STATE OF WASHINGTON

OFFICE OF THE CORRECTIONS OMBUDS

2700 Evergreen Parkway NW • Olympia, Washington 98505 • (360) 664-4749

March 8, 2020

Steve Sinclair, Secretary
Department of Corrections (DOC)

Office of the Corrections Ombuds (OCO) Investigative Report

Attached is the official report regarding the OCO investigation into the death of an incarcerated individual. We appreciate the opportunity to raise concerns regarding the delays in medical treatment provided to the individual, the lack of response to his grievances regarding his medical treatment, and the need for improved processes to ensure individuals with cancer receive timely treatment. We look forward to working with DOC to amend current policies and practices to better ensure that all incarcerated persons' health, safety, and rights are protected while they are within state confinement.

Any member of the public who wishes to report a concern to OCO is welcome to contact the office at (360) 664-4749 or at the address above. All concerns are logged into the OCO database and used as part of its overall reporting to policymakers and analysis of issues within DOC.

Sincerely,

Joanna Carns

Joanna Carns
Director

cc: Governor Inslee

OCO INVESTIGATION
INVESTIGATION CONDUCTED BY CAROL SMITH, ASSISTANT OMBUDS - HEALTH CARE SPECIALIST

Summary of Complaint/Concern

On August 8, 2019, the Office of the Corrections Ombuds (OCO) received a complaint, on behalf of an incarcerated individual, which alleged the following:

- The complainant was diagnosed with squamous cell cancer in his right ear canal and did not receive the necessary and recommended cancer treatment. The complainant stated, "By DOC not providing me treatment, they have decided my fate and are determining I do not deserve to live."

- The complainant alleges DOC failed to follow medically necessary and recommended treatment of Chemotherapy and Radiation for his cancer diagnosis. The complainant also reported several canceled Oncologist appointments with no explanation provided to him. This failure to follow treatment recommendations has resulted in the complainant being terminally ill from cancer.

- The complainant further alleges the lack of response to his medical complaints when he followed DOC's kite and grievance policy. The complainant alleges he received delayed responses, non-responses, and at one point was reprimanded for asking for cancer care and treatment.

OCO Statutory Authority

- Per RCW 43.06C.005, OCO was created to assist in strengthening procedures and practices that lessen the possibility of actions occurring within DOC that may adversely impact the health, safety, welfare, and rehabilitation of incarcerated individuals, and that will effectively reduce the exposure of DOC to litigation.

- Per RCW 43.06C.040, OCO has the authority to receive, investigate, and resolve complaints related to incarcerated individuals' health, safety, welfare, and rights.

OCO Investigative Actions

- As part of this investigation, OCO reviewed DOC's policy outlining cancer care within the Offender Health Plan.

- OCO reviewed related kites/grievances, contacted incarcerated individuals, reviewed medical records, interviewed DOC staff and external providers.

- OCO was able to verify facts through medical documentation, DOC policy review and interviews.

OCO Summary of Incident

- This complainant received a life threatening cancer diagnosis and was informed he would receive treatment. A series of bureaucratic delays resulted in the individual not receiving care for five months while waiting on a transfer to a facility closer to where staff determined that his treatment would be provided; meanwhile, he was not provided treatment at his current facility.

- Even after transfer to the new facility, treatment was not provided and soon thereafter it was determined that his cancer had progressed too far for chemotherapy. Palliative immunotherapy was provided, but radiation therapy suffered additional delays. The complainant ultimately decided to refuse radiation therapy.

- Further, the kite and grievance procedures failed to do exactly what they are designed to do: communicate concerns with the medical provider for follow up and ensure the complainant was receiving necessary treatment. The complainant's kites and grievances were often returned for rewrites and then were administratively withdrawn, or received either nonresponses and/or minimizing responses.

Timeline of Diagnosis and Treatment

- February 27, 2018 – Complainant was seen for right ear pain and hearing loss. Diagnosed with otitis externa left [sic] ear and treated with antibiotic drops. To have follow-up in one week.

