UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

RODNEY FUSSELL, et al.,	:	**Case No. C-1-03-704**
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Plaintiffs,	:	
	:	
v.	:	
	:	
REGINALD WILKINSON, et al.,	:	
	:	
Defendants.	:	
	:	

REPORT: ODRC – MEDICAL SERVICES
FINAL REPORT OF FINDINGS
Prepared by: Medical Investigation Team (MIT)
Fred Cohen, Investigator

1/26/05

I. INTRODUCTION

This document represents the final; albeit somewhat attenuated, report of the Medical Investigation Team (MIT). That is, the initial agreement to study medical care in the Ohio Department of Rehabilitation and Correction (ODRC) called for the Investigator, Fred Cohen, and the team he would assemble, to visit a sample of correctional facilities to gather relevant facts and report by December 15, 2004. In the view of the MIT, a clear pattern of problems emerged early in our work and was confirmed as we continued. Thus, while some detail might be lacking, it was agreed that the MIT might discontinue the additional planned site visits and move to the Final Report-Discussion stage.

Class counsel and the Attorney General's office agreed to reduce the number of facilities visited from twelve to eight and to have the Final Report based on those visits and the other fact-finding activities of the MIT. In the interest of an expeditious resolution of this litigation, the parties also agreed that this document might consist of a rather summary narrative fully supported by the MIT member's individual site visit reports.

The individual reports, then, are attached as an extended Appendix A and will serve as the fact-based foundation for the narrative.

The one major exception relates to the work of the court endorsed, Independent Fact Finder, Fred Cohen, who also is the principle author of this Report. Mr. Cohen used the bulk of his time during site visits to conduct group interviews with inmates who had varying degrees of contact with the DRC medical system.

Ms. Annette Chambers, serving then as the "point person" for Assistant Director Tom Stickrath, importantly assisted Mr. Cohen's selection of inmates for these sessions. Over the course of the site visits Mr. Cohen met with approximately 200 inmate-patients.

His impressions from those meeting will be presented in Section VI separately from the rest of the Report, which is primarily a distillation of the MIT members' individual reports and their subsequent input after reading a first draft of this document.

II. METHODOLOGY & TECHNIQUES

The MIT membership is: (1) Fred Cohen, Esq., LL.B., LL.M; (2) Ronald Shansky, M.D.; (3) Madie LaMarre, MN, A.P.R.N., B.C.; (4) Barbara Peterson, R.N.; and (5) Mike Puisis, D.O., who joined the team on October 18, 2004. The resumes of the MIT are attached as Appendix E.

The MIT met initially on April 29, 2004 in Tucson, Arizona to discuss organizational and operation concerns. Among the matters discussed and agreed upon were the following items:

- Boundaries: The parameters of our mission were to be investigatory and fact-finding. We were not asked to "consult" or to provide recommended solutions should problems be uncovered. Parenthetically, these parameters subsequently were relaxed and at the December 1, 2004 interim feedback meeting, this writer was allowed by mutual consent to use normative language and refer to standards in a non-binding, benchmark fashion. This Report will also follow that more relaxed approach, but will not offer any concrete recommendations for change.
- Site Visits - General: We agreed that a properly selected sample of prisons would provide the necessary data we need for our Report. We selected prisons by security level, mission (for example, reception), and geographic spread.
- Site Visits - Specific: The following shows the proposed facilities and dates for visits.

Central Office & ORW	June 28, 29, 30
CRC & Frazier	July 26, 27, 28, 29
Lebanon & Warren	August 23, 24, 25, 26
Lorain & Mansfield	September 20, 21, 22, 23
SOCF & Hocking	October 18, 19, 20, 21
CMC & Dayton	Nov/Dec 29, 30, 1, 2
Chillicothe & Central Office	December 13, 14, 15, 16

- Site Visit - Process: Dr. Shansky was asked to serve as "Field Marshal" and to thus make the site visit field assignments for each MIT member. That has been done subject to change as dictated by unpredictable factors occurring in the field. Site visits were to begin with a brief courtesy call on the Warden and any staff members he might select.

Representatives of Central Office were to be invited to attend site visits, but to not play any active role nor participate in inmate-staff interviews. No exit interviews were to be conducted because investigative exits are terribly time consuming and participants invariably ask, "What should we do?" We agreed that should we uncover a life-threatening situation or one with potentially serious medical consequences we would report this to a responsible official for corrective action. Counsel for both sides was to be informed. After every visit each team member was to prepare a report for Fred Cohen who was to review and retain such reports, and which would serve as the basis for the final report, as noted earlier.

- Standards for Review: This, of course, is a very important and very delicate issue. We elected not to use such criteria or terminology as "deliberate indifference," "reckless," or "malpractice." We also elected not to authoritatively rely on standards such as ACA or Joint Commission, except as a guide, and not as some determining factor. We chose also not to use the term "community standards." Such terminology as "clearly adequate (or inadequate) for the task at hand" might be used and we could point out any deficits and the consequences of such deficit (i.e., staff, education, training, medication, delay in care, etc., etc.) Where referral policy calls for something to be done in a certain way or in a certain timeframe, then we elected to note compliance or non-compliance by this standard.

I believe it is fair to say that the MIT abided by all of these initial decisions. There were several instances where the MIT believed that a particular inmate was "at risk" and we notified appropriate staff and counsel about the need for corrective action.

The following table lists the meetings held and actual site visits conducted, along with the relevant dates:

Table I
Medical Investigation Team (MIT)
Meetings and Site Visits
As of December 9, 2004

Meeting Place/Facility Visited	Date
Initial Organization Meeting (Tucson, AZ)	April 29, 2004
Central Office	June 28, 2004
ORW	June 29-30, 2004
CRC	July 26-27, 2004
Frazier	July 28-29, 2004
Lebanon	September 20-21, 2004
Warren	September 22-23, 2004
SOCF	October 18-19, 2004
Hocking	October 20-21, 2004
CMC	November 29-30, 2004
Central Office Meeting	December 1, 2004

Our site visits were facilitated by the excellent cooperation of DRC staff, especially Ms. Annette Chambers, and representatives of class counsel and PRAC. This is not the mandatory, formal thank you; this is a genuine expression of gratitude for providing helpful pre-site information, for making useful physical arrangements while we were on site, and for being open and candid with us. While our present work was facilitated in this fashion, the overall cooperative attitude will facilitate the attainment of any agreed upon change. In other

jurisdictions of which we are aware, counsel clash over minutiae and officials attempt to hide or obfuscate. Our work was done within a climate receptive to change and with contending parties willing to work toward agreed upon improvements.

III. OVERVIEW & BACKGROUND

As this Report unfolds there are a number of criticisms leveled at the medical and dental care being provided. Those criticisms must be placed within the framework of providing such care in an inherently coercive environment, for a group of people with little political or social support for their health problems, problems that far exceed those in the open society. Indeed, it would be difficult to overstate the generally poor health and high-risk practices of most prisoners.

One expert put it this way:

> Prison populations are characterized by astonishingly poor health or other limiting disabilities. A recent report prepared by the U.S. Department of Justice showed that 31 percent of state and 23 percent of federal prison inmates report having a learning or speech disability, a hearing or visual problem, or a mental or physical condition. Compared to non-prisoners, prisoners suffer disproportionately from many conditions, including tuberculosis, HIV and AIDS-related disorders, sexually transmitted diseases, hepatitis C, severe mental disorders, and substance abuse. Prevalence rates may be several to many more times higher than the prevalence rates for the same conditions among non-prison populations. The poor health status of prisoners reflects many factors, including lifestyle choices, impoverished backgrounds, and prior lack of access to health care.

> Prisoners' poor health status is confounded by their limited access to health care while incarcerated. Before the 1970s, the notion that people imprisoned or detained for crimes should be provided with basic health care was deemed absurd. And until the U.S. Supreme Court and other federal courts stepped in with opinions such as those in **Estelle**, relatively few official attempts were made to improve the lot of prisoners. The correctional health care landscape has since changed significantly, due in no small part to a substantial volume of prisoner litigation over access to health care, as well as to the work of professional health organizations that have aided in the establishment of minimal requirements for correctional health services. Despite these efforts, some prisoners have no or extremely limited access to health care. (Citations omitted)[1]

Despite the clear constitutional mandate to avoid deliberate indifference to inmates' serious medical and dental conditions, it is difficult to recruit and retain physicians and nurses, medical care is expensive and often underfunded and prison medical care (like mental health care) must negotiate the boundaries of security to deliver needed health care. For example, the higher the security status of the prison, the fewer patients that can be seen due to such factors as searches, shackling, and escorts.

Thus, DRC had a daunting task in the delivery of health care services and that problems were uncovered should not be surprising or seen as evidence of *mala fides*. DRC literature indicates at least some agreement with our emphasis on the special problems of correctional health care:

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[1] T. Howard Stone, Ethical Dilemmas in Correctional Health Care Settings in Management and Administration of Correctional Health Care, I-1, 1-8-9 (Civic Research Institute, Inc. 2003).

> Meeting the health care needs of the inmate population remains a constant challenge. The population is aging, and prior to incarceration, most did not receive regular medical and dental care and/or had life-styles that were not compatible with good health. The Bureau of Medical Services must therefore treat a multitude of chronic and potentially life-threatening illnesses. Continuing advances in accepted medical treatment further increase the challenges of meeting these needs.[2]

IV. THE SPENCER REPORT & HEALTH CARE REVIEW TEAM REPORT (HEREAFTER, STICKRATH REPORT)

The MIT reached early agreement that the above referenced Reports were to serve as platforms for our work. While we did not necessarily agree, for example, with Dr. Spencer's call for adding one nurse to each prison for the Quality Assurance(QA)/Quality Improvement(QI) function, we did agree that QA or Continuous Quality Improvement (CQI) are very important functions and were deficient.

Our approach importantly differed from the Spencer and Stickrath Reports in our emphasis on clinical practice. The Spencer Report essentially deals with organization and process. There is nothing on inmate satisfaction, the quality of medical care, and it has little to say about staff except that there are important shortfalls.

In the brief time allotted to his work and working alone Dr. Spencer did a commendable job and provided the MIT with a valuable basis for going forward.

