ROBERT B. GREIFINGER, M.D.

September 8, 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 27 – 28, 2014, interviews with staff, review of documents and review of medical records. I made prior visits in January 2012 and July 2013 and I 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 health services administrator to assure the reliability and validity of my findings.

Medical and nursing care is provided through a combination of MDOC employees and contracted physician and mid-level providers through Corizon, Inc. The reorganized program has clarified lines of authority and accountability. This has led to a reduction in barriers to timely access to appropriate care for many prisoners.

I found the medical care improved in many areas, compared to my last visit. There are some notable exceptions, listed below, in the areas of acute care, performance measurement and quality improvement, and medication management. I shared my findings with WHV staff and DOC attorneys at an exit briefing on August 28, 2014.

Findings

Mental health care and suicide prevention

1. 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.
2. During the course of my visit, I identified six current prisoners in segregation who had prescriptions for antipsychotic medication.[1] Dr. Dvoskin will evaluate these cases.

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Acute Care

3. In my report, dated July 23, 2014, I noted that WHV was deficient in dealing with a patient with acute mental illness who was not eating or drinking. In that case, there was poor communication between nursing, medical, and mental health staff members, and no treatment plan. The case resulted in a life-threatening case of dehydration.

4. Patients on hunger strikes have reasons for not eating and/or drinking such as psychosis or anger. A hunger strike is a life-threatening condition. On this visit, a similar case came to my attention.[2] This woman had a long, documented, history of mental illness. She first became symptomatic at WHV on May 23, 2014, when she became incontinent of urine. She flooded her cell on June 13, 2014 and was "treated" with discharge of a conductive electrical device, with no referral to medical or mental health staff.

5. She became agitated and apparently psychotic in June 2014 and was put into segregation on June 17, 2014 for observation for what was initially diagnosed as schizoaffective disorder on her third day in segregation, and diagnosed as psychotic, mania by the facility psychiatrist on June 19, 2014. On June 18, 2014, the psychiatrist documented that she should be scheduled for a PA 252 hearing, an internal medicine evaluation, and laboratory testing. None of these three intentions were fulfilled.

6. She was noted on multiple occasions to be confused, anorexic, and urinating on the floor. She had daily mental health and nursing visits. On June 20, 2014 she was smearing her food. She continued to decompensate and was noted to be refusing food and water on some occasions. She was seen on multiple occasions by nursing staff, a psychiatrist, and mental health staff, but she never had the medical examination or laboratory tests. Staff also failed to monitor her weight, her vital signs, and her intake and output.

7. On June 25, 2014, she was admitted to St. Joseph's Medical Center with severe dehydration and severe neurological impairment. She has been residing in Duane Waters with continuing severe neurological deficit.

8. This patient never had a treatment plan, other than the psychiatrist's plan on June 18, 2014, a plan that was never actualized.

9. This is another case where poor communication among members of the health care staff led to serious harm.

10. I evaluated the care received by seven WHV prisoners who had emergency department visits for ambulatory-sensitive conditions between January and June 2014, i.e., to determine whether their care prior to the visit might have affected the outcome and whether care following the visit was responsive to the hospital findings. The care for all seven at WHV was acceptable.[3] This is an improvement.

    Recommendations: MDOC should monitor health care for prisoners on hunger strike and implement appropriate training to include, among other things, query and counseling on the reason for the hunger strike and medical monitoring to prevent serious deterioration and the need for hospitalization. Training and supervision should be provided to improve accountability for care, treatment planning, and improved communication among health care staff members.

Performance measurement and quality management

11. Repeat paragraph from my prior report: 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. The appropriately self-critical measures demonstrate opportunities for improvement, but there is no documentation of any action to improve access and re-measurement to evaluate the effectiveness of the intervention.

12. There is now some tracking of patients with chronic disease, such as diabetes, for timely follow-up and control, but no analysis of data in these areas.

13. Repeat paragraph from my prior report: WHV staff was not able to produce any clinical performance measurement for nursing, medical, or mental health care. It is possible that Corizon has been doing clinical performance measurement, but MDOC staff was not aware of it.

    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

14. I evaluated the chronic care for eight prisoners who had come to the attention of USDOJ. The care for four was acceptable and the care for one other was acceptable, except that there was no documentation of evaluation for her complaint of vaginal discharge.[4] The care for three had opportunities for improvement. One prisoner, with hearing impairment serious enough for her to have a pager, had not had an audiology evaluation in more than two years of imprisonment.[5] A second patient had a stroke related impairment of her upper extremity, for which she was prescribed and authorized to have a wrist brace; she never got the brace.[6] A third patient had viral hepatitis C, for which she had had unsuccessful treatment in 2013.[7] She was appropriately discharged from care for her illness in December 2013; however, new therapies have been available in MDOC since April 2014. This patient needs evaluation for the possibility of treatment with this newly available medication.

15. During my last visit, I noted very poor monitoring and evaluation of patients on the blood thinner Coumadin. On this visit, I reviewed the care for eleven prisoners who were currently on Coumadin. Monitoring and documentation on these patients was greatly improved, compared with July 2013. The care for ten of the patients was excellent.[8] One patient had missed four doses of medication, yet there was no documentation that the prescribing clinician was notified.[9]

    Recommendations: MDOC should assure continuity of care for all patients, especially for those patients with chronic disease and/or disabilities.

Medication management

16. I reviewed west side medication administration records for the month of August. I noted multiple serial refusals on patients with prescriptions for psychotropic medication (and one on thyroid medication), yet there was no documentation in the medical or other records that the prescribing clinician had been notified that their patients were non-adherent to medication.[10] In fact, many of the progress notes documented that the patients were "compliant" with medication, when they were not. Notably, all but one of these patients were not getting their evening medication. This is a good starting point to analyze for system failures. The matter of missed medication is a serious communication issue between nursing and medical staff.

Recommendations: MDOC should measure performance on medication administration and should train and supervise nursing staff on Operating Procedure 3.04.100C, Section 95.

Sincerely,

Robert B. Greifinger, M.D.