UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN

EVERETT HADIX, et. al.,

Plaintiffs, No. 4:92-CV-110

v. HONORABLE RICHARD ENSLEN

PERRY M. JOHNSON, et. al.,

Defendants.
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DEFENDANTS' HEALTH CARE PLAN SUBMITTED PURSUANT TO THE COURT'S PRELIMINARY INJUNCTION OF OCTOBER 19, 2005, AS AMENDED BY THE JANUARY 12, 2006 COURT ORDER

INTRODUCTION

On October 19, 2005 the Court ordered the Defendants to submit a formal written plan to address issues identified in the preliminary injunction and to accomplish the recommendations contained in Dr. Cohen's Third Report. The issues outlined in the Court's Order (numbered as 1-7 in the Court's injunction October 19, 2005) are also contained in the report of Dr. Cohen except the requirement in number 4 of that Court order which states "provide for the assessment and medical review of all patient deaths

and provide training to medical service providers concerning serious instances of inappropriate patient treatment." The Defendants intend to enhance their mortality review process through the use of outside professional reviewers who will provide a timely and complete review of all patient deaths occurring in a *Hadix* facility. This review will then be used to provide training for Medical Service Providers (MSP) and other Michigan Department of Corrections (MDOC) staff for whom inappropriate or less than optimal actions are identified.

To identify opportunities for improvement in the medical care provided and to ensure appropriate supervision of the MSP, the Defendants, in conjunction with Corrections Medical Service (CMS), have taken or will take the following actions: A number of the proposed actions have already been implemented. In these cases an implementation schedule will not be provided.

The January 12, 2006 Order accepted the Defendant's Health Care Plan except for requiring three deletions and requiring certain additional actions. Those deletions have been stricken. The additional requirements have been incorporated into the following plan (see page 22).

1) The CMS Associate Medical Director or Assistant Medical Director rounds each prisoner in segregation twice monthly in conjunction with the case management nurse. As areas of concern are identified, the CMS Associate Medical Director reviews the case and addresses the issues with the primary care MSP. Once the designated JMF segregation MSP is in place s/he will also participate in the twice monthly rounds.

During the rounds the CMS Associate Medical Director will note any prisoner who s/he believes should be evaluated to determine if the prisoner's medical condition

warrants the prisoner being moved to an inpatient, extended care, or other inpatient level of care.

Once the twice monthly rounding process reaches a point where the Associate Medical Director is comfortable that any possible problems or concerns are being identified and resolved by the JMF designated segregation MSP, the frequency of rounds by the CMS Associate Medical Director may be reduced, with the agreement of the Court's Associate Monitor, Dr. Robert Cohen.

2) The CMS Associate Medical Director reviews the patients in the Duane Waters Hospital (DWH) twice monthly in conjunction with the unit charge nurse. Again, as areas of concern are identified, the CMS Associate Medical Director reviews the case and addresses the issues with the attending physician.

The CMS Associate Medical Director reviews the health record of at least 10 patients per week in C-Unit and again addresses all the areas of concern with the C Unit assigned physician.

3) On a monthly basis the MDOC Jackson Medical Complex Medical Officer (RMO) or the CMS Associate Medical Director audits the records and care being provided to at least 50% of the prisoners with a chronic disease who are housed in segregation. As opportunities for improvement are identified, the CMS Associate Medical Director and the RMO addresses these issues with the MSP. Beginning with the December 2005 reviews of the segregation prisoners, the Defendants did and will continue to include those prisoners who have refused or who missed a scheduled offsite specialty appointment in the charts reviewed during the segregation audit.

4) The RMO will begin conducting case reviews (or audits) of targeted medical cases based upon predetermined criteria as part of an overall CQI process. As

opportunities for improvement are identified from these reviews, the CMS Associate Medical Director and/or the RMO will review the areas needing improvement with the appropriate MSP and other staff.

The order of the topics set forth below mirrors that contained in the "Recommendation Section" of Dr. Cohen's Third Report (Dr. Cohen's recommendations are in bold print).

Establish an acute infirmary capability of at least thirty beds at DWH.

