ROBERT B. GREIFINGER, M.D.

July 23, 2013

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 July 17 – 18, 2013, interviews with staff, review of documents and review of medical records. I made a prior visit in January 2012 and issued a report on my findings on February 3, 2012. 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.

Since my last visit, the MDOC has reorganized the medical care at WHV. Mental health care has been consolidated and is now operated with MDOC employees, supplemented with contract staff through MHM, Inc. Medical and nursing care is provided through a combination of MDOC employees and contracted physician and mid-level providers through Corizon, Inc., a successor corporation to Prison Health Services, 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.

However, based on my review of medical records, I found significant opportunities for improvement to reduce the risk of harm to prisoners, particularly to those with disabilities.

Findings

Mental health care and suicide prevention

1. The MDOC is in the process of codifying its directives and operational procedures for mental health services and has issued the first of three directives. The other two (on suicide prevention and managing disruptive behavior) are in draft form and are scheduled for implementation later in the calendar year.

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2. WHV is piloting a program of dialectic behavior therapy for patients with serious mental illness and/or personality disorders. Staff is optimistic regarding outcomes for those enrolled.
3. The number and rate of suicide attempts have declined. This is a positive achievement.
4. Initial training in suicide prevention is provided person-to-person, but ongoing training remains online only. MDOC has not provided special training for health care personnel, but plans to do so.
5. WHV continues to use inmates to provide 1:1 suicide watch and has continued the policy of alternate day mental health visits to those on 1:1 watch. In practice, the alternate day policy is alternate *weekdays*, wherein there are three-day lapses on holiday weekends. These policies and practices do not conform to the recommendations of DOJ suicide prevention expert, Lindsay Hayes.
6. We were repeatedly told that these watches are supplemented by constant video surveillance of the cells. However, when I visited Unit 1, there was no one observing the camera monitors.
7. MDOC has expanded and clarified the criteria for being put on the mental health caseload. The current caseload is about 700 of the 2,000 women prisoners in the facility. This is an improvement, however, barriers to access to the caseload remain, for example, the patient discussed in the section of this report on hunger strike.
8. Mental health treatment planning has improved for mentally ill patients who are housed in the residential treatment facility (RTF), however documentation of treatment planning for patients on 1:1 suicide watch is highly deficient. I reviewed the records of seven patients on the RTF at the time of my visit.[1] Six of the seven had treatment plans. Of seven patients on suicide watch, however, only two had documentation of mental health treatment planning.[2] These latter two were vague and not helpful.
9. Counsel for MDOC identified three "serious" suicide attempts in the past six months.[3] The care for one of these was highly deficient.[4] On January 2, 2013, this patient saw mental health professional L. The patient told the mental health professional that she was taking only one of the three prescribed tablets of Trazadone because it made her sleepy. L. documented this in the record, but apparently did not notify the prescribing practitioner or the nursing staff. The patient continued to receive three tablets daily and overdosed on the Trazadone nine days later, whereupon she had to be sent to the hospital.
10. The consolidated mental health program has better lines of authority and accountability. Directives and operating procedures are not fully implemented, nor is suicide prevention planning for health care staff. The criteria for being on the mental health caseload are improved.

    MDOC 1:1 watches and mental health staff follow-up on suicidal patients fall below national expectations.

    Treatment planning for prisoners on 1:1 watch is deficient, though it has improved for patients in the RTF.

In at least one instance, mental health staff neglected to inform the prescribing practitioner that her patient was not taking prescribed medication, though the patient continued to receive it.

Recommendations: MDOC should fully develop and implement its planned directives and operating procedures and implement appropriate training for health care staff. Suicide watches and follow-up should conform to Lindsay Hayes' recommendations. Treatment planning for prisoners on suicide watch should be monitored and improved. Mental health staff should be re-trained and monitored to prevent communication lapses that can result in serious harm to patients, including overdose and the need for hospital care.

Use of force

11. MDOC would not produce a list of occasions where conductive electrical devices (CED) (known as Tasers) were deployed. I had been interested to determine whether nursing and/or mental health staff had been involved for patient evaluation and treatment, where appropriate. I did find one occasion where a CED was deployed.[5] In this case, there was no documentation in the medical record that nursing or mental health staff evaluated the prisoner immediately before or after the deployment. It is critical for health care staff to evaluate the prisoner in these cases, since many highly agitated prisoners (where a CED is deployed) are mentally ill.

Recommendations: MDOC should assure appropriate nursing, medical and mental health involvement where use of force has been deployed, especially with the use of CEDs.

Hunger strike

12. 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. I identified one patient who was not eating, drinking, or taking her medication for five days.[6] She ultimately got severely dehydrated, as indicated by her pulse rate of 144 beats per minute, and was sent to the hospital emergency department (ED) for hydration. That heart rate indicates that the patient was close to being in shock. There is no indication in her medical record that any one asked her why she wouldn't eat or drink, though she was seen daily by nursing and mental health staff. Therefore, there was no treatment plan because no one inquired as to the reason. Further, though it is policy to weigh patients on a hunger strike daily, not one weight was recorded in the medical record during her episode of illness.

13. This patient was not put on the mental health caseload until nine days following the treatment in the ED.

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.

Performance measurement and quality management

14. 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.

15. 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.

    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

16. During my last visit, I found chronic care to be acceptable, except for the recording of peak expiratory flow on patients with asthma.