- March 6, 2018 – Complainant was seen by practitioner for ongoing right ear pain with intermittent discharge. Oral antibiotics prescribed; to have follow-up in two weeks.

- March 16, 2018 – Complainant returned to practitioner; pain was worse, there was increased drainage, and eardrum was possibly ruptured. Given another course of a different oral antibiotic.

- March 26, 2018 – Complainant returned to practitioner. Pain was even worse after treatment with both antibiotics, and had spread to behind the ear and into the jaw; there was decreased hearing. Given another course of antibiotic ear drops; plan was to prescribe a new oral antibiotic the next day.

- March 29, 2018 – CT scan of the orbits showed findings concerning for osteomyelitis [infection of the bone]. ENT consult and MRI were recommended.

- April 4, 2018 – Complainant seen by ENT who recommended six week of culture-directed antibiotics, along with ID consult and MRI of the skull base.

- April 18, 2018 – MRI was markedly abnormal. Admitted to the hospital, treated with IV antibiotics. Discharged on April 23 with plan to continue IV antibiotics for six weeks.

- May 15, 2018 – Complainant returned to ENT. Biopsy performed.

- May 17, 2018 – Pathology report from tissue biopsy revealed squamous cell carcinoma. Recommended neuro-otology consultation for temporal bone resection [surgery].

- June 1, 2018 – Complainant seen by neuro-otologist. Diagnosis was that it was either malignant otitis externa [an infection] or cancer. Pathology slides were to be reviewed by UW pathologists. At this point, the complainant first received the diagnosis of potential cancer. The note stated the patient is upset about the news given to him by the outside provider and the "Pt reassured to give it time and his issues will be sorted out."

- June 4, 2018 – Re-review of the slides again confirmed cancer.

- June 12, 2018 – Despite the above confirmation, the patient's medical chart states Malignant Otitis Externa +/- Squamous Cell Carcinoma. "Will require surgery scheduled ASAP."

- June 18, 2018 – The complainant was admitted into the Infirmary with a diagnosis of Malignant Otitis Externa/Squamous cell in the right ear.

- June 21, 2018 – Surgery was performed on the tumor and partial lateral temporal bone resection of the right ear.

- June 29, 2018 – Case reviewed by UW Tumor Board. Recommendation for CT scan.

- July 20, 2018 – CT scan showed slight progression of findings involving the right temporal bone, felt to be due to cancer.

- July 24, 2018 – Complainant seen again by neuro-otologist. Recommended immediate referral for oncology and radiation.

- August 20, 2018 – Seen by medical oncologist. Complainant wanted to stay closer to Shelton, so the plan was to refer to "radiation oncology in Olympia and subsequent medical oncology care locally." This did not happen.

- August 28, 2018 – Seen by neuro-otologist. "Being geared up for chemoradiation." Again, no appointments occurred.

- August 31, 2018 – Seen by medical director, "to see Rad Onc in Olympia and will be referred to Oncology at recommendation of UW ENT." Again, no appointments occurred.

- September 10, 2018 – Seen by radiation oncology, who recommended additional tests, referral to medical oncology and CT simulation. Medical oncology appointment did not happen until January and the CT simulation was scheduled but then cancelled.

- October 3, 2018 – The tumor was observed protruding from the right posterior auricle and squirting blood.

- October 24, 2018 – Complainant seen by practitioner. Patient "would like to know when [treatment] will start."

- November 13, 2018 - Complainant was officially transferred to MCC. The chart notes read, "Authorized for radiant care at UWMC, will begin radiation soon." Cancer treatment was not scheduled nor initiated.

- November 16, 2018 – Medical provider at MCC sent an email stating; "I really appreciate the great hand-off with this guy. He is doing about the same. At his last neuro-otology appointment, they still did not recommend surgery and emphasized the importance of radiation treatments. Our scheduler is getting the radiation lined up with oncology, so that should happen soon." No chemotherapy or radiation was scheduled or provided.

- November 30, 2018 – The complainant's chart notes state, "Radiology Tx Scheduled." No cancer treatment was scheduled or initiated.

- December 12, 2018 – Complainant seen by radiation oncology. "Still has not had postop chemorads as recommended." Patient had a progression of symptoms.