The Stickrath Report is an internal document and lacked physician participation although there were a number of medically trained staff involved. The Report itself is self-critical and

[2] Ohio Department of Rehabilitation and Correction, Bureau of Medical Services Homepage, http://www.drc.state.oh.us/web/medical.htm, last accessed 12/14/2004.

candid concluding, "that a number of improvements and restructuring to Ohio's correctional health care system is needed." (p. 128)

There are some 140 recommendations made, some of which have been implemented and others that are at various stages of development. More important at the moment than any particular changes is the Department's creation of a climate receptive to change. The Governor's office has been involved in one fashion or another with the Spencer and Stickrath Reports creating further assurance that the MIT findings will not come as a total surprise.

The Stickrath Report did call for additional staffing following a staffing analysis by all institutions. The staffing recommendations are as follows:

- The Office of Correctional Health Care's central office staff should hire an Assistant Medical Director.
- The Office of Correctional Health Care's central office staff should hire a Nursing Director.
- A total of 21 Quality Assurance Coordinators should be hired at institutions with a determined need for this position.
- A total of 34 health care staff should be hired for the institutions that include the addition of 15 Registered Nurses, 9 Licensed Practical Nurses, and 10 medical clerical positions.
- One full-time Phlebotomist should be added for North Central Correctional Institution and Marion Correctional Institution, and two (2) part-time Phlebotomists for Franklin Pre-Release Center and Pickaway Correctional Institution. (Recommendation 124, p. 145)

Please note that the staffing recommendations are not reproduced because of our agreement or disagreement with them. They are reproduced to illustrate DRC's analysis and its

commitment to seek fairly substantial increases albeit with no reference to an increase in frontline physicians.

The Columbus Dispatch (Mar. 9, 2004) reported on DRC's commitment to have 57 new health care workers at an annual cost of $3.5 million. (A later article referred to 60 positions being sought.) The Governor's office reportedly ordered budget cuts of $13 million for the fiscal year ending June 2004, then up to $27 million for the next year representing significant hurdles for DRC.

V. DRC PROFILE

As of December 2004, DRC had 32 institutions, with two of those operated privately. In fiscal year 2002 the total Department expenditures were $1,495,523,003, with medical costs totaling $115,043,858 or 7.7% of the budget.

In fiscal year 2003, the total prison budget dropped to $1,371,549,558 and medical costs were reduced to $113,975,768 although, this now represented 8.31% of the total budget.

The DRC inmate population was 44,917 in 2002, 45,402 in 2003, and 42,727 in March 2004. Two prisons have been closed and SOCF and OSP are running well below their rated capacities.

In 2003 payroll expenses for medical services were 33.7% of the total medical expenditures while mental health was 36.3%. On the other hand, in the same year the cost per inmate was calculated at $70.70 per day with medical care costing $7.23 per day and mental health $3.96 per day.

According to DRC public information: The Bureau of Medical Services is responsible for the oversight and coordination of the delivery of health care services to all inmates incarcerated in Ohio's prisons. There are several levels of health care within DRC.

The first and most basic level of care is provided through primary health clinics established at each institution. These are staffed by a combination of civil service and contract health care professionals. The health care team at each institution manages the day to day operation of health care services by providing primary care and addressing the routine health care needs of the inmates. In addition, several institutions have small infirmaries that provide 24-hour nursing care for inmates with acute illnesses not requiring hospitalization.

Two skilled nursing facilities, Frazier Health Center located in Orient, Ohio and the Corrections Medical Center located in Franklin County, provide more intensive health care treatment. Some inmates with serious illnesses or disabilities may be permanently assigned to one of these facilities during their incarceration. The MIT visited both of these facilities.

A third level of health care is available through a contractual arrangement with The Ohio State University Medical Center (OSUMC), where emergency room and inpatient hospital services are provided, and surgeries and advanced diagnostic testing take place. The 2005 annual contract with OSU is at a cost of $42,000,000. Physicians from OSUMC also conduct specialty clinics at the Corrections Medical Center. Inmates from all institutions are scheduled for these clinics as needed.

Acute level hospital stays are to be minimized by use of the Corrections Medical Center and Frazier Health Center as step down facilities. The Corrections Medical Center is also viewed as a resource in providing specialty care through the OSUMC/DRC partnership, long-term care beds, and a special care unit for the terminally ill. The OSUMC/DRC partnership also supports a dialysis unit at Frazier Health Center that provides treatment for 40 to 50 inmate dialysis patients, making it one of the largest such units in the state.

In March 1995, the Department implemented telemedicine, an interactive video technology that provides specialty medical consults to Ohio prison inmates. This program has been generally well received. The technology links 32 DRC institutions across the state and the Bureau of Medical Services with the Corrections Medical Center and The Ohio State University Medical Center. Approximately 5,000 such patient consultations are now completed each year, with 19,000 having been completed since implementation of the program.

DRC, like many other correctional agencies, has implemented a $3 "co-pay," drawn from inmates' personal accounts. This fee is assessed for each self-initiated request for medical treatment. No inmate, however, is to be denied needed medical care because of an inability to pay this fee. Mental health services and follow-up in chronic care clinics are supposedly exempt from this policy.

There are few areas arousing more inmate ire and frustration than the co-pay provision. This will be discussed, *infra*, but it is worth noting here that inmates regularly claim being charged for chronic care follow-up and relate that they often refuse to seek care in order to preserve limited funds for necessary or desired commissary items.

VI. IMPRESSIONS: FRED COHEN

In this section I present the impressions formed from meeting with various inmate groups, typically four groups of eight (8) inmates each day for the two days of our visit. In addition, as the non-clinical team member I also talked with various staff, on and off the record, toured the facilities and spoke at length with MIT members.

Parenthetically, my procedure was to check my group session impressions with our clinical experts who were doing record reviews. Invariably our views coincided.

First, a general impression formed by me from the numerous inmate-patient groups I conducted: There is deep and widespread dissatisfaction with medical and dental care. Often there was anger for example, at ORW, at other places, Frazier, for example, there was a sense of resignation.

Early in our site visits, MIT members pointed out consistent mismanagement of cases, minimal counseling and follow-up, and a high potential for interruption of care when transfers occur. On the other hand, access to OSU seemed at least favorable and my inmate-groups were generally not unhappy with the care received there. They were, however, concerned about OSU medication recommendations consistently being ignored or changed. The inmates believed that the medication recommendations were being changed and often for no apparently valid reason. Beginning with ORW, our first site visit, a series of problems were repeatedly voiced, and reported here not necessarily in order of importance.

1. Too many doctors and nurses view inmate medical complaints as presumptively contrived or overstated and this attitude of mistrust too often contributes to a sterile arms-length treatment relationship. One doctor in particular was repeatedly singled out for "uncaring" care.
2. It is often difficult, or simply takes too long, to access nurses' sick call, although it seems easier to see the nurse than to see a doctor thereafter when there is a referral.
3. Some doctors — especially at ORW, then Lebanon/Warren — were harshly and repeatedly singled out either for wholly unresponsive care or "care" that is so remote that the doctor never even physically examines a patient, maintaining a physical distance. I heard multiple instances of basic errors: inmate had a broken wrist and the ankles were x-rayed; inmate prescribed blood pressure meds "But I don't have high blood pressure!"

Diagnostic procedures are done and the individual never learns of the results. Indeed, lab tests are universally completed after the physical examination at reception and if abnormal, not usually addressed. Thus, a partial breakdown in medical care begins "at the front door." One would think that a reasonable oversight system would have discovered and fixed such a basic and potentially harmful problem.

At Frazier, inmates reported that C.O.s tell them, "You ain't bleedin', you ain't needin." Representative? I don't know for certain, but it is expressive of an attitude that some inmate-patients ascribe to some staff at that facility.

4. There are few deeper resentments than those related to the co-pay; inmates claim to be charged repeatedly even when it is a return visit for the same chronic care. Inmates with meager funds claim they bypass sick call to avoid being charged and then not able to afford needed commissary items.

   The Stickrath Report, Sec. 32, p. 133, recommends some important changes regarding the health care co-payment. Thus, the problems with co-pay appear to be known and await only a remedy that satisfies legitimate agency and inmate concerns.

5. Medication changes seem to be made regularly after a transfer with little or no explanation and recommended medication from OSU too often is not provided causing fear and anger among inmate-patients. Bolstering this observation is the following observation by Dr. Ron Shansky: The lack of communication between physicians and patients is a common problem seen throughout our evaluation of the different services provided. This absence of communication with regard to medication changes results in inmates feeling they're getting the wrong medications or that the physicians working for the Ohio Department of Corrections are purposely not providing the necessary or

recommended medications prescribed by the "experts" from Ohio State University. This perception on the part of the inmates results in grievances and other problems. Any time a medication is being changed for a patient, this change has to be discussed with the patient and the basis for the change made clear to the patient.

6. Groups become more credible to me when they mention a Dr. X or a Nurse Y as "good" or "caring" and I heard enough of that both to credit much of the negative comments and to also realize there are some very skilled and dedicated staff out there doing good work under difficult conditions. You cannot underestimate how important these caring staff are to the inmate population and how much they need to be supported.
7. Early on, one forms the impression that this is a nurse-driven system, and the impression strengthens over time. Inmates recount instances of doctors asking nurses for their medical diagnosis; nurses overruling a non-objecting doctor's diagnosis; and nurses deciding on medication and even treatment plans. Study of the records, to be elaborated on *infra*, seems to confirm this. There is, then, an overriding absence of physician oversight of health care delivery at virtually all facilities.
8. Early on, one senses the lack of oversight by Central Office. This impression is not gleaned so much from inmates but from conversations with various staff members. The contracting system itself undermines consistent application of policy and without effective Central Office review, quality issues go undetected and policy application seems hit and miss. Dr. Spencer appears to have said as much.
9. Underfunding and, therefore, understaffing, becomes quite obvious when you visit Lebanon/Warren and find 27 or 28 combined physician hours for 3000 inmates, well under the minimal 1 FTE physician per 1000 inmates recommended by the National

Commission on Correctional Health Care (NCCHC at p. 111. APHA would require 1 FTE doctor for every 200-750 inmates.)

VII. MAIN FINDINGS

This is the most fundamental section of this Report. It encompasses what I delivered as "Main Talking Points" on December 1, 2004 at the "feedback" meeting previously described. Those "Talking Points" have been embellished and expanded for this document, but still importantly represent a distillation of the individual reports. (See Appendix A)

Each member of the MIT has importantly contributed to this section and reviewed it prior to distribution. There will be an occasional overlap here with the previous "impressions" section and I have not attempted to eliminate the overlap in the belief that here there is a different voice, so to speak, and the repetition may provide emphasis rather than redundancy.