1. **This unit will require 24 hour nursing staffing and seven day a week MSP staffing.**
2. **Emergency medical coverage will be provided by DWH ER, when necessary.**
3. **When the unit is filled, patients requiring this level of care are to be sent to Foote Hospital.**

In order to assure patients receive the proper level of care, Defendants intend to immediately provide services for the most acute medical and surgical patients in community hospitals rather than DWH. There will be beds at DWH designated for sub-acute care and other transitional care, and long term and/or rehabilitative care.

Defendants plan to convert 22 beds at DWH to beds termed as "sub acute/transitional" beds. The type of patient being accommodated in these beds will include at a minimum:

(a) Patients requiring short term post acute hospital care prior to returning to a regular housing unit;

(b) All prisoners discharging from the Secure Unit hospital who will be returning to a *Hadix* facility. All these patients will be admitted to the sub- acute/transitional beds

for at least 24 hours prior to returning to their housing unit. This will provide a single point of reference for physician-to-physician referrals to assure that discharge orders are quickly implemented and prisoners are not placed in general population before they are physically able to do so.

(c) Patients needing 24 hour or short term pre and/or post operative care as appropriate;

(d) Patients from the *Hadix* ambulatory facilities who may require, on a short term basis, more aggressive medical management (but not acute care) than is available in the ambulatory setting;

(e) Patients undergoing specialized treatment whose needs may be better accommodated in an inpatient setting during parts of their treatment [i.e. patients undergoing chemotherapy who are suffering significant negative reactions (such as nausea and vomiting) to the treatment];

The sub-acute/transitional beds at DWH (approximately 22 beds) will be used only for the transitional /sub-acute admissions or step down discharges from other acute units when the patient becomes sub-acute. If these beds are not filled they will remain empty until needed (patients requiring chronic or extended care will not be admitted to the sub-acute/transitional unit). It is anticipated that these beds will be operational by January 30, 2006.

Discharges from Foote Hospital will no longer be accepted after 4:00 pm Monday through Thursday or after noon on Friday. They also will not be accepted on the weekend or holidays. These patients will remain in the community hospital. While Dr. Cohen suggested a 30 bed unit, the largest unit at DWH contains only is 22 beds. Defendants currently believe that it is more appropriate to divide the transitional/sub-

acute beds among several units at DWH as opposed to consolidating them all in one unit as this provides for better utilization of the space and staffing. Under this arrangement, Defendants believe this increase to 22 sub-acute/transitional beds will be sufficient.

The sub-acute/transitions beds will have 24 hour nursing staff (as the beds in DWH currently do) and will have seven day per week MSP coverage. There will be regular MSP coverage Monday thru Friday and a minimum of 4 hours per day on the weekends and holidays. As is currently being done, emergency medical coverage for the sub-acute/transitional beds will be provided by the DWH emergency room staff when necessary.

The Defendants will prepare a preliminary staffing analysis for DWH reflecting the planned additional sub-acute/transitional beds. The staffing analysis will cover nursing, administrative and MSP staff, and will reflect the increased number of patients, and their acuity. Defendants will provide a staffing chart to Dr. Cohen which indicates the nursing and administrative staffing which will be present on each of the inpatient units at DWH. Each of these documents was provided to Dr. Cohen on December 16, 2005. Defendants will prepare a follow-up report to be submitted to Dr. Cohen three months after the sub-acute/transitional beds become operational. At this time, data on the admission and discharge rates, bed utilization, length of stay, patient acuity, and other information required to update the analysis and staffing plan developed on December 16, 2005 will be available. Should there be an unexpected need for more staff than planned for in the December 16, 2005 analysis, staff can be supplemented through the use of contractual staff.

When the sub-acute/transitional beds are filled, patients needing the level of care provided in these beds will be sent to a community hospital, or other patients will be admitted to acute care facilities in the community or transferred to an appropriate level of care to accommodate those needing the sub-acute/ transitional beds.

Defendants also will convert beds currently housing general population "campers" in C-Unit to medical special needs beds and provide appropriate staffing to accommodate the increase in patient load for nursing, physician, and other necessary support services.