- December 19, 2018 - Complainant's chart notes state, "Pt was advised that Radiation is "futile" at this point in his disease progression."

- January 4, 2019 - Complainant's medical chart notes stated the provider had a discussion with the complainant surrounding end of life cancer care. From this point forward, the treatment became focused on pain management. All future medical appointments consisted of changes or increases to pain medications such as; Oxycodone, Morphine, Xylocaine, Acetaminophen and Ibuprofen.

- January through March 2019 – Complaint recommended for palliative immunotherapy and underwent three cycles.

- May 9, 2019 – Complainant seen by medical oncology. Disease progression noted despite immunotherapy. Medical oncologist felt it was difficult to justify continued treatment given significant side effects and no benefit. Short course of palliative radiation recommended. Complainant willing to consider in the future.

- June 14, 2019 – Complainant interested in palliative radiation.

- July 2, 2019 – Complainant given medications for increased pain; no mention of the palliative radiation.

- July 30, 2019 - The case was discussed with Oncology and the provider chart notes state palliative radiology may still be of benefit. This was an attempt to control the ear pain, headaches, bleeding and oozing from his ear and other cancer symptoms.

- August 15, 2019 - The MCC medical provider stated in her chart notes they, "Discussed with the FMD and emailed to try and schedule radiation oncology sooner."

- August 27, 2019 - The MCC medical provider documentation stated, "Scheduled for radiation oncology f/u very soon-will follow up with their recommendations."

- August 30, 2019 – Complainant seen by radiation oncology. Plan was palliative radiation over 4-6 weeks daily. Was to return "soon" for CT simulation and MRIs.

- September 30, 2019 – Complainant seen by radiation oncology. MRIs showed further progression of disease. Plan was palliative radiation in two weeks.

- October 15, 2019 – Complainant finally scheduled for first treatment. The complainant decided against radiation due to it not having any lifesaving measures attached to the treatment.

- January 1, 2020 – Complainant passed away.

OCO Findings

- OCO substantiated the complainant had a diagnosis of ear cancer which required immediate medical treatment. This diagnosis and the need for medical treatment was directly communicated to the facility medical providers; unfortunately, no cancer treatment was provided.

- OCO substantiated that this complainant met the DOC policy criteria for ongoing cancer treatment, which included the recommended treatment of chemotherapy and radiation for life saving measures. Although OCO found several emails, medical documentation and chart notes that reflected the complainant's need to be scheduled for cancer treatment or that stated that appointments would be scheduled "soon," neither chemotherapy nor radiation treatment occurred, either at the complainant's first facility nor after he transferred to Monroe Correctional Complex.

- OCO substantiated through a chain of emails that there were several bureaucratic processes and disorganized communication that impeded the complainant's transfer to a

facility for cancer treatment and directly impacted the failure to treat him. Despite the patient's diagnosis of cancer, he had to be approved by both a medical transfer committee and then by an LWOP (Life Without Parole) committee, both of which processes were delayed, and then by the time he was approved, the receiving facility was reportedly "full," resulting in another delay. He further was impacted by the transition of his original medical provider to Headquarters, which should have elevated and assisted him receiving attention, but instead it appears that he fell into a gap, with a sole Physician Assistant repeatedly and persistently trying to notify as many people as possible as the months dragged on.

- In an email sent September 10, 2018 – several months after the first diagnosis of cancer and two months after the complainant was told he would be transferring to MCC for treatment – the complainant's case had not even been presented to the transfer committee for review. A Physician Assistant at Washington Corrections Center asks the Facility Medical Director (FMD), who was transferring to Headquarters, how to proceed with the patient. The FMD responds that he is "happy to help out" but that day-to-day care needs to transfer to another doctor and that he is "pretty sure" that he had submitted necessary documentation and referrals for continued care.

- On September 25, 2018, an email indicates that a patient's medical trip was canceled because he was transferring. At this time, he still had not been presented to either the transfer committee nor the LWOP committee, as documented below.