17. On this visit, I reviewed the chronic care for six patients with moderate or severe asthma.[7] I identified these patients from the list of prisoners with current prescriptions for inhaled controller medication for asthma, e.g., the inhaled corticosteroid beclomethasone dipropionate HFA. Appropriate documentation of chronic care visits and measurement of peak expiratory flow rate was excellent in all six patients.

18. I did note one patient who had no chronic care visit for her chronic hepatitis C for 11 months.[8]

19. My most startling finding was the care for patients on the blood-thinning medication Coumadin. Blood-thinners are used to prevent life-threatening blood clots for patients at high risk, such as those with atrial fibrillation or deep vein thrombosis. There is a narrow therapeutic index with this medication, requiring repeated laboratory monitoring of clotting potential called INR, typically every two weeks. If the level is too high there is risk of death from hemorrhage and if the level is too low, the patient is at risk of death from a blood clot to the brain or lungs. At the time of my visit, I reviewed the records of all seven patients with a current prescription for Coumadin.[9] Only one of these seven has had an INR measured since June 4, 2013.

20. The reason for the lapse in care for patients on Coumadin was a personnel change. The lead physician left the facility in early June 2013. He had managed the care for these seven patients. MDOC and its vendor, Corizon, failed to transfer the assignment of these patients, putting six of the seven at high risk of life-threatening consequences.

    Recommendations: MDOC should assure continuity of care for all patients, especially for those patients with life-threatening conditions such as those on Coumadin.

Acute care

21. Performance on acute care was poor. I reviewed the records of 19 patients who were sent to the ED during the past three months. Each of these patients had an ambulatory care sensitive condition, i.e., a condition that may have been amenable to better ambulatory care in the facility either prior to or following the hospital visit. The care for five of the 19 patients was acceptable, with appropriate care and documentation prior to and following the ED visit and/or hospitalization.[10]
22. Patient ST filed multiple sick call requests for difficulty breathing.[11] She was not seen for five days when she was sent to the hospital with pneumonia. She had an x-ray that was read as abnormal three days after returning to the facility, yet she had no further follow up to assess her recovery.
23. Patient BR filed a request for care for shortness of breath and an officer referred her to the medical unit for the same problem nine days later.[12] There is no documentation that she was seen by a provider
24. Patient HA may have had a seizure.[13] She was sent to the ED, but had no outbound or inbound nursing notes and no follow-up, despite a recommendation from the ED that she have a neurologic evaluation.
25. Patient RO also had a seizure and head injury, but received no follow-up evaluation or care.[14]
26. Patient CA was discussed above in the section on hunger strike.
27. Patient KE is discussed in the Coumadin cohort, discussed above.[15]
28. Patient DU was sent to the ED for abdominal pain, yet there is no documentation of any follow-up in her medical record.[16] Likewise for Patient SN.[17]
29. Patient AL had a 14-day lag to receiving a first dose of medication, though it had been verified.[18] As a result of that delay, she had a seizure and had to be sent to the ED.
30. Patient WE was found unresponsive and sent to the ED.[19] There was no inbound progress note, no record of the emergency room visit in the medical record, and no follow-up in the facility.
31. Patient DA was sent to the ED because of chest pain and returned with a diagnosis of epigastric pain.[20] She had no follow-up evaluation or treatment documented.
32. Patient LA had a stroke and stayed in the hospital for five days, yet she had no physician evaluation or follow-up on her return.[21]
33. I also evaluated the care for nine patients provided by mid-level practitioners. The records were derived from clinic logs. The care for six of those patients was acceptable.[22]
34. Patient HA had to wait five days to be seen for a painful acute ear infection.[23]
35. Patient JO received an injection of a powerful corticosteroid, with no written order and no progress note to describe the rationale and plan.

36. During my review, I found lags to medication that caused harm, including one trip to the ED. I found lags to access to acute care that caused harm, including several trips to the ED. I found very sloppy care and documentation around ED trips for ambulatory sensitive conditions that resulted in no follow-up for patients with serious medical needs.

    Recommendations: MDOC should monitor the timeliness and quality of care, medication, and follow-up of patients with acute conditions and implement remedies.

Staffing

37. The health services staff vacancies have been reduced substantially since my prior visit. On the first day of my tour, there were 4.0 registered nurse vacancies, 4.0 LPN vacancies, and no vacancies for physicians or mid-level providers.

38. Staffing levels have improved to an acceptable level.

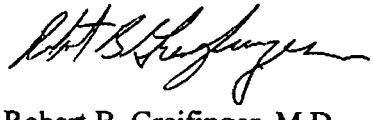
Ethics

39. During my review of medical records, I noted that mental health staff was seeing patients for "parole evaluations." I learned from the chief psychiatrist that there is no written policy distinguishing summary of pertinent information for the parole board and performing evaluations for the purpose of making parole recommendations. The latter would be an ethical lapse if the recommendation were to be used in any way to lengthen prison stay.

40. While I did not note any specific case of an ethical lapse, I believe that MDOC should have a written policy that prohibits health care staff treating a patient from participating in any forensic evaluation of that patient.

    Recommendations: MDOC should assure that mental health staff is trained on the difference between an evaluation for the purposes of treatment with evaluation for the purpose of determining sentences and parole. A written guideline would be very helpful as a basis for this training.

Sincerely,



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Confidential Endnotes