Establish a Unitary Medical Records System

1. **Assure that all laboratory studies are available in Serapis**
2. **Assure that all medications are available in Serapis**
3. **Link the Serapis system to the pharmacy computer system for order entry**
4. **Enhance the drug interaction function of SERAPIS/Tiny Terms to include HIV medications.**
5. **Train and certify all nurses and MSPs in the system(s) before they begin working at the Hadix Facilities**
6. **Expand the SERAPIS system to include all clinical areas, specifically the Dialysis Unit, the JMF Segregation Unit, the DWH Emergency Room, DWH and C-Unit, and the Specialty Clinic Areas of DWH.**
7. **When Telemedicine is used on a routine basis (e.g. Dr. Hutchinson, Dr. Middlebrook) SERAPIS terminals should be available**

Defendants will ensure that all laboratory studies and medications ordered in all ambulatory clinics in the *Hadix* facilities are entered in Serapis. Upon completion of the

training of all providers, this will be accomplished. In addition, by January 31, 2006 Defendants will develop a means so that medications ordered in the emergency room, and those ordered by the select specialists providing clinics at the DWH are also entered into Serapis. This will provide the complete listing in Serapis of all medications prescribed for each patient.

A Request for Proposal (RFP) for a new pharmacy system has been submitted to the Michigan Department of Management and Budget. It is anticipated that the bidding process will allow identification of an appropriate provider by March 1, 2006, with implementation to follow in an orderly way in as short a time period as is feasible but no later than 90 days after award of the contract. The RFP requires that the vendor manage the MDOC pharmacy and delivery system; provide supplemental staffing to the existing Civil Service staffing to maintain staffing at optimum levels; upgrade the equipment and practices at the onsite pharmacy in DWH; and, oversee pharmacy assistants that the Defendants will place at each of the ambulatory care units to receive medications and deliver keep-on-person medications. An additional requirement of the RFP provides that a link be established to the Serapis prisoner electronic record to assure direct physician ordering through linkage to a new pharmacy computer system to be provided by the vendor. The new pharmacy computer system required under the RFP will have enhanced capabilities for identification of drug interactions.

Defendants have redefined the MSP training and orientation schedule to accommodate additional hands-on training for MSPs. This training will be provided by an experienced trainer with a clinical background during the MSP orientation to the MDOC. No MSP will be considered to be part of the regular schedule until s/he has received training on the electronic health record, can conduct entire visits using the

electronic health record, and have a full understanding of the chronic care clinic and other essential MDOC basic requirements. This portion of the plan became effective October 1, 2005. Nurses performing functions which require the use of Serapis will be provided formal and on the job training and will be proficient in the use of Serapis prior to working independently.

Defendants plan to expand Serapis to the emergency room and the Dialysis Unit by the end of January, 2006. A Serapis terminal is now functional in the dialysis unit and the unit staff will be required to enter all the medication orders and laboratory requests into Serapis. All dialysis unit staff have been trained and directed to use the electronic record when ordering all medication orders and laboratory tests. There are functional Serapis terminals in the JMF segregation unit.

In addition, there is a terminal in the DWH emergency room, and staff is beginning to utilize the information from the ambulatory electronic record to assist staff as they manage the urgent care needs of these same prisoners. The medication and laboratory orders for oncology, hematology, and infectious disease specialists operating in the DWH onsite clinics will be ordered through Serapis. This will be implemented after training is completed, but no later than January 31, 2006.

With regard to recommendations to use Serapis in C-Unit and DWH, it should be noted that Serapis is an ambulatory health record with little functionality for acute inpatient care. There may be future potential use in the areas of lab ordering and medication ordering and delivery. All resources, however, are currently being utilized to move all ambulatory facilities to the electronic record. Effective April 1, 2006, the results of all laboratory studies ordered at the Hadix ambulatory facilities will be maintained in

Serapis and will be available for review to the nursing and medical staff at Serapis terminals in C-Unit and DWH.

Defendants will assure that the ambulatory record can be viewed electronically at intake to C-Unit and DWH in the form of a patient overview. The overview will include diagnosis information, vital signs, existing medications, allergies, key lab results, and pending lab work or procedures. The full record will be viewable to assure access to the full MDOC ambulatory health history. Discharge planning will be provided through the electronic medical record by providing a discharge record entry as prisoners leave DWH and C-Unit. This will assure flow of necessary information and improve continuity of care at the receiving facility.