- On October 8, 2018, the Physician Assistant emailed the acting FMD at Washington Corrections Center (WCC) to inquire into whether the complainant had been presented to the medical transfer committee for the transfer to Monroe. The response from the new FMD was that the complainant's case had not even been presented yet due to a "very abbreviated call" and because the FMD had "managed to leave my transfer conference folder at home."[1]

- On October 15, 2018, the patient still hadn't transferred. The FMD, responding to another attempt by the same Physician Assistant to get attention to the complainant said, "I didn't have enough clinical info in myfile [sic] about him. I did get 7 presented though."

- Two days later, on October 17, 2018, medical staff appears to have approved the transfer and sent an email to the Associate Superintendent to say "this plan is at you. Medical would like him expedited to MCC."

[1] The FMD later relayed that he was the FMD for two major DOC facilities at all relevant times. FMDs usually cover one major facility so covering two was "quite challenging and ultimately not tenable."

- Two days after that, October 19, 2018, the Physician Assistant tried again to raise attention regarding the complainant, sending an email to the FMD saying "At his last apt with the surgeon a probe was placed in his ear and since then his ear has been bleeding with increased ear pain…Do you know how soon he may transfer and should [redacted] see if we can get him back up to the UW for eval by the surgeon?"

- By that point, the complainant's approval for pain medications had run out, so the Physician Assistant then had to advocate for renewal of the pain meds.

- On October 22, 2018, the Physician Assistant sent an email to another medical staff with Urgent in the subject line, stating, "There is a delay of care you need to be aware about and may require your intervention."

    - The response to the email was from the original WCC FMD, now at Headquarters, saying that although he had been approved at transfer committee one month ago, "things were held up regarding some communication about his possibly refusing transfer and/or treatment. Now that sounds resolved and the case just needs to be reviewed due to his LWOP [Life Without Parole] status, which is in progress. Sounds like he is at the top of the list for transfer when it is approved. In the meantime we should start working on scheduling him for UW radiation oncology to expedite his care."

- The Physician Assistant then sent another email on October 22, 2018 to the current WCC FMD asking one of them to meet with him because she had been telling him that he was awaiting transfer to MCC to start his cancer treatment. She notes, however, that she doesn't know when he will transfer and the earliest he can see the ear surgeon at this point is 11/13 [note: at which point it would be three months since his last surgery].

- The response from the WCC FMD on the same day, perhaps realizing at this point that too many delays had happened says, "We can't delay his treatment waiting for transfer….[we] can always ask for an extra transport team should that be needed." He then sends an email to classification staff, asking, "Is he going to Monroe? Hard to track all this stuff." The classification staff responds saying, "Yes sir. Monroe it is. It will still be a bit. He's a LWOP case and needs to be cleared by the committee."

- On October 24, 2018, the Physician Assistant sends an email again, "Hello, Have you heard from HQ is this offender is [sic] schedule [sic] for medical transfer to MCC?" The response that she received was that the complainant was "targeted for WSR [at MCC]" but that now "WSR is full."

        - The Physician Assistant sends an email to Headquarters staff asking, "Can you help with this process?"
        - The response from medical staff is, "I don't see where I can intervene in the LWOP committee. Dr. [redacted – the former WCC FMD who was now at Headquarters] may have more of an ability to navigate than I do. What I can say is that we need to make sure he is scheduled and facilitate that he see the off-site provider as needed or specified. If that means that we have to start treatment while he is with us, so be it. If we need to request contract nursing staff to assist with his care, like CNAs, we will do that until a more suitable placement can be obtained for him." Apparently, these options existed all along but had not been previously discussed, nor was it clear who had the responsibility to make this decision.
        - Then follows a series of emails between a triangle of medical and classification staff, trying to determine when he was going to be moved and what the next step should be. It is not apparent that at any point anyone decided to get on the phone to get to a final discussion and decision point.

    - On October 26, 2018, the Physician Assistant sends an email to both the former and the current FMDs reiterating the history of the patient's delays in care and transfer. She shared that she had spoken with the FMD at MCC who was apparently completely unaware of the patient and that she had followed up with staff who also knew nothing about the transfer. She concludes, "I don't know why the delay in transfer has occurred."