VIII. MIT CONSENSUS POINTS

Turning now to an MIT consensus on what I earlier termed "talking points."

1. Policy/Protocol: There is a 26-page analysis of the P & P. That document is attached as Appendix B. Madie LaMarre's summary, which we adopt, is as follows: "The ODRC medical directives are divided into medical policies and protocols. The 26 policies cover administrative, operational, personnel, legal, dietary, and quality improvement areas. The Medical Protocols cover dental, dietary, infectious diseases, medical, nursing, operational, pharmaceutical and quality improvement. *** Many of the policies and protocols are outdated. The ODRC does not reference any current standards for treatment of chronic illnesses. The protocols often make general statements regarding 'standard medical practice' or 'current CDC guidelines' without providing specific references to staff for guidance. The practical effect is that is that the ODRC does not

have a standard by which to hold health care staff accountable for their practice. Many of the policies are unclear as to whose responsibility it is to implement policies or practices. Policies often state that something shall be done, but do not clarify who specifically is responsible; therefore no one is responsible.[3] Regardless of policy, MIT observation and health record reviews showed that the nursing staff assumes primary responsibility for implementation of the health care program, with minimal physician oversight. This reflects well on nursing staff efforts to provide good care to patients, but places too much responsibility on nurses for patient care."

In the words of Dr. Shansky, "The current system creates avoidable liability. . .by not providing adequate policies and procedures, nor adequate resources."

That single sentence encapsulates the overall findings of the MIT. Policies and procedures (or protocols) create the organizational and operational framework for a health care system. The term "resources" is intended to include physical and human resources.

Resources alone, of course, do not guarantee an adequate health care delivery system. There must be reasonable access by the inmate population to the various mechanisms designed to identify need and to provide care. The components of a medical program include intake/screening, basic ambulatory care, specialty care, inpatient care, and emergency care.

As this Report will make clear, our investigation revealed problems, some quite significant, in all these areas. We also found some significant strengths. For example, virtually every inmate interviewed at CMC spoke well of the care received at OSU. We

[3] As this matter proceeds, closer study of the content and relationship of the protocols and policies is strongly indicated.

found significant numbers of caring clinical staff, staff that should serve as a foundation for future progress.

2. Contractual: The contractual arrangement with physicians encourages contract physicians to minimize care; doctors focus on the number of sick call follow-up visits and chronic care clinic visits without regard for the quality of those visits. Thus, most patients seem to be seen by physicians for only a brief encounter with very little documented physician evaluation. Physician examinations are rare and when they occur they lack thoroughness. Patient contacts, without regard to time spent and how, seem to be the primary concern of the contract physicians. This is not, however, an indictment against contracting, only how it is presently done in Ohio.

   One of the best examples of this problem was found at the Warren and Lebanon Correctional Institutions. At those institutions, a total of 26 or 27 hours per week of physician time was provided to the combined 3000 inmates. This is little more than one half-time doctor for 3000 inmates. It is impossible to provide adequate care and appropriate communication with both nurses and patients in that little amount of time. The results at Lebanon and Warren can be clearly seen, demonstrated by our findings. With regard to sick call, in only 30% of the charts was the inmate's complaint thoroughly described. Usually descriptions consisted of a single word. This is not an adequate history and doesn't allow for an adequate assessment of the basis of the patient's problems. A patient suffering from a serious disease who described weight loss was not queried regarding his food intake or his energy level, and there was no basis to determine the cause of his weight loss. Another patient who had an abnormal electromyogram was seen

for follow-up of back pain, and no history was taken at all. Thus the sick call process was in fact inadequate.

Furthermore, the care provided to patients with common chronic diseases was also deficient. Our visit occurred in the early fall of 2004; one patient with newly diagnosed diabetes in September of 2003 had no physician visit in the intervening year. Another patient whose diabetes was poorly controlled had no change in his medications prescribed. Thus, poor control was guaranteed in the future, along with the associated cardiovascular damage. A patient with elevated fat in his blood and an elevated hemoglobin A1C was seen recently, but there was no change in his medications. In fact, the official chronic care visits appear to be conducted by a nurse, and the physician appears to write orders at a later date. Patients with hypertension did not have a heart exam by the physician. A patient with asthma who had to take systemic steroids twice since January has had no peak flow evaluation and has never been placed on inhaled steroids, which are safer, in order to prevent the need for systemic steroids. This same patient has not had a physician evaluation since November 2003.

What appears to have happened is the low-bid process, without a defined required set of physician hours, has resulted in inadequate numbers of dollars being allocated for physician services; and then the physicians, responding to the contract monitoring requirement, only focus on ensuring that patients are seen for sick call with the required time frame. This results in timely but inadequate sick call visits and completely inadequate physician attention to patients who have known serious diseases such as hypertension, diabetes, etc.

Contracting for physician services frequently is seen as advantageous to hiring physicians through a civil service process. However, the contracting system utilized needs to ensure that (a) there are sufficient dollars allocated to provide the necessary physician time so that patients with serious problems are seen both timely and thoroughly, and (b) that the contract monitoring requirements focus not just on timeliness of sick call, but on adequacy of all services, including sick call, chronic care, urgent and emergent services, specialty service follow-up, etc. All of these things can be achieved through a contracting process.

3. Training: Policy and protocol training for the field seems insufficient; policy manuals at facilities (for example, ORW) were dated and incomplete as were health record forms. For example, there is no system to train nurses regarding the Nursing Protocols and Assessment Forms. The expectation voiced by Central Office is that the institutional leadership is to orient and train the nurses regarding the protocols. However, this is impractical given the volume of protocols and forms, and the expertise required to provide instruction regarding their use. Not surprisingly, in not one of the facilities the MIT visited were the protocols and forms consistently in use. Similarly, there is virtually no evidence of nurse or physician training regarding the chronic illness clinic protocols. However, given our earlier assessment of the protocols as dated, one would not remedy the training deficiencies until the standards themselves are revised. From a personnel perspective, Central Office lacks the capacity at this time to conduct adequate training for the system, and carry out its monitoring responsibilities.
4. Reception: The medical reception process is inadequate at CRC and ORW. Contributing to this is inadequate staffing, policies, and deficiencies in the ODRC medical reception

forms. With regard to staffing the Physician and nurse practitioner staffing is completely inadequate to conduct a meaningful medical history and physical examination. At CRC, clinicians spend an average of 4 minutes with each patient. Inmates reported that the physical examination took less than one minute.

Other than the 14-day time frame for completion of medical reception, policies do not address the time frame for which specific components (medical history, labs, dental examination) are to be completed. At both CRC and ORW, reviews showed that intake screening lab tests routinely take six weeks to obtain and file in the health record. Often laboratory tests are not filed in the record at all. Clinicians do not address abnormal clinical and laboratory findings, such as hypertension and severe anemia. At ORW, screening tests, such as gonorrhea and chlamydia were not being conducted on all patients. Health care staff does not notify patients timely of HIV antibody test results.

With regard to medical record forms, the Initial Medical/Mental Health/Substance Abuse Form (DRCS170, Rev 1/00), is focused exclusively upon mental health and substance abuse issues. The only question that is medically related refers to a history of head injury. There are no questions, for example, related to symptoms of tuberculosis (cough, fever, weight loss, night sweats), mobility or other sensory impairments (deafness, blindness) that might indicate the inmates' need for special housing upon arrival. The form does not facilitate the early identification of medical problems requiring immediate referral or special housing.

The Health History Form (DRC5301, Rev. 11/99) contains no questions regarding history of HIV infection, weight loss or night sweats.

The Physical Examination Form requires clinicians to document only abnormal findings, rather than to document both pertinent normal as well as abnormal findings. For example, if a patient complains of chest pain, it is as important to document that the lung and heart sounds are normal as it is to document abnormal findings. MIT reviews showed minimal to no documentation of physical findings on the form. As a result, clinicians often failed to identify obvious medical needs and develop appropriate treatment plans. Indeed, clinicians tend to ignore high blood pressure when known and inmates with known serious medical conditions often do not have this information translated to the physical examination form.

5. Transfers: Intrasystem transfers are troublesome, as suggested earlier in Section VI. DRC Medical Services Policy (68-MED-01) briefly addresses the Intrasystem Transfer process, however it does not provide sufficient guidance for the nurse conducting the review. For example, the policy does not address the need to review the record for recently completed or pending consultations or physician orders initiated at the previous facility that have not yet been implemented. The policy does not provide guidance or criteria for referral of patients to the physicians upon arrival.

   Protocol B-12, "Use of Intrasystem Transfer/Receiving Forms" does, indeed, address these matters but for reasons that remain unclear, policy and protocol combined do not work to create a functional system.

   MIT reviews showed that the process was inconsistent and in some cases nonfunctional. This was most glaring at Frazier, for example, where staff reported actually being unaware of when inmates arrived at this facility. The intrasystem transfer process must ensure continuity of medical care, however staff often failed to note pending or recently

completed consultations; chronic illnesses; or to accurately ensure timely continuity of medications. When chronic illnesses were identified, referrals to the physician for follow-up care often were not timely, even when the disease was poorly controlled.

6. Chronic Illness Care: The basic CIC system is in place in that nurses schedule patients to see the physician every three months, however the quality of the physician visits is poor and CIC forms are not consistently used. Health record documentation shows that many of the clinic visits are meaningless because the physicians do not take adequate histories, conduct physical examinations, nor reference key laboratory tests. Because of the inadequate assessments, physicians often do not change treatment plans based on how the patient is doing.

   There is no coordination between the scheduling of laboratory tests with the chronic illness clinic visit. Therefore, labs often are outdated or "pending." Even when labs are ordered and obtained in timely fashion, there is no system, at any facility the MIT visited, for the timely tracking and retrieving of laboratory reports and then filing them in the record.

   Patients are not scheduled for clinic visits based upon severity of illness or the degree of control of the patient's disease. Clinicians see patients whose diseases are poorly controlled with the same time frequency as they see patients whose diseases are well controlled. There is virtually no physician or nurse documentation of patient education regarding chronic illnesses. The MIT was concerned that the scheduling nurses do not understand clinical guideline requirements.