It is not feasible to require that all community based specialists who provide specialty clinics at DWH be required to document or order in Serapis. However, Defendants will require that the dictated or written note summarizing the findings of the specialist (the properly completed 409 Form) is made available to the provider in the ambulatory areas within one working day of the specialty clinic visit. The specialist will be directed to call or email the ambulatory care provider regarding all urgent recommendations.

Dr. Hutchinson currently has access to Serapis and utilizes it for documentation of his telemedicine visits. Defendants have provided a system for Dr. Middlebrook to access Serapis and for his telemedicine visits since January 1, 2006.

Ensure automatic renewals of all chronic medications

1. Monitor distribution of chronic medication

2 Prepare a regular study/report on medication renewals

3. Require all medications from all clinical sectors (DWH, C-Unit, Segregation, Dialysis) to be entered in SERAPIS

Defendants presently have a system in place to monitor the distribution of chronic medication and ensure renewals. Defendants will assure use of the system through oversight and audit. Nurses will routinely review medication orders and receipt of medication records to ensure that the medications are ordered and renewed as needed. Nurses will also review records to ensure the patient receives the ordered chronic medications as required.

Defendants have initiated a study of all cases of prisoners claiming to be out of medications at JMF and SMT. The study on medication renewals, including chronic medications on the automatic renewal system, was commenced at JMF in February, 2005 and will continue as long as is needed. A nurse reviews each kite on which the prisoner claims to be out of medication, or when the prisoner claims that he did not receive his medications. If, upon review, it appears that the prisoner did not receive a medication as needed, it will be provided within 24 hours. This system has been in place at JMF for a few months and is now implemented at SMT. Quarterly reports on the actual number of prisoners who did not receive medication have been generated from the study at JMF. Reports will be generated on a quarterly basis for both SMT and JMF and attempts to identify and correct any systemic reasons for the missed medication will be put in place under MDOC's CQI component. By April 15, 2006, a study similar to that currently being done at JMF and SMT will be initiated at RGC.

Defendants will continue with this study and continue to develop and analyze the findings of these studies and take necessary corrective actions should problems area develop Defendants agree to require that all medications from the ambulatory clinics,

the dialysis unit, and the ER be ordered in Serapis. However, as indicated above, it is not possible to require this from C Unit and DWH except at the time of discharge to an ambulatory clinic. The major advantage of having all medications ordered in Serapis is that there is then a complete listing of all the medications prescribed for a particular patient in one location in the Serapis system. The provider does not need to check both paper medical records and Serapis to see the complete listing of medication prescribed for each prisoner. With the additional provisions that medications be entered into Serapis from the ER, dialysis unit, specialty clinics areas, and upon discharge form DWH and C Unit, this complete listing will be available and maintained.

Define the Role for the Jackson Complex Regional Medical Director

1. **member of Jackson Medical Complex Senior Leadership Team**
2. **oversight of CMS specialty consultation program**
3. **oversight of CMS contract employees**
4. **medical leadership for QI function, including audits and studies**
5. **oversight of Dialysis Program**
6. **oversight of C-Unit/DWH clinical complex**
7. **clinical liaison to pharmacy**
8. **establish and maintain a continuing education program at the Jackson Complex**

Defendants have defined the role of the JMC Regional Medical Officer as above and believe that the role encompasses all the areas outlined by Dr. Cohen. However, the direct supervision of the CMS staff is the role of the CMS Associate Medical Director. This includes direct oversight of the CMS clinical staff working in C-Unit and DWH. Defendants have agreed with Dr. Cohen's suggestion that there should be an

assistant to the CMS Associate Medical Director. The Defendants have instructed CMS to begin to recruit for that position. This will further enhance the direct supervision of the MSP. The JMC Medical Officer and the CMS Associate Medical Director work closely together to provide a comprehensive CQI oversight and educational program for staff in the *Hadix* facilities.

Obtain Autopsy Reports of all deaths

By statute, the need for an autopsy in Michigan is the sole determination of the County Medical Examiner, the prisoner's family, and in some cases may be requested by two or more registered voters in the county. It is not always possible to obtain an autopsy as this is not in the control of the Defendants. The Defendants will request an autopsy for all unexpected deaths. The Defendants are also pursuing other options to be able to obtain an autopsy in all cases.

