

The Rapid Pulse

August 2004

The Director's Perspective

By Dr. Eugene Migliaccio

In the June issue of *The Rapid Pulse*, I talked about two new initiatives in DIHS: 1) Training for RNs to conduct physical exams and 2) the advent of the electronic medical record. In this installment, I want to talk about another initiative: the bed management program.

The bed management program was initiated to monitor the short stay units (SSUs) at our facilities, and in response to the Bureau of Immigration and Customs Enforcement's (ICE) initiative for a centralized model for bed space utilization.

Ultimately, we want to ensure that the "right" detainee is utilizing the most appropriate bed space. This is monitored daily by the Managed Care Branch in Washington, DC.

Currently, DIHS has five Short Stay Units (SSUs) and two Tuberculosis Isolation Facilities (TIFs). The bed management program has proven to be a value-add to DIHS in the area of cost-savings, because we are able to utilize our own resources when appropriate, decreasing the need to send patients off-site for care.

For example, TB screening at the SPCs results in early detection of possible active TB in our detained population. The TIF units at Port Isabel and Florence, as well as airborne infection isolation units in the SSUs, have decreased the need for off-site hospital admissions. In Fiscal Year (FY) 03, there were approximately 300 admissions to the TIF Units.

The average cost for admitting a detainee to an off-site facility is \$900/day, with the average length of stay ranging from five to 14 days. Utilizing the TIF Units has helped us to realize a cost savings of \$4,500-\$12,600 per detainee.

The average cost for a hospital admission is \$600 per patient per day. The average length of stay is four days. By utilizing the SSUs, DIHS has saved \$2,400 per detainee.

The bed management program also includes Columbia Care, a long term care facility in Columbia, South Carolina. A designated MCC oversees admission criteria, daily charges, and discharge planning. The MCC also provides ICE with alternative medical and/or mental health care in a cost effective environment for long term or high maintenance detainees. This management has enabled DIHS to maintain a lower average daily census and decreased billed charges than previously possible.

The bed management program owes a great deal of its success to employees in the field who update the web based Hospitalization Report daily. Clinical information is submitted on hospitalized detainees, TB isolation patients, and short stay unit patients.

These updates are reported daily to the Branch Chiefs. This is another unique example of how DIHS teamwork has succeeded in providing ICE with cost saving quality health-care management.

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Our Mission:

We protect America by providing health care and public health services in support of immigration law enforcement.



The Promotion Party— In Pictures



LCDRs Newman, Hochberg and Singleton



LCDR Newman, CDR Seligman, and LCDR Singleton



LCDR Newman celebrates

Your Body, Your Health

By Luzviminda K. Peredo-Berger M.D.

This is the first of what will be a monthly column on adopting and maintaining a healthy lifestyle for the rest of your life. Either I or LT Rick Newton R.N. will contribute.

The column will focus on diet, exercise, stress management and risky behaviors that affect our quality of life. Hopefully the column will help to incorporate healthy choices into our daily lives as well as the workplace.

On a daily basis, newspapers find issue with the American diet and the rising risk of obesity. I hope to provide a sound, reasonable approach to controlling overeating and at the same time discuss nutritional trends.

Why should we be interested in adopting a healthy lifestyle? There are a host of diseases related to lifestyle choices. Obesity not only effects how we look and feel but it has been linked to heart disease and we know now that diabetes is considered a risk factor for atherosclerotic disease. Type II diabetes is now associated with the bulging waistlines of Americans and their deteriorating diet choices.

Although chronic diseases have been and are treated with traditional medicines, it is possible to treat and manage them with aggressive lifestyle modifications. Cardiovascular diseases may be nearly reversible with the addition of regular aerobic exercise, reduction in dietary salt and concentrated sugars, and saturated fats. Prostate, colon and breast cancer are associated with diets high in fat.

In addition to avoiding certain foods, others may play a protective role. We should be eating a balanced diet with plenty of fresh fruits and vegetables that contains

“antioxidants” like plant sterol esters, cranberries and even “moderate amounts of chocolate that may provide a cardio-protective effect. Each future column will be much more specific and address different lifestyle choices.

Options to maintain a healthy lifestyle require discipline and self control. It won't be easy with all the fast food choices available, but let's try to be at least informed and gradually improve the quality of our lives.

DIHS Headquarters held a promotion party for those officers who were recently promoted. A great time was had by all!



Congratulations to recently promoted officers Sara Newman (O-4), Tom Hochberg (O-4), Jay Seligman (O-5) and Rebecca Singleton (O-4)



Dr. Migliaccio with Christine Williams, who was promoted to O-6.

More Scenes From The DIHS HQ Promotion Party!



Dr. Migliaccio and LCDR Singleton



Dr. Migliaccio and LCDR Hochberg



The Cake!

