ROBERT B. GREIFINGER, M.D.

August 24, 2014

Mellie Nelson, Esq.
U.S. Department of Justice
Civil Rights Division, Section on Disability Rights
1425 New York Avenue, NW
Washington, DC 20005

Re: Women's Huron Valley Correctional Facility

Dear Ms. Nelson:

This is a report on the medical care provided to women with disabilities at Women's Huron Valley Correctional Facility (WHV) in Ypsilanti, Michigan. My opinions are based on my visit to the facility August 11 - 12, 2015, interviews with staff, review of documents, and review of medical records. I made prior visits in January 2011, July 2012, July 2013, and August 2014 and issued reports on my findings. My opinions are expressed to a reasonable degree of medical certainty. If I receive any additional materials, I may choose to supplement my report. In this report, prisoner identifiers are contained in confidential endnotes.

All of my medical record review was done in conjunction with the WHV health services administrator to assure the reliability and validity of my findings.

Medical and nursing care is provided through a combination of Michigan Department of Corrections (MDOC) employees and contracted physician and mid-level providers through Corizon, Inc. MDOC appointed a new warden to WHV about six months ago.

I found the medical care provided to prisoners at WHV continues to improve, compared to my prior visits. Corizon recently appointed a new medical director for the facility. She intends to focus attention on supervision of the nurse practitioners. However, notwithstanding the improved tone among staff and improved processes, several areas still have opportunities for improvement. These include medication management; clinical supervision; quality management, including clinical performance measurement; and communication between the jail management system, the electronic medical record, and the pharmacy program. I shared my findings with WHV staff and MDOC attorneys at an exit briefing on August 12, 2015.

I was accompanied on this trip by DOJ consultant Joel Dvoskin, PhD, a licensed clinical psychologist, who will report on mental health care and suicide prevention, and James Welch, RN, who will report on nursing practices.

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Findings

Mental Health Care and Suicide Prevention

1. During the past three months, a conductive electrical device (CED) was deployed on two occasions involving three prisoners. I reviewed the medical records and incident reports of the three prisoners on whom a conductive electrical device was deployed.[1] The first woman had serious mental illness and has been difficult for mental health and correctional staff to manage. On the latter occasion, the device was deployed on two women who were having an altercation in their cell. All three women were on the mental health caseload and on medication. A mental health worker saw one on the day of the deployment; the other two were not seen until the Monday following the Friday deployment. Nursing staff documented appropriate care in each case, on the day of deployment.

2. I reviewed the medical records and incident reports on six other occasions during the past three months where the CED was displayed, but not deployed, or, on one occasion, used only to record a medical emergency.[2] In these cases, there was nothing remarkable about the prisoners' medical care.

3. I reviewed the care for the only patient at WHV who was placed in four-point restraints (on multiple occasions) during this calendar year.[3] Dr. Dvoskin will comment on her psychiatric care. The medical records indicate that nursing staff was not taking or documenting vital signs, nor was there documentation of hydration status. I also noted that the custody notices of the dates and times that the patient was restrained were not accurate on both occasions that I reviewed.

   Recommendations: A mental health worker should evaluate any prisoner on whom a CED is deployed within 24 hours. Nursing staff should be trained and supervised to take and record vital signs and document the hydration status, among other things, of inmates who are in restraints. Custody staff should be trained to accurately record and report dates and times that restraints are applied.

Performance Measurement and Quality Management

4. Repeat paragraph from my prior reports: Clinical performance measurement is an evidence-based mechanism to identify opportunities for improvement, typically based on nationally accepted clinical guidelines. WHV staff holds quarterly meetings and performs some measures of access to care, though there is no indication in the minutes of the quality management committee of any presentation or analysis of data.

5. Tracking of patients with chronic disease has improved substantially. This includes reminders for scheduling and stratification of degree of control (e.g., good, fair, and poor) for the purposes of intervention and assessment of performance. The staff has improved its ability to reach out to patients who have missed visits and to intervene with those who have poor control of their disease. This is a meaningful improvement.

6. Repeat paragraph from my prior reports: WHV staff was not able to produce any clinical performance measurement for nursing, medical, or mental health care. I was unable to determine if these data were available and withheld or if there were no such data.

7. MDOC would not produce mortality reviews, even for eyes–only review without taking copies.

   Repeat Recommendations: MDOC should expand its performance measurement to clinical areas, including mental health, following nationally accepted clinical guidelines. MDOC should incorporate its access and clinical performance measurement into the quality management committee meetings, including quantitative and qualitative analysis of data, problem identification, barrier reduction, and follow-through.

Chronic Care

8. At the time of my visit, there were 60 prisoners at WHV who were being followed with diabetes. Of these, 16 were classified as having poor control. I reviewed the records of four of those classified with poor control and one who was not on the list, but who was refusing insulin and was in poor control.[4] The facility medical director treated two of these patients and each of the two nurse practitioners treated the other three. The physician care and documentation was excellent. However, there were opportunities for improvement in treatment planning and documentation for each of the nurse practitioners. One of the diabetics had rapidly increasing weight, A1C hemoglobin, and fasting blood sugars, yet the nurse practitioner did not consider increasing or changing medication. Another was refusing her insulin and the nurse practitioner did not document that she counseled the patient or sought consultation from a physician. The latter patient was also refusing medication for HIV with no indication that the nurse practitioner had informed the physician. The nurse practitioner did not make a mental health referral on this patient, though she should have.