Assure that Specialty Care services are available to all prisoners, including those in Segregation.

Specialty Care is available to all prisoners including those in segregation and/or quarantine. Defendants have initiated a program in segregation at JMF which provides that if custody staff reports that a prisoner has refused his specialty or offsite appointment, a nurse visits the patient to ensure that he actually did refuse. If the prisoner did refuse the appointment and continues to refuse his appointment, that prisoner will be required to sign a release (AMA) form. Defendants also intend to further modify this procedure so that a case manager nurse will inform prisoners that they have an upcoming specialty appointment, and also convey to the prisoner the importance of attending the appointment. If the prisoner indicates that he does not want the specialty service, the prisoner will be counseled by the case manger nurse on the importance of

the appointment. If the prisoner still intends to refuse his appointment, a release will be provided and the MSP will be informed by the case manager nurse that the prisoner plans to or did refuse the specialty appointment. A similar system will be put in place for the quarantine/segregation unit at RGC.

1. **Obtain data from CMS as needed to assist in analysis of Specialty Care**

Data is already available and Defendants will ensure that it is made available to the Chief Medical Officer to assist her/him in analyzing specialty services.

2. **Maintain the current MDOC Specialty Care Computer System**

Defendants plan to maintain the current specialty care computer system and are now using it to track appointments at DWH and C-Unit as well.

3. **Provide MSPs with weekly lists of the status of their outstanding consults.**

The MSP in the ambulatory areas are provided the report on the status of their outstanding appointment every two weeks, and the CMS Associate Medical Director also reviews this list with the MSP every two weeks. As of October 1, 2005 the list has been provided to the *Hadix* facility ambulatory care MSP weekly, and the Defendants will continue the biweekly meetings between the CMS Associate Medical Director and the ambulatory area MSP.

4. **Provide handwritten consultation forms to providers within twenty four hours of consultation, if dictation is not available.**

Defendants agree to do this.

5. **Require telephone contact by specialists to MSPs when urgent medical information needs to be communicated.**

Defendants will have CMS request this of all the specialists. Defendants shall ensure that there is a prompt review of all specialist reports (both hand-written and dictated) so that any urgency noted by the specialist can be acted upon immediately by the facility providers.

6. **CMS should not "pend" consultation while awaiting dictated consults when the consultant has written or called the MSP with specific recommendations.**

CMS will re-emphasize to the specialists the need to provide a comprehensive initial consultation report (a 409 report).

Develop an enhanced program of monitoring the clinical function of the Dialysis Program

1. **Monthly meetings, hopefully becoming quarterly, should be held with Dr. Middlebrook, the Dialysis Administrator, JMF Leadership, designated MSP(s), the Jackson Complex Regional Medical Director, and CMS Deputy Medical Director.**
2. **The monthly evaluation form currently in use needs to be revised and enhanced.**
3. **Include structured interviews with Dialysis patients as part of the monthly dialysis monitoring form, and include Dialysis patients, where appropriate, at the monthly meetings.**

Currently Defendants hold monthly meetings between the Health Unit Manger at JMF and the Dialysis Unit on-site supervisor regarding issues of the dialysis unit, including discussion of operational issues and the flow of information. These meetings will continue. Beginning in January, 2006 an additional clinical meeting has been and

will continue to be held at least every other month to monitor the clinical care delivered in the Dialysis unit. These meetings will include the CMS Associate Medical Director, the JMC Medical Officer, Dr. Middlebrook, and the dialysis patient's primary provider.

Modifications to the monthly evaluation form (audit tool) currently used to audit the dialysis patient care will be considered by the CMS Medical Director and the MDOC Medical Director, with input from Dr. Middlebrook. Structured interviews with patients will be performed periodically as part of the ongoing Performance Improvement/Quality Assurance process.

The Health Unit Manger at JMF currently holds monthly meetings with representatives of the dialysis patients (similar to the Health Care Forum meeting held at JMF). During this meeting, issues of concern related specifically to the dialysis patients are discussed and solutions sought.

