Given the low volume of HSRs in low intensity complexes, additional APPs are not needed to cover the transition to self-scheduling.
- Per the model, all low intensity complexes need 1 FTE PA regardless of the patient census. The PA FTE was amended from .8 to 1.0.
- Supervision requirements call for .1 psychologist to supervise the PA. ADCRR should combine this FTE with that of other psychologists in the system who can absorb this supervision via remote interaction with the PA.

TUCSON COMPLEX

Tucson is a high intensity complex with census of 4,625 residents and a very high number of patients with serious outpatient and inpatient mental health needs. Tucson operates 7 units. In the Catalina unit, it has 200 new SNU beds and 100 new IPC beds that are not yet fully operational or staffed. It also operates Manzanita SNU with 46 beds and Rincon IPC with 66 beds, which will both remain open. Tucson also operates a very large Level 4 residential mental health unit with 374 beds and a transitional mental health unit with 18 beds. Excluding SNU and IPC patients, there are 1,315 patients in close custody, or 28% of the total population. At Tucson, 77% of patients are empaneled to APPs and 23% are empaneled to physicians.

The daily average number of patients on MH watch is the highest in the state at 44, which is more than double the number at the next highest closest complex.

Tucson Health Care Utilization Compared to Average for High Intensity Complexes

	Tucson	AVERAGE	Tuscon Variance
Average total monthly meds	8,929	5,962	50%
Patients on any meds per 1,000	802	806	-1%
Patients on psych meds per 1,000	402	390	3%
Patients witih any chronic condition	603	602	0%
Average weekly HSRs per 1,000	110	117	-7%
Medical provider visits per 1,000	246	213	16%
Chronic care visits per 1,000	122	102	20%

The table shows average health care utilization per 1,000 patients at Tucson compared to the average of the other high intensity complexes. Tucson has 16% more medical provider visits and 20% more chronic care visits, though the portion of patients with any chronic condition is at the average with the other

high intensity complexes. The staffing model provides an adjustment of 5% FTE medical providers to address this demand.

Tucson also administers 50 % more total medications than the average for other high intensity complexes, and the staffing model provides an adjustment of 15% FTE for LPNs to cover this demand.

The table below summarizes the staffing plan for Tucson and compares it to the current contracted staffing. Relevant notes follow.

Tucson Staffing Plan (FTEs)													
	Physician	APP	Transition APP	RN	LPN	MA	EMT/ Paramedic	Psychiatrist	Psych NP	Psycholo-gist	Psych Associate	Behavioral Hlth Tech	Psych RN
Staffing Plan	5.6	6.9	8.2	62.5	75.5	13.9	31.7	8.7	7.2	8.3	52.7	42.3	17.4
Contractual Requirement	5	18		69.3	69.1	1	8.4	3	18	10	24	15	11.5

- Staffing for the SNU and IPC beds are not included, so medical/nursing staffing is understated.
- The FMD may see up to 100 patients of medium complexity. This equates to .25 FTE. Accordingly, the total physician number may be reduced by .25 FTE if 100 patients are empaneled to the FMD.
- Physician staffing will need to be allocated across all seven units.
- Psychiatrists for residential care are separate from outpatient psychiatry. Only outpatient psychiatrists collaborate with Psychiatric NPs.

WINSLOW COMPLEX

Winslow is a low intensity complex with a census of 884 in three units. The Kaibab Unit houses 368 residents with close custody designations, for which there is an adjustment in the staffing plan. There are no residential or inpatient mental health units, and patients needing mental health watch are rare, with a monthly average of less than one. Though the population is limited to MH Levels 1 and 2, there is a monthly average of 47 patients on psychotropic medications. At Winslow, 90% of patients are empaneled to APPs and 10% are empaneled to physicians.

Key health care utilization indicators show that Winslow patients use a comparatively low volume of chronic care services, though their population of patients with any chronic condition is about equal to the average for the low intensity complexes. No adjustments to staffing are indicated.