   A patient at Lebanon who had hypertension, diabetes, and asthma had been seen almost every three months by the nurses but had not been seen by a physician for the diabetes or

asthma for over a year. Although five months prior to our visit the patient was seen for hypertension by the physician, there was no blood pressure taken at that visit, thus the physician was making therapeutic judgments without adequate data. One patient who had an elevated blood pressure in April 2004 has not had a physician visit since. In fact the patient has not seen a physician since November 2003. At ORW, none of the patients being followed for diabetes had adequate objective clinical data in the chart in order to assess the control of the disease, which is necessary in order to design the appropriate treatment plan. Similarly, a patient at ORW who is known to have a clotting disorder and had had open-heart surgery and deep vein thrombosis has had no physician note regarding these problems. In all of these ways, the absence of physician involvement as well as physician communication with patients creates avoidable liabilities for the Ohio Department of Corrections.

7. Consultations: ODRC has a well-organized scheduling system for specialty consultations and procedures. However, the scheduling process (once a month scheduling) has a built in delay in the scheduling system of up to a month. For example, if the physician requests a consultation on the 16th of a given month, the appointment request will not be faxed to CMC scheduling until 15th of the following month, thereby building in an automatic 30 day delay.

   It was reported to us, however, by ODRC officials, that in the case of an emergency an instant fax process may be, and is, used to make an appointment. No policy or protocol forbids that procedure.

   Although the timeliness of **initial** clinic appointments did not appear to be excessive (with the exception of gastroenterology and possibly neurosurgery), the frequency of

appointment cancellations for all clinic appointments is 25%. When added to the built in scheduling delays this represents further delay in diagnosis and treatment of medical conditions. Cardiology, neurology and gynecology in particular were problematic with respect to appointment cancellations. Access to gastroenterology services is 9-12 months at this time, even for patients with known serious health conditions. Although data was not provided, access to neurosurgery consultations was reliably reported to be problematic.

When the primary care physician orders the consultation, the nurse, rather than the physician, completes the request form. This often results in a consultation request form with an inadequate patient history, physical and laboratory test information, and questions the consultant is to address. Following the consultation, the requesting physician does not see the patient to review the consultant findings and recommendations with the patient, and determine whether the patient understands the plan of care and is in agreement. Often, no one sees the patient following the consultation. Rather, management of patients is being driven by the consultants and nurses (writing the consultant orders that the physician co-signs), rather than by the primary care physician. This means that once the institutional physician orders a consultation the physician does not consistently monitor the patient for that condition. It is therefore not surprising that there is virtually no documentation of physician or nurse education concerning the consultation findings and recommendations. If the patient is lost to follow-up for any reason, the primary care physician will never know this because he/she does not monitor the patient. MIT review found that patients were often lost to follow-up and consultant recommendations were not implemented.

Contributing to the lack of adequate care following appointments is the fact that consultation and hospital reports are not obtained and timely filed in the health record. The MIT found no meaningful system for tracking and obtaining consultation or hospital reports. On multiple occasions the MIT requested reports, and only then did staff print them from the computer. As a result, frequently there are no reports in the health record and staff is unaware of consultation findings and recommendations or of the patients' hospital course and need for follow-up care. The situation is aggravated by insufficient staff and no specifically designated position for this task. The lack of timely consultation and hospital reports is a serious and systemic problem that impedes timely medical care.

8. Medications: There is a pattern of the nurses writing initial orders for prescription medications, and then renewing medications without a correlating physician visit. This sometimes results in transcription errors that harm patients. Physicians often sign the medication orders without a clinical assessment of the patient. Therefore, the same medication regimen may be reordered without regard to whether the disease is well, or poorly controlled. This was most noticeable at CRC and PCI-Frazier.

   As a matter of policy, there is no health record documentation required to show that inmates receive prescription medications that are self-administered, such as high blood pressure or seizure medications or antibiotics. Although records are kept in the pharmacy, this information is never placed in the record, therefore the clinicians and nurses do not know whether the patient received medication, and if the patient is transferred this information does not accompany the inmate.

At CRC, as a matter of policy, when an inmate ran out of medication, the nurses borrowed the medication from another inmate. They even had a "Borrowed Medication Log" which, in effect, documented a legally dubious practice.

9. Medication Administration: Documentation of medication administration for inmates in general population is reasonably consistent with current nursing practice standards. However that is the only area of improvement noted. Medical records in many cases are disorganized making relevant information difficult to locate.

There is no medication compliance monitoring (this is an area included in the existing chronic care form) and no medication education so that inmates might make an "informed" decision.

ODRC does have protocols covering the documentation process but they are inconsistently implemented and there is no peer review or quality assurance mechanism in place to address people or process issues. Only one facility had a corrective action in place to address this failure. The offense when first documented resulted in an educational session and supervision of the employee. If this was adequate to correct the situation that was the end. If not disciplinary action was started.

ODRC also has protocols that address the areas of medication prescription and administration and there are mechanisms for reporting errors as well but there is no check and balance system currently used in daily practice to effectively manage the use and administration of medications. The impact of these system failures puts inmates at increased risk as especially noted with HIV cases. The inmate is seen by an Ohio State University physician by telemedicine. This physician prescribes the course of care, including medications. These physician orders are then copied by the nurse and signed

by the institutional physician without verification with the original orders or connection to the inmate's current condition by the primary care physician.

Providing medications with no explanation rarely promotes compliance on the part of the receiving individual. Without using an informed consent [or educational process] ODRC likely incurs the costs of wasted product and hospitalizations that may well have been avoided. Medication compliance is not tracked (it is an ODRC requirement for chronic care clinics) so there is no base for determining the efficacy of medications as prescribed. There is no correlation with the inmate's current condition by clinicians that has been documented to indicate the need for continuing or altering the course of medication and/or treatment.

Diabetics receive insulin without apparent regard for blood sugar levels. At one facility the insulin was drawn up in syringes prior to any inmate appearing. These injections were then refrigerated for later use, insuring that no inmate received what had been ordered. There are policies and protocols for diabetic diets but the use of these guidelines was not observed in any facility and inmates universally commented on the difficulties of following a diabetic diet.

While nurses have received the most attention and criticism for medication administration the entire process, beginning with the physician, should be reassessed and improved. The pharmacist is responsible for packaging the medication accurately (as prescribed) along with frequency (once a day, etc.) and specific instructions or cautions to be observed with individual medications, e.g. take with food. Pharmacists work limited hours in very limited space which may contribute to errors of omission and delays

in the provision of medications as ordered. These processes are not monitored and there are no guidelines established to define expectations or to measure against and improve. Likewise, the areas used for pill call are frequently 'multi-purpose' and require the transportation of medications to the area. We observed space that was poorly lit, limiting visualization of the inmate identification and ingestion. At one facility the nurse had to climb over the medication cart to transport additional medications back and forth depending on inmate need. The collaboration between nursing and custody staff was the only positive aspect of medication administration at this facility.

Medication rooms appear to be makeshift in many of the sites visited. Rooms without running water, for example, do not encourage hand washing. Refrigerators for medications were frequently in poor repair with doors which didn't close. When thermometers were present in the refrigerators the temperature readings were not recorded as required by ODRC protocols.

10. Informed Consent: DRC Medical policy regarding legal issues (68-MED-09) states that inmates shall have the right to informed consent and to refuse medical treatment. With regard to refusal of medical treatment, the policy does not specify who is to counsel the inmate regarding the risks of refusal of medical care and obtain the Refusal of Treatment Against Medical Advice form. However, MIT health record reviews show that it is predominantly nurses who obtain the signed refusals, even for life-threatening conditions. The health records do not consistently reflect that the nurses properly educate and document the risks to the inmate for refusing care. The most appropriate provider to conduct this education and counseling is the physician who recommended the treatment.

The policy also advocates use of force to obtain blood samples from inmates when they refuse court-ordered blood testing (e.g., paternity or HIV tests). While this may be legally permissible, using force as the initial strategy to obtain the blood sample places medical and correctional staff at risk for needlestick injury and exposure to blood-borne infections such as HIV and viral hepatitis.

Prisoners, of course, have very much the same right to consent to, or refuse, medical treatment as patients in the community. Consent to certain diagnostic procedures (for example, AIDS, TB testing) at times conflict with religious beliefs.

There is no monitoring (or recognition) of adverse drug reactions or medication errors (omission, incorrect dose, e.g.). There is risk inherent with all medications but there is no risk/benefit rationale available in the inmate's record. There is no documented informed consent that confirms that the nurse, the doctor, or the pharmacist has presented the anticipated benefit of the medication as ordered. There is no documentation of the identification of adverse reactions, which though unlikely, should be reported immediately if they occur.

11. Urgent Care: Another area in need of at least a "tune-up:" DRC Medical Services Policy (68-MED-01) addresses Emergency Services. The policy appropriately addresses emergency training that is required for health care and correctional staff. Although correctional officers are trained to be first responders, they are not required to initiate cardiopulmonary resuscitation (CPR). Since correctional officers are most likely to be the first personnel to respond to the scene, the failure to initiate CPR will greatly increase the likelihood that CPR will be unsuccessful. An example of this occurred at Warren Correctional Facility where an inmate was found hanging by correctional staff. When the

nurse arrived, the patient was lying supine with the sheet tied around his neck. Staff had not initiated CPR.

The only emergency drills conducted are to assess whether responders are able to arrive on the scene within 4 minutes. Drills are not conducted to determine appropriate security and clinical response to various types of emergency situations (e.g. uncontrolled bleeding, difficulty breathing, attempted suicide, etc.).

Emergency equipment and supplies vary from site to site. At Hocking Correctional Facility, for example, emergency equipment is dispersed throughout the unit (due to insufficient space) and there is no uniform system for ensuring that all emergency equipment is maintained in proper working condition.

When assessing patients in urgent situations nurses do not utilize protocols to evaluate and refer patients. This results in some patients not being appropriately evaluated and referred to physicians. Physicians, in turn, do not routinely see patients returning from the emergency room or, as noted earlier, those discharged from hospitals. This was demonstrated to result in lack of follow up of consultant recommendations and in failure to follow up on serious medical conditions. For example, at Hocking Correctional Facility a 68-year-old patient who was febrile, weak and disoriented was sent to the emergency room where he was diagnosed with urosepsis (a systemic infection resulting from an untreated urinary tract infection) and a dangerously high potassium level. The physician did not see the patient upon his return to monitor his condition.

