STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
P.O. Box 41100 • Olympia, Washington 98504-1110

November 19, 2020

Joanna Carns
Office of Corrections Ombuds
2700 Evergreen Parkway NW
Olympia, WA 98505

Dear Ms. Carns:

The Washington Department of Corrections appreciates the opportunity to respond to the OCO Report on the 'the incident review' completed by the Office of Corrections Ombuds.

Recommendation	Response
Employ an experienced patient advocate at every facility. Effective provider-patient communication positively influences health outcomes by increasing the patient's comprehension of their diagnosis, contributing to better treatment adherence, and improving overall patient satisfaction. Aside from assisting patients with navigating DOC's complex health care system, a patient advocate could facilitate communication and strengthen provider-patient relationships before they deteriorate beyond repair.	Health Services has submitted a budget decision package, which was submitted for legislative consideration requesting resources needed to improve patient-centered care. The proposal recommends nine non-clinical care navigators placed in the major facilities to chaperone patients through the care process to ensure timely access, and remove barriers to care. Meanwhile, the Department's quality care team has now initiated a review of the health-related grievance process to reinforce patients' ability to self-advocate in their own care plans.
Require a clinician evaluation after every declared medical emergency. This has been a recommendation in several recent OCO investigations, since the lack of full evaluation following a declared medical emergency has led to negative outcomes, including death. DOC should implement a clear policy and procedure that requires a full evaluation by a physician or advanced practitioner after every declared medical emergency, to ensure that diagnosis do not get missed.	Procedures to ensure appropriate follow up care after nursing encounters are under review. A quality improvement project has been initiated to analyze and optimize the process for reliably linking a patient to follow-up care at a pilot facility with a high number of emergency care visits. A clinical nurse educator is working with RN3s from Monroe Correctional Complex to establish a baseline process for nursing staff to follow which will include tracking of the patients and appropriate follow up scheduling with a practitioner. The team is now meeting biweekly to monitor progress and determine next steps to evolve the process with the goal

	to establish performance measures that can be shared with other facilities.
Educate medical providers on the components of a geriatric assessment, including how to assess for fall risk. Falls in older persons are a common occurrence and often result in an injury. While these are usually minor soft tissue injuries, they can sometimes involve significant trauma such as fracture, head injury, or major lacerations. • Incorporate an assessment of fall risk into the intake history and physical examination of all incarcerated individuals age 50 or older. A Timed Up and Go Test, as an example, can be performed in twelve seconds and therefore would not represent a significant increase in the time it takes to perform an intake physical. • Require a formal multifactorial fall risk assessment to ensure the safety of those who experience recurrent (two or more) falls, report difficulties with gait or balance, or seek medical attention or declare a medical emergency because of a fall. DOC has provided training on the Hendrich II Fall Risk Model in the past, but it does not appear to be routinely and consistently utilized.	The Department has signed a contract to make use of the Hendrich II Fall Risk Model (HIIFRM) for the Department's nursing program. The Department's nurses are now being entered into the HIIFRM system. The Department's director of nursing, health services administrator and nurse educators are reinforcing ongoing training module for departmental nurses of the HIIFRM. The Department acknowledges that a fall risk assessment should be required for those with mobility and/or an identified fall risk and can work toward codifying that requirement after the completion of widespread training. The Health Services (HS) Continuous Quality Improvement Program (CQIP) committee plans to review the US Preventive Services Task Force recommendations regarding identifying older individuals at increased risk for falls by the end of calendar year 2020.
Develop a formal protocol for determining when a geriatric patient needs a wheelchair to assist with daily activities. • Support the justification for – or refute the need for – a wheelchair through a formal functional assessment of the patient, rather basing the decision on subjective opinion. For geriatric patients in the community, physicians collaborate with their physical therapy colleagues to make this determination. Since DOC employs or contracts with its own physical therapist(s), such	The DOC HS CQIP committee plans to review the topic of assessment for geriatric mobility device by the end of calendar year 2020, with the goal of identifying ways to provide practice support for appropriate and consistent device prescribing.