    - On November 13, 2018 – five months after the re-confirmed diagnosis of cancer – the complainant was finally transferred to MCC. A month later, his chemotherapy still had not occurred and he was told that his cancer had too far advanced for treatment to be effective.

- OCO substantiated the grievance process was not effective nor responsive to the complainant's repeated attempts to bring attention to his medical concerns. As evidenced, the complainant continued to send multiple medical kites, file medical grievances and file multiple appeals to his grievances asking to discuss his treatment options, yet no cancer treatment was provided.

    - On May 9, 2018, the complainant sent the facility physician a medical kite asking to see him about this pain management. No response was documented.

    - On May 22, 2018, the complainant sent a medical kite wishing to speak with his physician. The complainant reported his medication has expired and he had pain in the bone next to his ear. The complainant further states he needs help coming to terms with the news of his cancer. He wanted to know why he was not already at UW Medical Center, and why they were not moving faster for treatment. He

ended the kite with, “Just need confirmation all is being done.” This kite was sent to his physician on 5/22/2019 and was not responded to until a month later on 6/27/2018 with, “See in IPU.”

- On July 7, 2018, after the complainant had received a diagnosis of cancer, the complainant sent a kite to his physician asking, “What is next, some kind of prognosis so we can put together an acceptable game plan to get rid of this cancer.” No response was documented.

- On August 3, 2018, the complaint sent a kite to his physician updating him on the bleeding on his pillow from his ear and asking is this normal? The only response was to listen for a callout.

- On August 23, 2018, the complainant sent a kite to his physician asking for more pain medication for headaches related to his caner. No response was documented.

- On August 27, 2018 the complainant sent a kite to his physician requesting a meeting to go over his cancer treatment. The only response was to again tell him to sign up for sick call.

- On October 4, 2018, the complainant sent a kite to the Physician Assistant requesting to meet to talk about his cancer treatment. No response is documented.

- On October 31, 2018, the complainant sent a grievance regarding WCC allowing him to “fall through the cracks” and not receive his cancer treatment. “It’s now been 4-5 months since my surgery and the cancer is growing again.” No response is documented.

- On December 1, 2018, the complainant attempted to grieve headquarters for “putting up barriers” to his cancer care. The grievance was returned to the complainant for a rewrite.

- On December 11, 2018, the complainant submitted a grievance against the DOC medical division “for not having my cancer treated long before now. When I was in Shelton over five months ago I was diagnosed with cancer! About four months ago I went to UW Medical Center/Cancer and had surgery by one of the countries [sic] best cancer surgens [sic]…Now nearly five months later I am being told I need kemo [sic] and an aggressive radiation treatment, for seven full weeks every day, but the weekends. A month ago DOC Headquarters sent me here to Monroe TRU facility to get treated, yet after being here a month I am no closer to treatment other than the distance. DOC let me fall into the cracks and may have cost me my life in doing so.” The response from DOC was “I must request a rewrite. There is too much extra information and too much writing to fit into the complaint.” It was sent back to him and then administratively withdrawn.

- December 19, 2018, the complainant sent a grievance stating, "Was sent here for appointments, for care, yet no appointments with specialist yet." He later sent in appeal on 2/1, which was also returned to him twice for rewrites on 2/8 and 2/15.

- On December 26, 2018, the complainant sent a kite to his physician to put him on the call out to see her at her earliest convenience. The kite response was appropriate, relaying that he would be seen on January 2, but as demonstrated by his second kite on January 2, he was not in fact seen on that day.

- On January 11, 2019, the complainant sent in a grievance stating his complaint was, "why didn't I receive treatment 3 months ago when Dr. Rubenstein from UW ordered it." He was also upset that he hadn't been transferred to MCC to get scheduled for his cancer treatment. The response stated the delay was "due to your sentence of LWOP, approval for your transfer was 1st required by the CRC, then there was a delay because of a new medical director at WCC and then [the complainant] required approve from the Deputy Secretary in order to move you to MCC."