At Warren Correctional Facility, from 6/16/2004 - 8/30/2004, an AIDS patient (RC) presented emergently on eight occasions for symptoms of fever and shortness of breath that were attributed to an HIV-related pneumonia (PCP). In several instances, the nurse

did not evaluate and refer the patient according to ODRC's Nursing Protocols. The physician did not fully evaluate and adequately treat the patient for PCP pneumonia. The patient had been non-adherent to his antiretroviral therapy and medications that would have prevented PCP pneumonia, but there is no documentation in the record of counseling with the patient regarding the need for medication adherence, and risks of non-adherence (pneumonia, death). The patient's condition worsened over time, resulting in two visits to the hospital (one ER visit and one admission). The physician did not see the patient following his return from an outside hospital to evaluate the patient and his understanding of the treatment plan.

A further example of the poor physician follow-up was a patient at the reception center who presented with chest pain, pressure in the chest and tingling in the chest. He was given nitroglycerin and sent out with the EMT squad. He was admitted to Ohio State University Hospital and ultimately underwent a cardiac catheterization which demonstrated abnormalities in his coronary arteries. He was also placed on five anti-hypertensive medications and was found to have an elevated cholesterol level. Since his return, there has been no physician follow-up. This patient is at very high risk for developing a heart attack.

Another example is a patient at Warren Correctional Institution who developed sudden onset of left arm weakness and left leg numbness in March. He was ultimately sent out to OSU and diagnosed with an intracranial bleed. He returned to the institution, and several days later developed a headache and twitching with weakness. He was transferred back to OSU and refused admission. He also refused infirmary placement and was sent directly to his housing unit. However, since returning to the housing unit, he had not been seen in

follow-up by the physician. In most systems, although patients may refuse treatment, they may not refuse placement in a housing unit, as that's a bed assignment and they have no right to refuse a bed assignment.

An example of poor physician follow-up occurred at the Warren Correctional Institution where a patient with a brain tumor presented with unsteadiness. He was brought to the infirmary and then sent out. He ended up at CMC, where he stayed for five weeks with a diagnosis of fever and unsteadiness. He was returned to Warren and about a week later was seen by the physician on sick call as the result of a sick call request. The physician note demonstrates no knowledge of the prior problems that this patient suffered and no effort to follow up on them.

12. Sick Call: There is an ODRC policy for Nursing Guidelines for Assessment and Triage with an effective date of December 1, 2003. The policy does not address the specific time frame in which inmates are to be seen, only that the inmate will be seen at the next scheduled sick call, and that if the number of requests is greater than the nurse can see, the inmate may be deferred until the next scheduled sick call. This can result in inmates being deferred for indefinite periods of time. For example, at ORW, the timeliness of being seen in sick call varied from 1 to 7 days. The ODRC policy does not address nurse referral to physicians. It was reported that this subject is addressed in the physician contracts; however this does not provide sufficient guidance to nursing staff.

There is no training provided to nurses regarding use of the nursing protocol and assessment forms. Not surprisingly, the (dated) protocols and forms are not consistently used at DRC facilities. In general, the quality of nursing assessments is poor, lacking in adequate historical and physical assessment data.

At ORW, health care staff is not conducting daily rounds in segregation.

The records we have reviewed indicate that Doctor's sick call is scheduled within 24 to 72 hours depending on day of the week, need, etc. (and actually may occur on the same day as nurse's sick call). Thus, timeliness of the appointment itself seems not to be a significant issue, except at ORW. The issue has been the conduct of the physician during sick call, (for example, has there been any physician assessment or is the action taken simply based on information from nurse's sick call; does the documentation provide any information to support action taken or the fact that no action was taken; is the information based on observation or self-report).

Physical assessment data is incomplete and frequently appears to be inconsistent with the care provided or outcomes. At ORW, for example, there were days when no one was seen at sick call (5/4/04) and for the five days in May that we studied 48% of those scheduled is the highest number seen with 18% the lowest and 31% (15 of 49) the mean.

13. Infectious Diseases:

A) TB Infection: Staff was found not to assess and monitor TB patients according to ODRC Policy, Inmate TB Skin Testing and Treatment Guidelines (Infectious Disease Protocol C-3). The protocol does not indicate what standards are used to establish guidelines, such as the Centers for Disease Control and Prevention (CDC). The protocol is somewhat confusing as it discusses both TB infection and TB disease. The protocol does not indicate the treatment regiment for patients with active tuberculosis and what staff should do if the disease is diagnosed (i.e., should patients be transferred to CMC). The protocol requires that patients with TB infection should be evaluated monthly, however, this was not found to be actual practice in any of the facilities.

The protocol indicates that patients with liver function tests 2 times normal or with symptoms of INH toxicity must have medications discontinued immediately. This is problematic because many patients placed on INH will have elevated liver enzymes. Centers for Disease Control and Prevention (CDC) guidelines indicate that patients with liver enzyme elevations of 3-5 times normal may be continued on medication. Therefore, this policy may inadvertently result in premature discontinuation of patients on medication and defeat the purpose of prophylaxis, which is to prevent active tuberculosis. MIT reviews showed that at CRC, there is no tracking system of patients in the TB infection clinic. Nurses do not thoroughly interview newly arriving patients reporting a history of TB infection for symptoms of active TB (cough, fever, weight loss). These patients usually, but not always, receive a chest x-ray to rule out active TB. This is important because patients with active TB are infectious to others, and patients with TB infection (normal chest x-ray and no symptoms) are not infectious to others. Once TB therapy is prescribed, clinicians and nurses are not adequately monitoring patients during the course of their TB therapy to ensure that they adhere to the medication and to screen patients for medication side effects. This is important because the medication used to treat TB infection can damage the liver, and many inmates are at increased risk of liver disease due to other conditions such as hepatitis B and C. In addition, nurses renew medications automatically without the appropriate clinical evaluations. In addition, the problem of TB infection is often not listed on the Problems List.

B) Hepatitis C: The hepatitis policy is confusing and should be reviewed and coordinated with the Hepatitis C treatment protocol, which is a reasonable basis for a protocol for treatment of persons with hepatitis C infection. It does need, however,

editing for clarity and there are some revisions that should be undertaken to make it more current scientifically. Some problems are:

a. It does not address the role of liver biopsy.

b. It requires that a confirmatory PCR test be done to confirm infection; this is a costly test and does not need to be done in persons who are determined to be high risk, which is most of the individuals tested in prisons.

c. The role of who manages the patient is not addressed. Most of the physicians the MIT evaluated would not be appropriate to conduct these protocols. A specialist should be involved in carrying out these protocols.

d. It is not clear who is responsible for what: for example, what is the role of the primary care physician, nurse, specialist, etc.

C) HIV: HIV medical care at the facilities was found to be so profoundly inadequate as to amount to no care at all. This is so despite reasonably good access to infectious disease consultation services at OSU. There appears to be a fundamental lack of knowledge and training of the DRC primary care physicians regarding HIV care. At virtually every facility MIT visited, physicians do not conduct meaningful histories and physical examinations; monitor laboratory tests that reflect disease control or metabolic side effects of medications; provide prophylaxis for the prevention of opportunistic infections nor counsel patients about their disease, medication side effects and the critical importance of adherence. Physicians do not monitor patients to ensure that infectious disease consultant reports are obtained and timely reviewed, and that consultant recommendations thereafter are implemented. At some facilities, patients may have had numerous infectious disease consultations over a period of a year, with no report being

produced and filed. Thus, the physician is unaware of consultant recommendations. The physicians' repeated lack of effort to obtain consultant reports and laboratory tests raises serious, systemic concerns.

At PCI-Frazier unit, one patient had been prescribed the same antiretroviral regimen for 7 years, and had been failing therapy for at least 5 years. His condition was clearly deteriorating; yet no effective action was taken to improve his condition. At several facilities, health records showed that patients had developed pneumocystis pneumonia, a preventable infection, because the physician had not prescribed prophylaxis. Clinicians discontinued antiretroviral therapy for patients who were nonadherent to medications due to side effects, rather than treating the side effects or working with the infectious disease consultant to find a regimen with fewer side effects. Nurses routinely rewrite medication orders; sometimes committing errors by leaving off one of the antiretroviral medications. This practice will almost certainly lead to HIV drug resistance and reduce future treatment options for patients.

D) MRSA: In August of 2003 the Columbus Dispatch began a series of articles on healthcare in the Ohio correctional system. An investigation completed with WBNS-TV identified a system of questionable care focusing on a 19-year-old Pickaway inmate who died of toxic shock syndrome as a result of an undiagnosed methicillin resistant Staphylococcus Aureus infection (MRSA).

ODRC implemented a medical protocol following this death to insure that wounds would be cultured to isolate the organism(s) involved and also to identify the families/types of medications that could be most effective in treating the identified organism.

Unfortunately, this positive step alone has not proven to be enough to curb the occurrence

of this 'institutional' or nosocomial infection. ODRC now tracks by institution the number of MRSA cases found. Pickaway Correctional Institution continues to account for 23% of MRSA cases. For the eleven months where data is available there have been 494 diagnosed cases, 115 at Pickaway.

ODRC, currently, conducts no surveillance studies; that is, the routine and orderly collection of information regarding the occurrence of a disease. Each institution has an Infection Control Coordinator identified and there is a position in Central Office that serves as a resource and/or reference point for these employees. We found no consistency in training and education for these employees and uncovered no evaluation of the data that they submit. Institutionally it is used to identify endemic rates and to identify high and low risk areas. Data from surveillance is used to identify clusters or epidemics when established thresholds for disease occurrence are exceeded. The assessment and evaluation of this data may result in changes in process or procedure to control the spread of disease.

As part of gathering data, Infection Control nurses can reinforce applicable protocols (e.g., hand washing, isolation techniques, cleaning) and identify new or continuing problems. Included in the data gathering process is a review of the nursing care plan (non-existent in most facilities surveyed) and an evaluation of the level of care being provided by licensed staff (there was no evidence that this competency factor is evaluated).

Infection rates across institutions can be compared using the same definitions for all infections for all facilities. Using the number of infections (numerator) and the total number of inmate days or the number of inmates at risk (denominator) may then identify

infection rates. Infection rates by site, service, organism and procedure are then tallied. A summary of antibiotic sensitivity patterns may also aid clinicians in selecting proper antimicrobial therapy.