Winslow Health Care Utilization Compared to Average Low Inensity Complexes			
	Winslow	Average	Variance
Patients on any meds per 1,000 inmates	690	663	4%
Patients on MH meds	47	NA	NA
Patients with any CC diagnosis per 1,000 inmates	546	529	3%
Average weekly HSR per 1,000 inmates	108	98	11%
Medical visits per 1,000 inmates	233	243	-4%
Provider CC visits per 1,000 inmates	108	133	-18%

The table below summarizes the staffing plan for Winslow and compares it to the current contracted staffing. Relevant notes follow.

Winslow Staffing Plan (FTEs)													
	ian	APP	Transition APP	RN	LPN	MA	EMT/ Paramedic	Psychiatrist	Psych NP	Psycholo-gist	Psych Associate	Behavioral Hlth Tech	Psych RN
Staffing Plan by Model	0.5	1	0	9.0	11	1.4	0	0	0	0.1	0.4	0.0	0.0
Staffing Plan with Adjustments	1	1	0	9	11	1.4	0	0	0	Combine	1	0	0
Contractual Requirements	1	3	0	12.6	7.2	1	0	0	0	0	1	0	0

- The staffing plan calls for .5 physician FTE. The complex has a full-time Facility Medical Director who sees patients and can provide clinical consultation to AAPs. The physician panel size is 86 patients. The staffing plan has been adjusted to 1.0 physician FTEs and the position is covered by the FMD position.
- Given the low volume of HSRs in low intensity complexes, additional APPs are not needed to cover the transition to self-scheduling.
- Per the model, all low intensity complexes need 1 FTE PA regardless of the patient census. The PA FTE was amended from .8 to 1.0.
- Supervision requirements call for .1 psychologist to supervise the PA. ADCRR should combine this FTE with that of other psychologists in the system who can absorb this supervision via remote interaction with the PA.

YUMA COMPLEX

Yuma is a high intensity complex housing 4,405 residents in five units. Yuma has a relatively large population of high complexity outpatient mental health patients. At Yuma, 81% of patients are empaneled to APPs and 19% are empaneled to physicians. There are no transitional, residential, or inpatient MH units. The average number of MH watch patients is nine. Yuma has 779 patients in close custody, or 18% of the population. This calls for staffing adjustments per the staffing model.

Key health care indicators in the table show that though the portion of Yuma patients with one or more chronic conditions mirrors the average for high intensity complexes, health care utilization is far lower on every measure.

Yuma Health Care Utilization Compared to Average High Inensity Complexes			
	Yuma	Average	Variance
Patients on any meds per 1,000 inmates	683	806	-15%
Patients on MH meds per 1,000 inmates	303	390	-22%
Patients with any CC diagnosis per 1,000 inmates	604	602	0%
Average weekly HSR per 1,000 inmates	27	117	-77%
Medical visits per 1,000 inmates	64	213	-70%
Provider CC visits per 1,000 inmates	43	102	-58%

The table below summarizes the staffing plan for Yuma and compares it to the current contracted staffing . Relevant notes follow.

Yuma Staffing Plan (FTEs)													
	Physician	APP	Transition APP	RN	LPN	MA	EMT/ Paramedic	Psychiatrist	Psych NP	Psycholo-gist	Psych Associate	Behavioral Hlth Tech	Psych RN
Staffing Plan	4.4	6.8	5.7	55.1	61.1	12.5	22.6	2.7	6.0	4.3	23.6	10.4	5.2
Contractual Requirement	2	10		18.9	14.9	1	4.2	2	4	2	12	5	2

- The FMD may see up to 100 patients of medium complexity. This equates to .25 FTE. Accordingly, the total physician number may be reduced by .25 FTE if 100 patients are empaneled to the FMD.

Respectfully submitted,

Donna Strugar-Fritsch

Marc F. Stern

Appendices

Appendix 1 Pilot Project, Sites, Staffing, and Implementation Plan

The staffing plan is built on assumptions based on the Injunction requirements and new models of care and applied to every complex within ADCRR. However, we believe it would be unwise to expect ADCRR to adopt a plan to hire all the positions in the plan right away. Rather, we believe that the patients, defendants and plaintiffs would be best served by a pilot that tests the proposed staffing and allows an opportunity to revise the final staffing based on experience with it. The pilot we suggest would be robust and time-limited, would create direct experience with staffing of all services that can be applied as modifications to the plan herein, and would become the final staffing plan.