Assure Access to Care for All Patients in Segregation

1. Maintain continuity of MSP care with assigned patients.

DEFENDANTS' PLAN: Additional MSP staff will be added to JMF so that there will be a designated provider in segregation 5 days per week. The designated provider will be responsible for the JMF segregation population and will work in conjunction with the nurse case manager as defined in Defendants' February, 2005 plan. The designated provider responsible for the patients in segregation may be periodically rotated in order to retain qualified MSPs, but a specific provider will be designated to care for the segregation population as opposed to the current system of assigning each JMF provider one day per week to segregation.

2. Maintain SERAPIS terminal in Segregation clinic

DEFENDANTS' PLAN: There has been a Serapis terminal in segregation connected to a lap top computer available for use. The lack of its use by the MSP was a performance issue which has been addressed. In addition to the laptop, a desktop computer with Serapis has also been placed on the segregation unit. Both will remain there and be maintained.

3. With rare exceptions, all clinical encounters with patients in Segregation should occur confidentially, without correction staff present, while maintaining correctional staff visual observation.

Beginning December 1, 2005 custody staff has not routinely provided in-room supervision during medical encounters conducted in segregation. They will provide visual observation. The doors to the examination area will remain unlocked and open but not to the extent that conversations between the patient and the provider can easily be overheard. There will continue to be exceptions wherein it is determined that custody staff must be present during the health care encounter for the protection of the medical staff and the patient. If the MSP or other medical staff feel unsafe or uncomfortable performing an exam on any prisoner without custody staff present they may request that custody staff remain in the room and custody staff will do so. The final decision is one of safety and security and must continue to rest with custody staff.

4. Clinical encounters in Segregation should only take place in the designated clinic area, not in "cell-side."

Defendants agree that clinical encounters should always be conducted in the designated health care areas and not cell side. However, if custody determines, based upon security needs, that a prisoner can not be brought out of the cell, (i.e., immediately after an altercation or during other times when the prisoner is disruptive) a preliminary

examination by nursing staff may need to be conducted cell-side to provide timely access to care. As soon as custody determines it is safe to do so, the prisoner will be taken to the health care area in segregation for a standard examination. Defendants agree that assessments should not be done cell side as a rule.

5. Assure that patients in Segregation have access to specialty care by having nurses verify refusals at the time of the refusal.

A process has been initiated at JMF wherein the case manager nurse informs the patient of his upcoming specialty appointment and informs him of the importance of the appointment to his care. An additional new process has been put in place in segregation in JMF. If a prisoner in segregation refuses to go to an offsite appointment the housing unit officer will call health care staff and inform them the prisoner is refusing the medical offsite appointment. The housing unit officer will also note on the detail and note in the log book that the prisoner is refusing the offsite appointment. The log entry will include the prisoner's name, number and lock.

Health care staff will discuss each refusal with the patient to ensure that he actually did refuse, and that he understands the need for the appointment. This will ensure that in the majority of cases of alleged prisoner refusals the nurse will have access to verify the refusal and counsel the patient at the time of the reported refusal. Health care staff will also note in the log book that they have concurred that the patient refused the appointment. The appointment will be rescheduled and if the patient continues to refuse, a medical release indicating that he is refusing the care will be obtained. A similar process was initiated at RGC in December 2005.

6. Identify the reasons for the current problem in obtaining DWH and C-Unit beds for patients with chronic medical problems who should not be housed in Segregation

Any prisoner whose medical needs cannot be met in segregation can be placed in a community hospital as medical needs or bed space dictates. With Defendants' plan for additional C-Unit and dedicated DWH beds there will be more beds available.

7. Identify other alternatives to permanent Segregation for HIV positive prisoners who are accused of sexual activity.

Defendant's policy is based on State statute (MCL 791.267) which requires that prisoners who are HIV positive and knowingly engage in activity that could transmit the disease be housed separately from the general population to prevent such activity. Defendants are reviewing their past approach and considering the establishment of more select criteria for placement in segregation and a system for possible movement out of segregation at an appropriate time that may be consistent with the intent of the statute.

8. Expand the current bi-monthly review of chronic care patients to include all patients in Segregation, and include interviews whenever problems are identified in chart review.