Basic analysis includes:

- Incidence-the number of new cases of a disease in a population at risk over a specified period of time;
- Prevalence-the number of persons with a disease (newly acquired or not) at a given time;
- Attack rate-the number of new cases in a population exposed to a particular risk.

This information should be shared both within the institution and across the correctional system so that individual performance can be reviewed and potential problem sites can be identified. Based on ODRC's current data collection and identification it appears that the attack rate is the only area addressed.

It should also be noted that hand washing before and after each inmate is examined and the proper cleaning of equipment can significantly reduce the occurrence of MRSA. This procedure is required not only for all staff (clinicians, custody etc.), but also for all inmates. There are minimal hand washing facilities for staff (all staff) and even more meager resources for the inmate population. Kitchens and food preparation areas need to be monitored closely as do the temperatures for cleansing of utensils, cookware etc. ODRC has made some initial, albeit limited, steps to address this costly and potentially deadly concern. The effective education and use of Infection Control Coordinators and the emphasis on continuity of care for primary providers along with standard procedures (e.g. hand washing) should be enhanced immediately. The cost of doing so should be

measured against the decrease in the occurrence of MRSA, the decrease in the use of antibiotics and the decrease in hospital or more intensive level of care days.

14. Infirmary: Infirmary care policy is addressed in the Medical Services Policy (68-MED-01). The policy does not provide written medical criteria for placing patients in the infirmary (e.g., poorly controlled diabetics without ketoacidosis, stable asthmatics requiring intermittent breathing treatments, etc). Rather, the policy vaguely states only that "placement shall be limited to short-term observation." The policy states that patients will be within sight or sound of a staff member at all times, however at SOCF, due to inadequate staffing, nurses are not assigned to be present in the infirmary. The policy does not address admission requirements or the frequency of medical and nursing monitoring.

As was noted with regard to "intrasystem transfers," there is a protocol for this area as well: B-23, "Guidelines for Routine Care of Infirmary Admission." The same problems, however, exist as to actual implementation.

Admitting nurses do not routinely notify the doctor to obtain orders such as vital signs, medication, and guidance as to what clinical criteria should lead to physician re-notification. The nurses do not routinely conduct admission assessments nor do they monitor patients each shift.

At PCI-Frazier unit, the infirmary physical plant is cramped and cluttered. The beds, mattresses and night tables are in poor condition. It was reported that additional beds were recently added to the infirmary, decreasing the physical space available to each inmate. Some beds are spaced less than 12-18 inches apart. The inmates keep their personal property at their bedside, including food, adding to the cluttered appearance.

The clutter of the environment contributes to poor sanitation of the unit. The bathrooms do not have handicapped shower access. A regular bathtub is available along with an elevated platform that is designed for transferring patients from a gurney for bathing. However, the platform reportedly is never used. There is one handicapped access whirlpool located in a long-term care unit in the back of ward 1.

At Frazier, nurses do not perform admission assessments, develop care plans, or write discharge summaries. The physician does not document admission notes, perform an admission history and physical, or write discharge summaries. The records reflect that the physician does not monitor and treat patients in a timely fashion for poorly controlled illnesses, implement consultant recommendations, or see patients timely following their return from CMC or OSU.

15. Medical Equipment: Medical equipment (otoscopes, syphgmomanometers, exam tables, etc.) are available in limited number, which means that often only one person at a time can conduct an evaluation, thus compromising efficiency given the limited number of staff available. This is an area where a more detailed study would be needed before detailed systemic remediation was undertaken. National standards here are either lacking or very general as in the language of "as determined by health care authorities."

    At some facilities, emergency medical equipment is not checked daily to ensure its readiness. There is no standardization of equipment and supplies to be kept in emergency response bags, nor a requirement to periodically check the bags to ensure that equipment and supplies are present and functional.

16. Medical Records: Medical records were often disorganized, and information difficult to locate. As noted earlier, there is insufficient staff and no specific designated position for

this important task, even at CMC whose primary mission is medical. There is a serious and systemic problem with retrieval and filing of laboratory and consultant reports, which repeatedly cause delays in care.

17. Staffing: Physician hours allocated to DRC facilities is inadequate. Nursing staffing is inadequate at medical facilities where medical acuity is high (PCI-Frazier Unit and Hocking). However it was not possible at this point in time to precisely determine the numbers of staff that would be required to provide adequate services. Nursing staffing may be inadequate at other DRC facilities, particularly given that nurses are required to perform additional duties such as medical records retrieval and filing. A more complete analysis, including numbers and distribution, was beyond the scope of the MIT review. Although we do not have precise figures, we came to the view that there is inadequate support/secretarial staff throughout the system. This helps explain why, when we are on site, requested information may be orally explained but not appear on the chart. This is another fairly important personnel issue that should be more closely studied before final conclusions are reached, or certainly before any re-staffing occurs. Support staff for secretarial and medical records services appear to be below minimums in the majority of facilities visited (CRC seems to be an exception but that should be more closely evaluated). Support staff frequently maintain inmate files and may also be responsible for scheduling outside appointments and transportation.

    There does not appear to be a tickler file system for follow up to insure that all test results and consultation reports are received and available at the parent institution when the inmate returns. This results in 'lost' information, untimely follow up and errors in medications, etc. The persistent lack of information seriously inhibits access to

reasonable and timely care and seems at least partly attributable to the dearth of support staff.

18. Mortality Review: One expert (Dr. Jack Raba) notes that mortality reviews can be essential indicators of the quality of a correctional health care program. Thus, "Systematic collection of epidemiological mortality data must be an essential component of an adequate prison . . .program."[4] A special study by Barbara Peterson concluded: "Simply stated, there is no quality assurance or improvement process in place. There is no documentation available that suggests even the simplest tenets of the existing protocol for mortality reviews are addressed at the institutional or Central Office level. This system does encompass the basic elements of what could be an effective and cost efficient healthcare program but it has been severely compromised by the lack of a meaningful source of direction and support." That report is attached as Appendix C. In addition, Ron Shansky, M.D., reviewed eleven (11) of the thirteen cases identified for review by Barbara Peterson and referred to at p. 3 of her Report (Appendix C). Dr. Shansky's analysis is appended as Appendix D. In sum, Dr. Shansky's detailed review discloses a pattern of failure to perform physical examinations, delays in physician's notes, delays (or omissions) in physicians' visits and monitoring, and the absence of a close look at the performance of various physicians.

What follows is a verbatim reproduction of Case #2 from the Shansky review:

[4] Jack Raba, M.D., Mortality in Prisons and Jails, p. 301 in Clinical Practice in Correctional Medicine (Michael Puisis, D.O., ed., 1998).

Inmate K.B.[5] entered the reception center in 1995 at the age of 20 with a history of asthma and obesity. He had an initial elevated blood pressure but later his pressure was reported as normal, without any medications. On 8/20/03, he complained of pain when breathing deeply and coughing up a small amount of blood in his sputum. His pulse was 120; his pulse oximeter reading was 94%. A nurse saw him, and despite his coughing up blood and an elevated pulse of 120, he was told to sign up for sick call. The next day, he again complained of the same symptoms; his pulse was 92, and he had an abnormal pulse oximeter reading. He was again told to sign up for sick call. On August 25, there is a note that he is to return for follow-up with the physician regarding his chest x-ray. An x-ray had been ordered by a physician on August 21, although the patient hadn't been seen. He was also given a lay-in and antibiotics. The x-ray revealed a large pneumonia or lung mass. A physician note on August 25 indicates "Patient feels better. Return in a month." On September 15, the inmate again complained of persistent cough with blood-tinged sputum. The physician note says "Persistent cough. Chest clear. Pneumonia improved." He was placed on a different antibiotic.

He was not seen again by a physician until February of 2004, although he did have repeat x-rays which showed some improvement and clearing of the pneumonia, although there was residual pathology in the base of the lung field. On February 4, 2004, he complained of a chest cold with slight

[5] Inmate number on file with Fred Cohen.

chest pain. His blood pressure was elevated. His other vital signs were normal. This was treated symptomatically. At 5:55 p.m. the same day, he complained of severe chest pain and difficulty breathing. His pulse was rapid and thready; the pulse rate was 148 and his pulse oximeter reading was 72%. He was placed on high-dose oxygen.

He complained at 5:55 p.m. of difficulty breathing and feeling weak. At 6:10, the nurse told the officer to call the ambulance, although because of confusion between the control center and the duty officer, the ambulance was not called until 6:20 p.m. The inmate stopped breathing at 6:40, and the ambulance arrived five minutes later. He had an autopsy which revealed acute and chronic pulmonary emboli. It is entirely probable that his initial pneumonia and subsequent problems were all related to chronic multiple emboli which could have been detected by physician evaluation and the ordering of a lung scan; however, this did not occur.

By way of contrast, Lindsay A. Hayes in Technical Assistance Report, page 27 (Nov. 19, 2004), after a review of recent prison suicides concludes, "The ODRC has both excellent policies and practices regarding the mortality review process following an inmate suicide." He found such review the strength of the DRC suicide prevention policy.

19. Physician Leadership and Physician Monitoring: This is a program run by nurses. At all sites, the number of physician hours was inadequate; including supervisory physician hours at Central Office. This scarcity resulted in having to engage in a form of rationing with nurses filling the management gap of the inadequate physician coverage. What appeared to result was that the focus of care was to see as many patients as possible

without regard to the quality of the encounter and to shift focus from monitoring patients with serious or acute illness to making sure all sick call patients were seen regardless of the acuity level. As already mentioned, another result of the rationing is that few physicians-patient encounters resulted in an actual physical examination of the patient and little if any history of the patient's illness was obtained. Nurses therefore were in effect managing patients with chronic illnesses. Patients with serious illness (especially at CMC and Hocking) were not afforded the level of physician monitoring necessary for their illness.

In addition, nurses appear to direct the selection and intervals of physician encounters. Physicians are not directing care in the sense that they do not decide when and how often patients with more serious needs are seen. The lack of physician hours also resulted in lack of supervision of physician quality as well and clinical direction of the program. Physician quality was not monitored at any site and therefore, inadequate physician care was never identified or reviewed with an eye toward improving physician practice. Lack of physician involvement in leadership functions resulted in inadequate policies and procedures and lack of improvement of basic clinical infrastructure problems that plague the system (e.g. seldom having a consultation report on the chart).