The pilot has the following elements:

- Pilots at two complexes, with the entire model of care, all new care processes, and the proposed staffing fully in place in one entire unit within each complex.
- Staffing of the pilots is based on the percentage of the total complex population that each unit represents extrapolated from the recommended staffing of the full complex.
- Staff assigned to these two units may not be assigned to any other unit during the course of the pilot. Staff must be half-time or greater employees of NaphCare and may not be, temporary, or PRN personnel. Registry personnel may be used if they have worked at ADCRR at least half-time for at least six months; the registry parameters in the Order do not apply to the pilot.
- The FMD and FHA must commit to full participation in the pilots and will likely need some back up to cover a portion of their other duties.
- The Health Services Division (HSD) will provide structure; training; and assistance with testing of processes, brainstorming and problem solving. There must be a dedicated team for the duration of the pilot and it must include a physician, an APP, an RN, and a psych associate, in addition to others determined by the HSD.
- HSD must make use of outside expertise in patient centered care. Our team has offered to provide this assistance but the choice is ADCRR's.
- The pilots must be robust and occur over not more than six months, in accordance with the basic schedule below.
- If the Court enters an order supporting this plan, the six-month pilot begins on the day the Court issues the order.

Pilot Sites

ADCRR has recommended San Carlos Unit at the Perryville Complex and Dakota Unit at the Yuma Complex as the pilot sites and is exploring the feasibility of these units with NaphCare at this writing.

Based on the 12/31 data used in this report, San Carlos houses 1,304 women representing 41% of the complex's 3,164 residents. The unit is the complex's largest by far, and houses only minimum security residents in open dorms. However, the complex covers medium, and close custody and all levels of medical and mental health care. The FHA and medical director will be able to extrapolate the experience with the staffing model in San Carlos to the rest of the complex, which will enrich what we learn about implementation beyond the pilots.

The Dakota Unit at Yuma houses 779 men who are close custody plus an additional 65 men in its detention unit. This comprises 19% of the full complex population of 4,405. Yuma has a relatively large

population of high complexity outpatient mental health patients, though it has no residential or inpatient MH units.

Pilot Staffing

The tables below show the proposed staffing of the pilot units, based largely on the percentage of patients in those units compared to the whole complex.

	Physician	APP	Transition APP	RN	LPN	MA	EMT	OB/ GYN	Women's Health NP	Psychia-trist	Psych NP	Psycholo-gist	Psych Associate	Behavioral Hlth Tech	Psych RN
Perryville Staffing Whole Complex	3.8	5.9	6.4	42.6	47.1	11.9	22.6	0.4	1.1	3.3	7.3	5.0	30.0	15.6	7.3
San Carlos Unit Pilot Staffing	**1.5**	**2.5**	**2.5**	**1.8**	**2.0**	**4.5**	**9.0**	**0.2**	**0.5**	**1.5**	**3.0**	**2.5**	**12.5**	**6.5**	**3.0**

	Physician	APP	Transition APP	RN	LPN	MA	EMT	Psychia-trist	Psych NP	Psycholo-gist	Psych Associate	Behavioral Hlth Tech	Psych RN
Yuma Staffing Whole Complex	4.4	6.8	5.7	55.1	61.1	12.5	22.6	2.7	6.0	4.3	23.6	10.4	5.2
Dakota Pilot Staffing	**0.8**	**1.5**	**1.0**	**11.0**	**12.0**	**3.0**	**4.3**	**0.5**	**1.5**	**1.0**	**4.5**	**2.0**	**1.0**