- On January 15, 2019, the complainant appealed his grievance. He made statements wondering why he did not receive radiation treatment after his surgery as medically recommended. The only response received to the complainant's question was, "II 1/18"

- On January 29, 2019, the complainant sent in an appeal to his closed grievance regarding not receiving cancer treatment. The grievance was returned and he was asked to rewrite his appeal based on his "adding new information to the grievance."

- On February 1, 2019, the complainant filed a new grievance against the Grievance Coordinator for allegedly falsifying information in his grievance regarding his medical treatment. That grievance was also turned back as "not grievable."

- On February 6, 2019, the complainant sent a hand written letter to the Medical Director asking for help with a returned grievance form. On this grievance form, he was being accused of being negative towards the staff about his lack of care. The complainant stated on his correspondence was all he wants is to be treated for his cancer. The complainant goes on further to say the only way he can complain is by filing a grievance and DOC has in a sense killed him by not providing him cancer treatment. The complainant also asked for a visit from the medical director. The complainant reported the visit did not occur and the grievance response was, "they had spoken with his physician and she wanted him to know she believed him when he said he was in pain."

- On February 15, 2019, the grievance was returned and the complainant was again instructed to rewrite his complaint.

- On February 20, 2019, the complainant received a kite back from the medical director reporting this was "an unfortunate circumstance" and wished he had been treated sooner.

- On February 28, 2019, another request for pain medication. No response is documented.

- On March 12, 2019, in the last documented written communication, the complainant sent another kite asking for a 5 mm bump in his medication for pain. The complainant asked the medical director again to come talk with him about his care and medication request. No response is documented.

- When interviewed regarding the above lapses in responses, the medical provider stated that they did not respond to kites because there were "so many" and they were "too busy."

- Prior to the OCO investigation and report, there was no internal process in place to conduct cross-department discussion about process improvements that impact patient care. The multiple bureaucratic delays that ultimately caused the complainant to languish until his cancer had progressed too far for treatment all occurred prior to the end of 2018. No meeting or discussion was held by medical staff with custody to discuss these delays and develop process improvements so that it did not occur in the future.

- Further, even the internal "patient safety" clinical review process that does exist is flawed. Reportedly, the only issue cited by the patient safety review conducted by a peer FMD prior to the complainant's death was "provider to provider miscommunication." The postmortem mortality review reportedly was more comprehensive, but still lacked the ability to address the delays in the facility transfer that ultimately impacted patient care.

OCO Recommendations

- DOC should ensure an expedited process is in place so that a team of DOC staff representing the medical, custody, and classification departments meet with incarcerated individuals who have been diagnosed with cancer and that all departments are working collaboratively to ensure that the patients are transferred to whichever facility is best situated to provide care.
    - Related, a care plan summary including current diagnosis, treatment plan, and any recommended institutional transfer should be provided to any individual diagnosed with a life threatening illness, with an updated copy provided when the plan is changed.
    - DOC should create a policy, procedure, and oversight process to ensure all medical transfers requiring life-saving treatments are expedited. Until transfers are expedited, appropriate care should be provided.

- Conduct a review and revision of clinical case management practices to include an internal quality assurance component.

- DOC should implement a chronic care management program with a clinical case management component and oversight.

- DOC should develop a chronic disease registry – particularly for cancer care – followed by a health care professional's review. Headquarters staff should have access and oversight responsibility, with accompanying accountability.

- DOC should document outside specialist treatment recommendations timely in the patient's medical records and require the DOC medical provider to make a reasonably immediate medical decision for referral or treatment.

- DOC medical staff should follow all medical recommendations made by any external oncology specialist, or document a reason not to based on their review and in conjunction with review by the Facility Medical Director and the DOC Chief Medical Officer.

- Conduct a review and revision of the medical kite and medical grievance process to ensure timely response and appropriate review by necessary medical personnel, particularly in cases involving serious, life threatening illness.

- DOC should create an internal quality assurance process, such as through the patient safety review process, to ensure that any non-medical department actions that impacted patient care are reviewed by all departments necessary to implement change and that process improvements are developed and implemented.