The state medical director should be responsible for promulgating all clinical policies and guidelines. This position should ultimately be responsible for all clinical care. All clinical staff should have a dotted line reporting relationship to this position. All physicians working in the system should be aware that their continued employment requires satisfactorily meeting the clinical standards of the medical director.

20. Credentialing: The courts have long held that adequate access to care requires access to an appropriately trained and credentialed clinician. In the free world, when adults have problems such as hypertension, diabetes, or asthma, they go to a physician and are provided services by a physician trained usually in internal medicine or family practice. Those are the disciplines that provide training and experience in handling adult common chronic problems. None of us go to see a surgeon, a radiologist, or an anesthesiologist to treat our asthma, our stomach pain, or our headache. Although 80% of the primary care doctors whose files were reviewed by Dr. Shansky are appropriately trained in primary care, there were approximately 20% trained in other, non-primary care disciplines, such as surgery, anesthesia, or some surgical subspecialty. Providing access to these clinicians for primary care needs is not providing access to an appropriately trained and credentialed clinician. This also creates avoidable liabilities for the State.

21. Misc.: While the MIT looked at ORW and the special needs of women, we did not look at the juvenile offender population serving adult time at Madison Correctional Institution. They, of course, have "special needs" based on the age and developmental stage and any remedial effort should accommodate this special group.

ADDENDUM: Individual Report on Correctional Medical Center (CMC) Site Visit: November 29, 30, 2004

INTRODUCTION

The MIT visited CMC on the above dates. The Interim Feedback Session at DRC was scheduled for December 1, 2004 and was held at that time.

A good deal of effort went into preparing for the December 1st meeting and obviously it was too soon to provide well-organized feedback from the just completed visit to CMC.

Fred Cohen prepared an initial draft of the Final Report before MIT members were able to prepare their now completed CMC site visit reports. In the interest of expediency, the report on the CMC visit is treated separately and not integrated into the topic flow of the main body of the Report.

We trust this will result only in a stylistic difference and not otherwise detract from this Report.

GENERAL

The Correctional Medical Center Prison houses both males and females up to maximum-security custody level. It has a capacity of 121 short-term beds, which are generally used for pre- or post-hospital admissions, of which 91 were filled. It also has 57 long-term beds, all of which were filled. There are two hospice rooms. For inmates who are admitted to hospice-level services in the period of time just preceding death, cadre inmates stay with the inmates at the bedside for the last 72 hours. There are 54 specially selected cadre inmates. There are 360 inmates who are seen per week for specialty visits, and the average age of the inmates seen is 46.

The budget is $35 million. There are 26 registered nurse positions, of which 8 (31%) are vacant; 26 LPN positions, of which 7 (27%) are vacant, although we were told that they are in the process of filling those positions. There are two full-time physicians and a part-time physician who works up to 20 hours. One of the full-time physicians is the medical director, and he spends a fair amount of time responding to questions and concerns from all of the prisons in the field.

As for staff vacancies, there are approximately 35 medical staff vacancies in total and officials are working hard to fill those positions. They attend job fairs and use print advertising. Temporary staff are used as an interim staffing measure.

There were 8 hours per week of psychiatric care available at the time of our visit. Many of these inmate-patients have troubling mental health issues often exacerbated by their physical illness. Sixty-four patients were on the mental health caseload (27 from the long-term unit) at the time of our visit. Fred Cohen spoke with, and was impressed by Dr. Heizleman, the psychiatrist, and recommended to Central Office that his CMC hours be extended by another full day (8 hours).

COHEN'S IMPRESSIONS FROM GROUP SESSIONS

The 16 inmates participating in the two group sessions were generally supportive of the care received at CMC. Only two expressed some reservations. The most frequent complaint was delay; delay as to diagnosis and subsequent care. When care was delivered it was characterized as "good."

Parenthetically, it is interesting to contrast the patients' evaluations with the record reviews by the MIT clinical experts that revealed many problems, some of which were life threatening.

The complaint most frequently and vociferously voiced by long and short-term patients related to the Aides. There was story after story of Aides not helping a handicapped patient at the toilet or with a shower; simply ignoring pleas for basic care.

The short-termers consistently complained about inactivity. "There is nothing to do. I want to go back to my home facility!"

Care at CMC and OSU generally were given high marks by these consumers.

To my medically untrained eyes, the physical plant and general atmosphere seemed quite good. I felt as though I was in a clinical/hospital setting and not a maximum-security prison, extended care nursing facility.

SHORT TERM CARE UNIT

Dr. Shansky reviewed records of patients on 3-North, the short-term care unit. He was informed that the policy on that unit was that the physician was required as part of the admission orders to indicate the patient's level or acuity status. This level determined the frequency of physician visits, nursing follow-up, etc. In at least four of the eight charts reviewed, there was no classification order.

The nurses, by default, classified patients not given a classification order at the lowest level of acuity, independent of the patient's actual acuity level. This resulted in a patient not being seen very aggressively; in fact, the lowest level requires patients be seen no more than once per week. This not only detracted from the care, but resulted in poor bed management, since interventions were delayed.

In summarizing his review of the above noted records, Dr. Shansky wrote:

My review of the CMC Short-term Unit records indicates that several of the patients entered at a fairly high acuity level but were defaulted to a lower acuity

status because no order was written, and therefore they were not timely seen by the physician. When the physician does see them, he seems to be unaware of several of their problems and does not address them, whether it's pain, laboratory reports, or chronic disease issues. In my view, the physician who writes most of the notes appears to not have the conscientious focus necessary to respond to the needs of these problems. It is also my view that if physicians are not writing levels of acuity, then the default should be that everyone enters at a high acuity level is seen by the physician within 24 hours and then can be reassessed to a lower acuity level. This was discussed with Dr. Reid, the state Medical Director, and he will look at the options in terms of modifying the current practice.

LONG TERM CARE UNIT

Dr. Puisis evaluated 49 of the 57 patients on the long-term unit and found that 23 of 49 (47%) were patients who were capable of self-care and could have been housed elsewhere. Please consult his CMC report (attached to Dr. Shansky's) for numerous examples.

Eleven of the 49 (22%) patients evaluated did not need nursing care but needed some assistance with movement or devices they used.

There were 15 of the 49 (31%) who required a long-term nursing unit. Even some of these patients could be properly cared for in a less intensive nursing environment. Frazier's inadequate functioning explains part of the reason for using CMC's more expensive housing.

There appears to be no standard utilization practice for patients on this unit. Exact reasons for placement should be recorded along with a treatment showing any continued need for this unit.

Actually, it was seldom ever clear from the medical record why people were on this unit. Dr. Puisis also discusses the numerous problems flowing from the physician disengagement from actively managing patients at CMC.

SPECIALTY CONSULTATIONS, BED-SPACE MANAGEMENT, AND MEDICAL RECORDS

MIT member, Madeleine LaMarre, focused on the above areas each covered in detail in her 13-page report appended hereto.* In sum:

- Although the timeliness of **initial** clinic appointments did not appear to be excessive (with the exception of gastroenterology and possibly neurosurgery), the frequency of appointment cancellations for all clinic appointments is 25%, that in addition to the built in scheduling delays, represent further delay in diagnosis and treatment of medical conditions. Cardiology, neurology and gynecology in particular were problematic with respect to appointment cancellations.
- Although data regarding gastroenterology and neurosurgery was not provided, access to G.I. and neurosurgery consultations, however is problematic. Delays of 9 and 10 months for serious matters were uncovered. (See M. LaMarre individual site visit report for charts showing consultation timeliness from Frazier and Hocking inmates.)
- The absence of adequate or specified medical records staff at CMC aggravates the access to records dilemma.
- OSU Bed Space Management: There appears to be no current DRC mechanism to review appropriateness of admissions and length of hospital stay at OSU. Patients are admitted for one reason and worked up for another. This likely increases hospital lengths of stay and hospitalization costs.

* Medical Transportation and HIV Care will be found in her appended full report.

- There is no active bed space management at CMC either. This may result in lack of beds for inmates returning from OSU, or those at other DRC facilities requiring a higher level bed.
- Acute Care Infirmary: Nurse's stations were dirty, cluttered and disorganized. Physicians do not conduct meaningful patient history and physical examinations upon admission to the infirmary. Serious health problems are ignored.
- Health Care Record Review: Six records were reviewed and each had significant problems. One such review is reproduced here (the others, of course) are located in the Appendix A.

D.L.[1]

This 58-year-old was admitted to CMC on 10/5/2004 following a coronary artery bypass graft x 2 in September 2004 that was complicated by MRSA osteomyelitis of the sternum and renal insufficiency. He also has diabetes, hypertension, dyslipidemia, bilateral foot ulcerations, and COPD. Upon admission, the nurse wrote an admission note.

The physician saw him on 10/6/2004 noting two large wounds in his chest that were draining serosanguinous fluid. His assessment was stable and his plan was "see orders." He saw him again eight days later on 10/14/2004 and noted that the wound was clean and planned antibiotics for six weeks. On 10/19/2004, he noted that the patient's hemoglobin was low at 7.0; two days later, a test showed that he had blood in his stool. The patient's white blood cell count was also increased suggesting possible increase in infection. The physician ordered a test to

[1] Inmate number on file with Fred Cohen.

determine the source of GI bleeding (ie.,EGD). There are no further physician notes over the next few days. However, on 10/24/2004 at 1825, the patient complained of chest pain. The nurse documented that she would notify the physician but there is no documentation that she did. The patient complained again at 0130 and the nurse documented a possible MI, and sent the patient out to OSU by squad.

On 10/29/2004, the patient was readmitted to CMC from OSU, having been diagnosed with pneumonia, acute renal failure secondary to vancomycin nephrotoxicity, and MRSA wound infection. The physician saw him on 11/1/2004 and did not reference his recent hospital admission. His assessment is "reasonably stable." The physician did not reassess the patient's recent anemia and GI bleeding. There are no further physician notes until 11/26/2004, however, in the intervening period (according to the OSU discharge summary) on 11/9/2004, the patient developed acute GI bleeding (hemoglobin of 6.8) and was admitted urgently to OSU intensive care unit where he received blood transfusions. He was discharged back to CMC on November 19, 2004. The discharge summary was not in the record.