9. Two years ago, I noted very poor monitoring and evaluation of patients on the blood thinner Coumadin. The care was improved in 2014. On this visit, I reviewed the care for three prisoners who were currently on Coumadin.[5] Monitoring and documentation on these patients was excellent. Medication continuity was well documented.

10. I reviewed the medical care for five women with HIV infection.[6] The care for two of them was good. The care for the other three was deficient in medication continuity. One woman was managed by a nurse practitioner who ignored clear documentation that the patient was not taking her prescribed HIV medication or her insulin. This woman should have been counseled extensively by the nurse practitioner and referred immediately to the infectious disease consultant who had seen her by telemedicine, as well as perhaps referred to mental health.

    Recommendations: MDOC should assure continuity of medication for all patients, especially for those patients with chronic disease and/or disabilities. Corizon should immediately enhance clinical supervision of the nurse practitioners who work at the facility to reduce risk of harm and to improve clinical responsiveness, documentation, and clinical outcome. Additional recommendations are addressed in Medication Management section below.

Complaints

11. I reviewed the medical records of nine women who were identified in complaints received by attorneys for the USDOJ.[7] Those complaints that focused on lapses in

medication and medication continuity were valid. These are addressed in the Medication Management section below.

12. Among these complaints, the care for the two who had hepatitis C was acceptable.

13. A patient who was found to be unresponsive and was sent to the hospital had been on psychotropic medication and medication for thyroid disease.[8] Reportedly, she had missed meals, though this was not documented in the medical record. Neither prior to her emergency room encounter, nor afterwards, did any clinician look to see if she was taking her thyroid medication and whether it was effective. In addition, no one sought to determine the cause of her episode of unresponsiveness.

    Recommendations: MDOC should follow the recommendations in the Medication Management section, below. MDOC should assure that morbidity reviews are performed for patients who are sent to the hospital, such as the patient described above in paragraph 13.

Medication Management

14. Medication management remains the foremost problem with the delivery of health care at WHV. I reviewed random medication administration records (MARs) selected from the pile of July 2015 MARs yet to be filed.

    a. Multiple women have serial no-show or refusals of medication.[9] Nursing staff does not consistently note this on the back of the MAR, nor do they notify the prescribing clinician that the patient is not taking their medication. These are documentation, training, and supervision issues that pose a significant risk of harm.

    b. New nurses are not properly documenting medication administration. As an example, there was no documentation of any medication administered to women on several housing units on two different days in late July. This is a training issue.

    c. Neither the pharmacy software system nor the electronic medical records system links to the facility locator system. As a result, a patient may be transferred to another housing unit or released and the nurses administering medication may not know. I noted several cases where the nurses noted serial no-show for patients who had been released, and likewise for patients who had been transferred to the other side of the facility. This is a serious issue for MDOC to address.

    d. In the infirmary, nurses preparing for medication administration were putting medication into little envelopes, labeled solely with the patient's name. This is called pre-pouring. It is an unsafe practice and likely violates the regulations of the state pharmacy board. This is a supervision issue.

    e. There are multiple lapses in medication renewal, on a systematic basis, when the pharmacy technician is off duty or on vacation. This is due to a failure to train competent backup.

    f. There is a flaw in the pharmacy software system that leads to unnecessary lapses in renewals of medication. When nursing staff notifies the pharmacy regarding a

refill, the time window accepted by the pharmacy is too narrow. For example, if nursing staff sends in a notice for a refill one day too early, the pharmacy assigns the prescription to "profile," and it does not get filled when it is due. This leads to unnecessary work for nursing staff, as well as to lapses in continuity of medication that can be life-threatening, especially in the case of medications such as anti-coagulants and HIV medications.

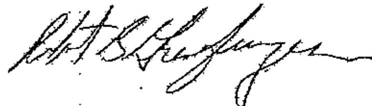
Recommendations: MDOC should measure performance on medication administration at each of the levels described above and should immediately train and supervise nursing staff on Operating Procedure 3.04.100C, Section 95. There is no reason that these deficiencies cannot be remedied in short order.

Copayment policy

15. MDOC policy is for nurses to refer prisoners to a physician when they have had the same complaint three times within a month period. There is a widespread belief among the prisoners that this means that they have to see a nurse three times, and pay three times, before they can access a physician. This misunderstanding of the policy is troublesome and increases distrust between nurses and their patients.

Recommendation: MDOC should train nurses on the correct policy, distribute a clarification to prisoners, and monitor to make sure the copayment policy is properly administered.

Sincerely,



Robert B. Greifinger, M.D.

Confidential Endnotes

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