- DOC should ensure that the internal clinical review "patient safety" reviews are rigorous and that it involves external participation to ensure that any and all lapses are discovered, examined, and necessary improvements are implemented.

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

June 16, 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 OCO investigation into the death of an incarcerated individual' completed by the Office of Corrections Ombuds.

Recommendation	Response
DOC should ensure an expedited process is in place so that a team of DOC staff representing the medical, custody, and classification departments meet with incarcerated individuals who have been diagnosed with cancer and that all departments are working collaboratively to ensure that the patients are transferred to whichever facility is best situated to provide care.	By the end of calendar year 2020, the department's Chief Medical Officer will create a workgroup in coordination with the Health Services, Reentry, and the Prisons Divisions to create a new diagnosis protocol that will be incorporated in the offender health care plan.
Related, a care plan summary including current diagnosis, treatment plan, and any recommended institutional transfer should be provided to any individual diagnosed with a life threatening illness, with an updated copy provided when the plan is changed.	By the end of calendar year 2020, the department's Chief Medical Officer will create a workgroup in coordination with the Health Services, Reentry, and the Prisons Divisions to create a new diagnosis protocol that will be incorporated in the offender health care plan. The referenced protocol will encompass a care plan summary process.
DOC should create a policy, procedure, and oversight process to ensure all medical transfers requiring life-saving treatments are expedited. Until transfers are expedited, appropriate care should be provided.	By the end of calendar year 2020, the department's Chief Medical Officer will create a workgroup in coordination with the Health Services, Reentry, and the Prisons Divisions to create a new diagnosis protocol that will be incorporated in the offender health care plan. The referenced protocol will encompass a process for ensuring medial transfers requiring life-saving treatments are expedited.
Conduct a review and revision of clinical case management practices to include an internal	The health services division has revised the Continuous Quality Improvement Process

quality assurance component	(CQIP) in place at both the local and headquarters level. Health services leadership conducted a thorough analysis of the utilized process and identified opportunities to enhance process, oversight and responsiveness. The outcome of this thorough review was the creation of a chief quality officer, expanded statewide CQIP, and addition of a patient safety committee both at the local level and the headquarters level. A system wide phased implementation of the patient safety committee began in fall of 2019. As CQIP is a monthly review of process (non-clinical) and clinical performance, the addition of a patient safety committee provided a weekly rapid response group, made up of both clinical and administrative leadership who could respond to patient safety concerns in real time, while forwarding systemic issues to the CQIP for analysis for systemic and or statewide implications. The approach allows immediate identification and intervention on behalf of the patient while also allowing for deeper analysis for potential larger policy, protocol or training adjustments.
DOC should implement a chronic care management program with a clinical case management component and oversight.	As part of the Health Services 2020 project, a multi-disciplinary group developed the structure, process, and resources needed to deploy the previously created tool for management of chronic care cases. Additionally, the clinical leadership approved a tracking tool with identified core chronic conditions that will be tracked at a headquarters level. Health Services data staff, working in collaboration with the project group, have developed the first stages of a self-service report and have produced a proof of concept to leadership. The report will provide real time information on the following clinical data points to include:

	•Follow up date of pending consults •Date of next onsite appointment •Date of next offsite appointment •Date of last medical encounter (provider) •Date of last nursing encounter •Date of most recent general consult •Date of most recent ER consult (if sent out) •Date of last lab •List of all chronic conditions •Next CC visit due date (based on frequency standards). The project is currently pending final clinical leadership review, development of final self-service report and deployment of additional resources required to deploy and maintain the program. Due to the COVID-19 pandemic response, health services staff are fully engaged in the COVID-19 effort, and the deployment of this project is on hold.
DOC should develop a chronic disease registry – particularly for cancer care – followed by a health care professional's review. Headquarters staff should have access and oversight responsibility, with accompanying accountability.	As part of the Health Services 2020 project, a multi-disciplinary group developed the structure, process, and resources needed to deploy the created tool for management of chronic care cases. Additionally, the clinical leadership approved a tracking tool with identified core chronic conditions that will be tracked at a headquarters level. Health Services data staff, working in collaboration with the project group, have developed the first stages of a self-service report and have produced a proof of concept to leadership. The report will provide real time information on the following clinical data points to include: •Follow up date of pending consults •Date of next onsite appointment •Date of next offsite appointment •Date of last medical encounter (provider) •Date of last nursing encounter