Summary: The physician did not monitor the patient closely following admission to the unit. This patient had symptoms of acute GI bleeding for which the physician ordered diagnostic studies, however, it appears that inpatient consultations are not treated any differently than outpatient consultations and thus the evaluation was not expedited. Upon the patients return from OSU on 10/29/2004, the physician did not pursue the status of his GI bleeding. From

11/5/2004 to 11/9/2004, as the patient's condition deteriorated, nursing notes are minimal. There are no physician notes during this time. The report of the patient's care at OSU was not in the record, thus the physician and nurses had no idea as to what had transpired. The health records are disorganized because there is no one to file the information. The patient returned from OSU on 11/19/2004 but the physician did not see the patient until 11/26/2004, one week later.

MIT member Barbara Peterson concentrated on infection control, medications, and administration, quality assurance, and record reviews.

INFECTION CONTROL

- In October 2004, there were 12 MRSA cases (3 CMC residents, 9 within 24 hours of arrival at CMC).
- Lack of coordination between members managing different portions of the program.
- Reporting systems for AIDS, Hepatitis, etc. is consistent with federal and state guidelines.
- No infection control surveillance log. MRSA plan was completed in summer of 2004, but there is no evidence of approval, implementation or education.

MEDICATIONS AND ADMINISTRATION

- Staff identifying inmates for medication by "recognition" alone does not meet current nursing standards.
- Medication administration records often have blank spots for important information.
- There is a questionable acceptance of "human error" in dispensing medication (35 errors noted since January 2004.)
- Medication rooms are small and in need of repair.

QUALITY ASSURANCE

- As with other facilities, there is no evidence of CQI initiatives being considered. (See report for CMC efforts.)
- No peer reviews at institutional or departmental level.

RECORDS

- Records are incomplete, hard to read, out of sync with patient care, significant time gaps from the time patients returns to CMC from OSU and receipt of the record of care received at OSU.

CONCLUSION

The above narrative report does not address every issue addressed in the individual reports appended hereto. The significant issues, however, are noted, although the reader/user is advised to consult the full reports.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

RODNEY FUSSELL, et al.,	:	**Case No. C-1-03-704**
	:	
Plaintiffs,	:	
	:	
v.	:	
	:	
REGINALD WILKINSON, et al.,	:	
	:	
Defendants.	:	
	:	

REPORT: ODRC – DENTAL SERVICES

Prepared by: Medical Investigation Team (MIT)

1/26/05

INTRODUCTION

As indicated at the meeting of the parties and the MIT on December 1, 2004, our study of dental care did not receive the same detailed attention as medical care during our site visits. There was no dentist on the MIT nor did we consult with any dentists. Thus, the clinical expertise that underpins the Medical Report is absent from this document.

Issues related to dental care did, however, frequently emerge in the inmate group sessions conducted by Fred Cohen. Other MIT members encountered problems related to dental care while conducting their review of medical records and interviewing staff.

The relevant policies were studied and some important data developed primarily with the help of Ms. Annette Chambers, representing ODRC.

What follows, then, may be viewed as a somewhat incomplete and to an extent impressionistic Report. Should the parties elect to resolve this litigation in a non-adversarial

fashion we feel confident that there is enough here to serve as the basis, for example, of a more comprehensive study and analysis as well as a further review of dental policies and protocols.

Fred Cohen is the principal author and investigator for this document and he accepts responsibility for any of its shortcomings.

POLICY & FINDINGS

Dental Service Policy, No.: 68-Med.-12, revised 4/16/04, is a central dental service provision and, based on our own investigation and a review of the complaint to contractor documents provided to the author, there is a pattern of noncompliance. Section D calls generally for dental screening within seven days of admission and a full dental examination by a dentist with instructions on oral hygiene and preventive care by dentally trained staff within three months of admission supported by needed x-rays.

On a strictly anecdotal level, observation of inmates during site visits disclosed numerous inmates with missing or obviously rotten teeth. Do these conditions lead to health problems associated with inability to properly eat, to problems caused by stress on remaining or healthy teeth, or to avoidable infections? The writer confesses not to know at this point, but believes this is the type of problem worthy of pursuit in the future.

Dental services are extended by private providers with Steven Huber having the contract for 18 facilities and David Donnelly[1] four facilities. There is one institutional civil service dentist at ManCi and Dr. Huling, the Dental Director, provides two days of direct care at London.

There is one dental provider listed for each prison regardless of size or function with additional dental staff ranging from zero (Hocking, e.g.) to a high of three (ManCi and London).

[1] Dr. Donnelly may have been replaced at Lebanon.

Further investigation revealed that there actually is more than one dentist at various facilities (number unknown at the moment) but contractually there is a single private provider.

The most consistent complaint from inmates is they never receive such preventive care as routine examinations, cleaning or scaling.[2] By policy, no root canals to save teeth are ever performed. Another complaint (ORW) relates to braces: If an inmate enters the system with braces, the braces are taken off, not adjusted and not replaced.

There is no data available as to the timeframe for an extraction after the need is established. It was determined that temporary dentures are not provided after teeth are removed and before the permanent dentures are fitted and in place. This, in turn, leads to questions about an appropriate, special diet and there is some evidence that it is not provided or at least not routinely provided. It would be important to know the time lapse between extraction and the receipt of the dentures.

One important indication of the quality of dental care is the extraction-restoration ratio. Annette Chambers kindly obtained that data for the facilities we planned to visit. Those ratios are as follows:

Dental Extraction: Restoration Ratios[3]

CCI:	Extractions	Restorations	
Total:	258	233	A ratio of 258:233 (1.1:1)

CMC:	Extractions	Restorations	
Total:	115	109	A ratio of 115:109 (1.05:1)

[2] Root canals are not performed as a matter of policy.
[3] CRC, PCI, and ORW had the highest ratios of extractions to restorations, in the 3 ½ to 1 area.

SOCF:	**Extractions**	**Restorations**	
Total:	48	28	A ratio of 48:28 (1.7:1)

ManCI:	**Extractions**	**Restorations**	
Total:	216	114	A ratio of 216:114 (1.89:1)

WCI:	**Extractions**	**Restorations**	
Total:	48	54	A ratio of 48:54 (1:1.25)

LeCI:	**Extractions**	**Restorations**	
Total:	115	77	A ratio of 115:77 (1.49:1)

PCI:	**Extractions**	**Restorations**	
Total:	300	84	A ratio of 300:84 (3.57:1)

LoRCI:	**Extractions**	**Restorations**	
Total:	34	56	A ratio of 34:56 (1:1.64)

CRC:	**Extractions**	**Restorations**	
Total:	263	70	A ratio of 263:70 (3.75:1)

DCI:	**Extractions**	**Restorations**	
Total:	52	35	A ratio of 52:35 (1.49:1)

ORW:	**Extractions**	**Restorations**	
Total:	361	111	A ratio of 361:111 (3.25:1)

HCF:	**Extractions**	**Restorations**	
Total:	69	27	A ratio of 69:27 (2.55:1)

At the suggestion of Dr. Shansky, we asked for data on infection control after an extraction. However, we learned that this is not data that is compiled. A case-by-case record review would be required to obtain this information.

By policy, the Dental Director must perform a documented peer review of each dentist employed or contracted by DRC and an audit of each dental clinic at least once every two years. The author reviewed Dr. Huling's audits of the facilities we were scheduled to visit.

Those Audit Reports are brief – typically 1 or 2 pages – with no evidence of inmate input and no imperatives; that is, where a problem is noted there are "suggestions," "be sure to's," "should," and so on. There are no "musts" or "wills."

For the most part, staff is congratulated for good work and offered encouragement and at times prodded (e.g., PCI do scaling after acute problems and before restorative work).

There is no overall assessment of compliance with policy or any sort of evaluation of outcomes or levels of inmate-patient satisfaction. That Dr. Huling appears to do this alone may well answer the question – why not?

On the other hand, the Complaint to Contractor and Complaint to Vendor files are rich with information on nonperformance and show a reasonably high level of internal oversight: impressions for dentures are found hidden in a dental cupboard; screenings within 7 days consistently reported as not done; agreed upon staffing hours not provided; fillings not done on time; a 75% backlog on fillings; three weeks to answer dental kites and then up to 2 months to be seen; 8 kites taken home by dental assistant; on-site providers simply not showing up as scheduled; dental tool inventories not double-checked, and so on.

The Dental Contractor Compliance Database for 2003 and 2004 is quite detailed and further review would be in order to help provide a more complete picture of the pattern of compliance or non-compliance.

With regard to oral surgery, the OSU contract refers to 100 patient visits per month for the oral surgery contract. DRC spent $196,933.71 on this clinic from 8/1/2003 through 6/30/2004.

For the first quarter of fiscal year 2004 (July – Sept.), DRC spent $52,398.15 on the oral surgery clinic.

Inmate James Love, #329-475 of Lebanon Correctional Institution, and a class member, prepared a document for the author entitled "ODRC Systemic Dental Problems Observed." The writer does not by this reference endorse Mr. Love's assertions. He does, however, raise issues worthy of further investigation. In sum, he asserts:

1. Dental equipment is not replaced when use exceeds recommended life expectancy, (e.g., cleaning tools too dull).
2. Failure to replace excessively worn cleaning tools presents risk of transmitting Hep-C and AIDS viruses.
3. Lack of advanced dental cleaning equipment endangers the health of the inmate population in other ways, e.g., cleaning loose teeth with older equipment (v. ultrasound) could result in the loose teeth being pried out.

Again, should this litigation go further and move toward a non-adversarial resolution, it would be prudent to obtain productivity data with regard to the contract dentists; study dental care requests and then resolution, dates inmates are seen, cancellations or failure to appear, and

the like. In addition, inmate education as to dental self-care and the availability of toothpaste, toothbrushes, interdental cleaners, and the like are worthy of study.

There should be further discussion on the utility of preventive measures, measures designed to avoid more expensive procedures thereafter. The writer understands that the case law does not clearly require such measures and this is suggested as a policy measure only.

Further investigation in this area must include dentist productivity data; how much time is spent with how many patients providing what type of service?

Finally, the author undertook considerable legal research on correctional dental care and was surprised at the amount of case law on point. It is still far less than medical or mental health care, but there is enough available to layout the basic, Eighth Amendment requirements for the area at the proper time.