The Primary Care Provider Concept

By Dr. Chang S. Park

The concept of the primary care provider system may serve as a model for our medical clinics.

Under this concept, each detainee would be assigned to a medical provider that takes full responsibility for handling the detainee's medical care needs. Arranging/assigning detainee caseloads to each provider would minimize duplication (abuses) and grievances because each provider would be familiar with the medical problems of his/her detainees.

This concept is designed to improve the delivery of health care services by enhancing continuity of care and promoting preventive medical care measures. It has been shown to decrease overall health care costs by decreasing unnecessary hospitalizations and treatments resulting from insufficient or inconsistent management of chronic diseases. This concept is also designed to function in the same manner as a medical office (ambulatory) in a community setting.

There are adequate numbers of midlevel providers to provide diagnostic and treatment services to the detainee population during the typical weekday hours when the volume of health care is delivered in our facilities. Supporting staff, i.e. nurses (RNs LVNs, etc), MRTs and medical assistants would perform duties that support the mid-levels and physicians as they see patients.

Virtually all patient care would be by an appointment, scheduled several days to weeks in advance through written requests from the detainee, or follow-up appointments determined by the providers. When fully implemented, 'sick call' will be eliminated.

Emergencies and after-hours care would be handled via a locally developed system.

This is not a staffing model guideline for the Health Service Unit. However, I would like to emphasize adequate staff must be available for this concept to be implemented. The primary care provider system is comprised of a core group of health care providers and support staff who provide direct patient care. In order to make it functional, administrative and non-clinical functions would be performed under the coordination of the HSA/AHSA and their assistants.

Facilities are encouraged to assign detainees to providers in an equitable manner. Assigning detainees may be discussed locally. Also, the facility must consider: (a) current staffing patterns, (b) ability to recruit and retain the desired mix of staff, (c) adequate administrative support staff, adequate number of examination rooms, consultant rooms, equipments, etc (d) unique facility missions and populations, and (e) coordination with local ICE and Custody staff.

When implementing this system, the following general guidelines should be considered:

1. Physician's role: The physician, as the licensed provider, is responsible for the care he/she delivers. It is his/her responsibility to consult with other provider members, to provide training and mentoring, and to be directly involved with the evaluation and treatment of severely ill and medically complex detainees.

2. While midlevels (licensed PA-C/NPs) are the primary care providers under the system, physicians are also responsible for providing direct patient care. Physicians will medically manage detainees

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with complex conditions on an ongoing basis, although the detainee is assigned to a midlevel. Physicians and midlevels must be supported by various health care and support staff in order for this model to be effective.

2. Mid-level providers: The midlevel provider will serve as the primary point of contact to detainees assigned to them. They will serve as the primary provider for routine requests for evaluation of new complaints, routing recurring visits for chronic illnesses such as hypertension, asthma, diabetes, etc., and emergencies when clinically indicated.

3. RNs (Clinical Nurses): Duties will include managing patient flow, prioritizing according to the level of urgency, responding to facility emergencies with midlevel provider or physician back up, coordinating the duties of Licensed Practical Nurses, screening new arrivals, assessing detainees returning from consultant visits or hospitalizations, and providing patient education.

They should perform routine (uncomplicated) 14 days physical examinations. RNs will perform their duties utilizing the DIHS RN Clinical Practice Guidelines, and under the coordination of a physician and a midlevel.

4. Role of other supporting staff: Individualized locally (see above factors)

5. After-hours coverage: Generally, after-hours, weekend, and holiday coverage will be provided by registered nurses bases on the facility's hours of in-house medical staff coverage. A mid-level provider may, under special circumstances, be assigned to evening and weekend coverage depending on the SPC's size and complexity.

6. Emergencies and SSUs: Local procedures will be established to provide for emergencies and SSU rounds. Monday-Friday except for holidays would typically be covered by RNs and the detainee's primary midlevel provider would see the detainee if necessary. Significant medical emergencies such as trauma, heart attacks, asthma attacks, seizures, etc. would be always treated by appropriate members.

7. Regardless of whether the detainee is in general population or an SSU, routine requests for appointments or call-outs would be handled similarly to regular clinic operations. Daily rounds to arrange urgent requests for care would be accomplished by the same staff member who conducts these duties according to local procedures.



News You Can Use

◆ Congratulations to Dr. Edmund Jedry on his certification as a Correctional Health Professional! Thank you Dr. Jedry for a job well done

◆ Congratulations to the El Centro, CA and Tacoma, WA facilities on passing the ICE detention standards review! Many thanks to everyone who helped ensure successful reviews at both sites.

Our Spirit:

We add dignity to a necessary process of alien detention, serving without fanfare at the forefront of public health protection for the American populace.