The CMS Associate Medical Director has initiated a bi-monthly (every other week) door-to-door round of prisoners in segregation with the case manager nurse. Monthly, the CMS Associate Medical Director and the JMC Medical Officer audit half of the patients enrolled in Chronic Care Clinics. Therefore, all are audited every two months. Whenever problems are identified in this audit/case review, an interview with the patient will be conducted.

9. Establish a functioning program of daily MSP rounds for all prisoners in Segregation.

Defendants believe that the system described in the last section coupled with the existing daily nursing rounds and increased MSP presence in segregation (5 days per week) will provide for enhanced awareness of medical issues in segregation and is sufficient to meet the medical needs of this population. The case manager nurse assigned to segregation is present in the unit on a daily basis and a working relationship between the case management nurse and the designated segregation MSP will provide a mechanism for the MSP to timely be made aware of all medical issues and needs of patients in segregation.

10. Establish a monthly meeting with mental health staff to review medical problems of severely mentally ill patients housed in Segregation.

There currently are monthly meetings held between health care staff and mental health staff which address issues of mentally ill prisoners, including those in segregation.

11. Review care at RGC Segregation/Quarantine Unit and develop a plan to assure patients receive necessary medical care, including specialty consultations.

Nursing staff have initiated daily rounds of prisoners in the RGC Quarantine/Segregation. A case manager nurse will be assigned to this unit as is the case in JMF. That nurse will review all cases in which the prisoner has indicated or custody staff have indicted that a prisoner refused to go to a specialty appointment as outlined above. If it is indicated that the prisoner refused, the nurse will see him and determine if he actually refused and why he refused. The case manager nurse will also

ensure that the MSP is aware that the prisoner did not go to the specialty appointment. This provision was put into practice at RGC in December 2005.

Enhance staffing to meet the expanded clinical responsibilities of the Hadix facilities

1.. **Increase staff at DWH**

2. **Increase staff at C-Unit**

3. **Hire staff for Acute Care/Infirmary Unit**

4. **Increase staff at JMF to cover new clinical responsibilities from the Dialysis program**

5. **Increase staff at JMF to adequately serve medical needs of prisoners in Segregation**

Defendants agree to expand the staff and have allocated two MSPs Monday through Friday at DWH. One new MSP has started and currently there are two full time MSPs covering the patients at DWH. The use of the two MSPs will be supplemented by onsite weekend coverage and holiday coverage to assure daily access to medical services. The compliment of staffing at C-Unit and DWH is increased to four full time equivalent positions. This provides for two full time FTEs for DWH, 0.75 FTE for C-Unit and .025 FTE for weekend and holiday coverage, and provides for relief for these positions. This is exclusive of the coverage provided in the ER. The staff at C-Unit has been increased to 0.75 FTE and additional staff will be added when the number of medical patients is expanded. According to the Defendant's staffing plan for the Transitional/sub-acute beds, Defendants have determined that an additional MSP is needed and will be brought on staff.

Defendants agree to increase staffing at JMF to 5 MSPs (four physicians and one mid-level). The additional FTE of MSP time at JMF will enhance both the coverage for the dialysis patients and those in segregation. The Defendants also anticipated changes in terms of the physician coverage and distribution of the dialysis patients.

AMENDMENTS TO THE PLAN AS REQUIRED BY THE COURT ORDER OF JANUARY 12, 2006.

2.a. Defendants must include within its Serapis computerized medical record system (or equivalent system) laboratory and Pharmacy records for prisoners at Dwayne Waters Hospital and C Unit.

The Defendants will comply with this requirement and will incorporate these elements into the Serapis applications at Duane Waters Hospital and C Unit.

2b. Complex sequential diagnostic evaluations shall be scheduled simultaneously, when appropriate, to minimize delay in the treatment of serious medical problems.

The Defendants will request that CMS instruct the utilization review staff to authorize and schedule these diagnostic appointments simultaneously, when ever appropriate and possible. The Defendants will also instruct the MDOC staff who schedule appointments to schedule these diagnostic appointments simultaneously, as soon as the authorizations are received.

2b. Defendants will submit four kinds of monthly reports (specialty care workload report, specialty care patient report, pending

consultations, and non occurring scheduled clinical appointments, listed by patient identifier).