collaboration should be easy to implement. • Create a checklist which outlines the criteria that should be met to issue a wheelchair prescription, so that decisions are consistent throughout the system. • OCO consultation with two separate orthopedic surgeons advised that patients with a history such as the Incarcerated Individual's are always maintained in either non-weight-bearing or "touch-down" weight bearing status until re-implantation of the joint prosthesis, since bearing weight on the spacer could result in damage to or dislocation of the spacer, or could cause erosion and/or deformation of the remaining bone. Given that these expert opinions conflict with the information which DOC obtained in the course of the Incarcerated Individual's care, DOC should utilize the specialists available through their existing RubiconMD contract to assist with the final decision for wheelchair appropriateness by providing an external, unbiased community perspective.	
Review DOC 610.650 with all medical staff, particularly the section on Emergency Health Care Services. Remind all staff that the incarcerated individuals have the right to declare medical emergencies, and they should not be denied access to health care.	During the November 5 Health Services Manager meeting, DOC policy 610.650 was reviewed with all health services managers and facility medical directors. There was an expectation made that they would remind all staff at their local levels of providing access to health care and not prohibiting the declaration of medical emergencies. Specifically, "a patient reporting a health emergency will not be denied access to health care, including evaluation and clinically indicated treatment, even when there is suspicion or history of abuse of the emergency medical system.

	Allegations of abuse of the medical emergency system will be referred to the Health Services Manager/Health Authority/designee after health care is provided."
Develop a formal <u>administrative</u> procedure for determining when a patient has misused the medical emergency system. Through the relationship between a provider and a patient, data is gathered, diagnoses are made, treatment plans are developed, treatment compliance is accomplished, and healing can occur. Therefore, infractions should not be issued by providers since this can damage the provider-patient relationship and negatively affect healthcare outcomes. • Assign the issuance of healthcare-related infractions to the facility's health services managers, although providers should offer relevant information for decision-making. • Include the facility's mental health provider(s) in the discussion, since misuse of the medical emergency system may signal an underlying mental health diagnosis that requires treatment.	Local multi-disciplinary teams, to include medical, mental health and nursing staff, at their weekly or bi-weekly (dependent on facility) will discuss patient behaviors when believed to be abusing the medical emergency system and the team will discuss the best manners to work through any abuse of the system, to include treatment of underlying diagnosis, if identified.
Strengthen the process of determining who is eligible for medication-assisted treatment. Denial of medication-assisted treatment for "behavioral issues" in a patient who would benefit from such treatment should require a mental health evaluation, rather than an opinion from a medical provider.	An updated protocol for the induction of medication for opioid use disorder has been posted which includes specifics regarding the identification of candidates for this treatment, as well as considerations for management and specialist support in cases complicated by suspected diversion.
Permit Violator patients to keep healthcare appointments that were scheduled prior to incarceration, provided that the care is consistent with the Washington DOC Health Plan/Offender Health Plan. This not only allows the patient to receive appropriate care without delay, but also helps keep the patient	Health Services practitioners can and have worked to get patients in custody on violation to their pre-existing community appointments. If a patient discloses a medically necessary follow up appointment upon intake screening, the practitioner can include that information in the scheduling referral and, if possible, the

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connected to a community provider so that care can continue upon release from DOC.	community custody officer can provide transportation.

The information provided by the OCO was useful to ensure the Department of Corrections is doing everything it can to ensure an incarcerated person's time in the agency's facilities is a fair and safe space for all incarcerated individuals.

We also appreciate your team's understanding of the unique processes across facilities and the addition of policies and procedures being put in place to address them. We are working towards proactivity and improving quality assurance processes throughout the department. Moving forward, Washington Department of Corrections will continue to collaborate with the Office of the Corrections Ombuds to implement additional policies, procedures, and security measures to continue to improve the facility operations.

Sincerely,

Steve Sinclair, Secretary
Washington Department of Corrections