Implementation Plan

PILOT PROJECT IMPLEMENATION PLAN																									
TASK	Prepare								Implement											Evaluate and Report					
	Month 1				Month 2				Month 3				Month 4				Month 5			Month 6					
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Train HSD team	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Present pilot complexes with staffing report and pilot	x																								
Meet with FMDs, MH leads, FHAs and DONs to introduce pilot concepts and expectations		x																							
Develop evaluation metrics		x	x																						
Design and implement complex-wide communication				x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		
Develop empanelment methodology		x	x																						
Conduct empanelment			x	x	x																				
Weekly meeting HSD and experts	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Weekly meeting HSD and sites		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Assign Primary Therapists				x	x	x																			
Hire all new positions		x	x	x	x	x	x	x																	
Train all staff on models, roles, etc.					x	x	x	x																	
Implement self scheduling								x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Implement daily huddles								x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Implement visit consolidation								x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Implement role of nurse risk managers									x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Implement primary therapists						x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Review, modify, problem solve								x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	
Modify empanelment as needed													x	x	x	x	x	x	x	x					
Design roll-out to other units and complexes																				x	x	x	x		
Refine staffing plan																							x	x	x
Identify other needs, unsolved problem, and opportunities																						x	x	x	x

Appendix 2 Patient Panel Assignments by Diagnosis

The diagnoses listed below were used as a proxy for estimating the current complexity of ADCRR's patients for the sole purpose of modeling patient empanelment by clinical complexity in this staffing analysis. While the methodology is intended to be informative, actual patient assignments to physician and APP panels should be made by ADCRR's facility medical directors (FMDs) based on individual patient complexity and need. We strongly recommend that FMDs begin patient empanelment using this methodology in order to expedite the transition and to create a uniform approach to empanelment across all complexes. FMDs should then confer with FHAs and make further adjustments to assignments that account for other patient complexities. These might include frequent ED or inpatient care for chronic conditions, co-occurring mental health conditions, age, clinical stability regardless of diagnoses, and other factors.

SINGLE DIAGNOSES THAT ALWAYS REQUIRE PHYSICIAN LEVEL OF CARE

Cancer
Congestive Heart Failure
Cirrhosis
Crohn's Disease
End Stage Kidney Disease
HIV
Lupus
Rheumatoid Arthritis
Multiple Sclerosis
Sickle Cell
Arrhythmia
Bleeding disorder
History of Myocardial Infarction
"Other Chronic Care"

COMBINATIONS OF DIAGNOSES THAT REQUIRE PHYSICIAN LEVEL OF CARE

Hypothyroidism plus:

- Lipid Disorder
- Bleeding Disorder
- Asthma

Seizure Disorder plus:

- Hepatitis
- Hypertension
- Coronary Artery Disease
- Lipid disorder
- Asthma
- Diabetes Type 2

Appendix 3 ADCRR Mental Health Levels and Caseload Calculations

The following are ADCRR's definitions of Mental Health Levels.

- MH-1: Prisoners who have no history of mental health issues or receiving mental health treatment.
- MH-2: Prisoners who have received mental health treatment in the past but do not currently have any mental health needs and have demonstrated behavioral and psychological stability for at least six months.
- MH-3: Outpatient Treatment
    - MH-3E: Patients who recently arrived at ADCRR and are generally stable but may benefit from regular contacts with mental health clinicians, or patients participating only in outpatient group psychotherapy.
    - MH-3D: Patients who were recently taken off psychotropic medications and need follow up for six months thereafter to ensure stability over time.
    - MH-3C: Patients who are stable, have adequate coping skills, and are able to manage their mental health symptoms through medication only, and who need infrequent intervention.
    - MH-3B: Patients who are generally stable but need regular interventions because they are receiving psychiatric and psychological services.
    - MH-3A: Patients in acute distress who may require substantial intervention in order to remain stable. All patients classified as seriously mentally ill ("SMI") are to be classified as MH-3A (unless admitted to a residential treatment or inpatient treatment program, and then classified as MH-4 or MH-5). Any patient under a Psychiatric Medication Review Board ("PMRB") order for involuntary administration of psychiatric medication are to be classified as MH-3A (unless admitted to a residential treatment or inpatient treatment program, and then classified as MH-4 or MH-5).
- MH-4: Residential Treatment. Patients who are admitted to a residential mental health program.
- MH-5: Inpatient Treatment. Patients who are admitted to the inpatient mental health treatment programs licensed by the Arizona Department of Health Services.