The Defendants will submit each of the four monthly reports to the Court, medical monitor, and Plaintiffs' counsel, beginning with the first report submitted on February 10, 2006. The reports will contain the following information for all specialty care appointments and specialty diagnostic procedures (CT scans, MRIs, EMGs, Stress Tests, Echocardiograms, etc), including those specialty clinics a held at Duane Waters Hospital and those appointments scheduled off-site :

2b.1 Specialty Care Work Load Report

a. List of all specialty clinics
b. The number of patients seen in each clinic during the month
c. The number of patients scheduled to be seen who not seen (cancellations) were
d. The number of patients with pending consultations (those patients with authorized appointments who are waiting to be seen in that specialty clinic)
e. The number of pending consultations which are past their requested completion date (the number of patients who have not been seen by the specialist within the time frame specified by the practitioner requesting the specialty consultation)
f. Whether the clinics were held at DWH or off-site.

2.b.2 Specialty Care Patients Seen

This monthly report will provide a listing all the patients housed in a *Hadix* facility who has received specialty care during the month. The report will be organized by clinic or appointment type when ever possible. The following information will be reported for each patient appointment:

a. Name
b. MDOC number
c. Initial or follow up consultation (appointment)

d. Diagnosis or reason for the consultation (appointment)
e. MDOC facility housing the patient
f. Date the consultation (appointment) was requested
g. Number of days requested by the practitioner
h. Date consult (appointment) occurred
i. Number of days elapsed if greater than the days requested. (This information will be provided in **bold print.)**

2.b. 3 Pending Consultation Report

This report will include all prisoners in a *Hadix* facility who has pending consults (is awaiting a specialty/off-site appointment), organized by specialty clinic or appointment type and will include the following information:

a. Name
b. MDOC number
c. Initial or follow up consultation (appointment)
d. Diagnosis or reason for the consultation (appointment)
e. MDOC facility housing the patient
f. Date the consultation (appointment) was requested
g. Number of days requested by the practitioner
h. Date consult (appointment) occurred
i. Number of days elapsed if greater than the days requested. (This information will be provided in **bold print.)**

2.b. 4. Non-Occurring Appointments/Patient Data

This report will list all scheduled clinic or off-site appointments which did not occur for each prisoner housed in a *Hadix* facility and include the following information:

a. Name
b. MDOC number

c. MDOC facility housing the patient
d. Location of the clinic/ appointment – DWH or off-site
e. Reason for failure of scheduled appointment to occur
i. Prisoner refusal
ii. Physician/Medical Facility cancellation
iii. Physician failure to attend
iv. MDOC transportation not available
v. MDOC cancellation of appointment (patient ate, equipment failure etc.)

2.c 2.d Defendants shall employ a nephrologists or a board certified internist to provide additional hours of service at the Dialysis unit. The hours of service of such provider or providers (together with such hours as are actually performed by Dr. Middlebrook) shall not be less than the regular work week of a full-time medical service provider for the facility. Dr. Middlebrook, or another nephrologist, will be responsible for the clinical care at the Dialysis Unit, and will supervise any additional non-nephrologists physician staff. Those hours of service shall be performed primarily at the JMF dialysis unit.

The Defendant agrees to do this and have requested that its agent, CMS, instruct Dr. Middlebrook to begin the recruitment process for a nephrologist or board certified internist for the dialysis Unit at JMF.

2 e. Defendants shall insure that all prisoners who are admitted to segregation in RGC and JMF will have their medical records reviewed by the assigned physician within one week of their placement in segregation. The physician assigned to the segregation unit at JMF will make joint rounds with the CMS Associate Medical Director on a monthly basis. The physician assigned to

care for patients in the segregation/quarantine unit at RGC will make rounds once a month with the Case Manager assigned to that unit.

The Defendants agree to implement this process. Once a designated physician has been assigned to the segregation unit at JMF h/she will make rounds once per month with the CMS Associate Medical Director. A physician will be designated to make rounds once per month in the special management housing unit (segregation/ quarantine) at RGC with the Case Manager Nurse.

Respectfully submitted,

Michael A. Cox
Attorney General

s/A. Peter Govorchin (P31161)
Attorney for Defendants

Date: January 23, 2006

Givorchin/Hadix/1992006833A/Pleadings-APG/Medical/Health Care Plan.012306