The following assumptions and calculations were used to quantify outpatient mental health caseloads for Primary Therapists .

Assumptions: 50 % of Primary Therapist 40 hours per week is available for clinical patient encounters. 20 hours per week for treatment per FTE PT at 4.3 weeks per month. Equates to 86.6 hours per month for clinical patient encounters.

OUTPATIENT LEVEL	CASELOAD CALCULATIONS	CASELOAD
C-D-E	Patients seen on average every 60 days, which is .5 times per month @ 1 hour each so .5 hours per month per patient. 86.6 hours per month allows for 173 visits.	200
B	Patients seen bi-weekly to monthly @ 1 hour per visit. Average 1 visit every 3 weeks or 1.3 visits per month per patient so 1.3 hours per patient per month. 86.6 hours per month allows for 66.6 patients in caseload	65
A	Patients need frequent visits but visits are brief. Assume average 20 minutes per visit, average 7 visits per month. Average 2.3 hours per patient per month. 86.6 hours allows for 37.4 patients per month.	40

Appendix 4 Staffing Plan Summary

This table illustrates the proposed staffing for all complexes and compares it to the contractual requirements between ADCRR and NaphCare through Amendment 12.

STAFFING PLAN TOTALS BY COMPLEX																		
	Douglas		Eyman		Lewis*		Perryville		Phoenix*		Safford		Tucson		Winslow		Yuma	
	Staffing Plan	Contract	**Staffing Plan**	Contract	**Staffing Plan**	Contract	**Staffing Plan**	Contract	**Staffing Plan**	Contract	**Staffing Plan**	Contract	**Staffing Plan**	Contract	**Staffing Plan**	Contract	**Staffing Plan**	Contract
Physician	**1**	1	**7**	3	**5.6**	3	**3.8**	2.2	**3.2**		**1.5**	1	**5.6**	5	**1**	1	**4.4**	2
APP	**2**	3	**10.9**	15.5	**15.3**	15.5	**12.3**	12	**2.9**		**2.6**	4	**15.1**	18	**1**	3	**12.5**	10
RN	**15.1**	8.8	**58.4**	27.3	**57**	30	**42.6**	30	**3**		**19.7**	0	**62.5**	69.3	**9**	0	**55.1**	18.9
LPN	**22.4**	5.1	**57.9**	42.8	**74.2**	38.9	**47.1**	31.3	**4.5**		**21.8**	14.7	**75.5**	69.1	**11**	12.6	**61.1**	14.9
Medical Assistant	**2.1**	1	**13.2**	1	**14.9**	1	**11.9**	1	**0**		**4.1**	9.3	**13.9**	1	**1.4**	7.2	**12.5**	1
EMT/Paramedic	**0**	0	**22.6**	8.4	**31.7**	12.6	**22.6**	4.2	**4.5**		**0**	0	**31.7**	8.4	**0**	1	**22.6**	4.2
Psychiatrist	**0**	0	**2.8**	2.2	**10.5**	3	**3.3**	0.2	**2.3**		**0**	0	**8.7**	3	**0**	0	**2.7**	2
Psych NP	**0**	0	**5.7**	9	**7.7**	8	**7.3**	1	**0**		**0**	0	**7.2**	18	**0**	0	**6**	4
Psychologist	**Combine**	0	**4.5**	8	**5.7**	8	**5**	2	**2.3**		**Combine**	0	**8.3**	10	**Combine**	0	**4.3**	2
Psych Associate	**1**	1	**27.2**	17	**45.3**	10	**30**	4	**14.1**		**1**	1	**52.7**	24	**1**	1	**23.6**	12
Behavioral Health Tech	**0**	0	**13**	8	**38.3**	9	**15.6**	6	**15.6**		**0**	0	**42.3**	15	**0**	0	**10.4**	5
Psych RN	**0**	0	**6**	5	**14.6**	4	**7.3**	13	**6.4**		**0**	0	**17.4**	11.5	**0**	0	**5.2**	2
OBGYN							**0.4**	4										
Women's Health NP							**1.1**	4										