	•Date of most recent general consult •Date of most recent ER consult (if sent out) •Date of last lab •List of all chronic conditions •Next CC visit due date (based on frequency standards). The project is currently pending final clinical leadership review, development of final self-service report and deployment of additional resources required to deploy and maintain the program. Due to the COVID-19 pandemic response, health services staff are fully engaged in the COVID-19 effort, and the deployment of this project is on hold.
DOC should document outside specialist treatment recommendations timely in the patient's medical records and require the DOC medical provider to make a reasonably immediate medical decision for referral or treatment.	The Department of Corrections chief medical officer revised the Offender Health Plan during calendar year 2019, under the Levels of Care Directory, to include specific time frames for providing diagnostic study reports to the ordering practitioner or designee and addressing for follow up on diagnosis and specialists recommendations. Please see the Offender Health Plan
DOC medical staff should follow all medical recommendations made by any external oncology specialist, or document a reason not to based on their review and in conjunction with review by the Facility Medical Director and the DOC Chief Medical Officer.	The Department of Corrections chief medical officer revised the Offender Health Plan during calendar year 2019, under the Levels of Care Directory, to include specific time frames for providing diagnostic study reports to the ordering practitioner or designee and addressing for follow up on diagnosis and specialists recommendations. Please see the Offender Health Plan
Conduct a review and revision of the medical kite and medical grievance process to ensure timely response and appropriate review by necessary medical personnel, particularly in cases involving serious, life threatening illness.	Health services has fully implemented a new medical kite tracking protocol at all major facilities. This phased implementation began in June of 2018 and became the mandated protocol in January of 2020.The process update includes a detailed tracking tool, daily retrieval, daily clinical triage and daily follow up. All triaged emergent or urgent kites are

	immediately addressed by health services staff for follow up with the reporting patients. All routine requests are forwarded to the appropriate discipline for response and action. The agency expectation is that all routine kites will be responded to within five business days. Each facility specific leadership is tasked to conduct periodic audits to ensure time lines are met, clinical triage is appropriate, and quality of responses, and to ensure staff are attempting to remedy at the lowest level as appropriate. The goal is to provide a rapid response and remediation of issues to avoid delays where possible and avoid a protracted grievance process. This allows critical staff to spend more time on patient care and support and lessens excessive administrative activities. The agency grievance process has undergone a significant overall modernization based on the recommendations of a multi-disciplinary work group to include the Office of Corrections Ombuds. The change most impactful for health services is the immediate inclusion at level 0 to allow rapid response to health care needs. Additionally, all level 2 grievance responses are now signed at the health service administrative level to allow appropriate discipline review and operational adjustments as needed. The emergency grievance process is still in place that requires immediate response and assessment by clinical staff to determine if intervention is needed with a follow up.
DOC should create an internal quality assurance process, such as through the patient safety review process, to ensure that any non-medical department actions that impacted patient care are reviewed by all departments necessary to implement change and that process improvements are developed and implemented.	The health services division has revised the Continuous Quality Improvement Process (CQIP) in place at both the local and headquarters level. Health services leadership conducted a thorough analysis of the utilized process and identified opportunities to enhance process, oversight and responsiveness.

	The outcome of this thorough review was the creation of a chief quality officer, expanded statewide CQIP, and addition of a patient safety committee both at the local level and the headquarters level. A system wide phased implementation of the patient safety committee began in fall of 2019. As CQIP is a monthly review of process (non-clinical) and clinical performance, the addition of a patient safety committee provided a weekly rapid response group, made up of both clinical and administrative leadership who could respond to patient safety concerns in real time, while forwarding systemic issues to the CQIP for analysis for systemic and or statewide implications. The approach allows immediate identification and intervention on behalf of the patient and the ability to include all divisions required in resolving the issue, while also allowing for deeper analysis for potential larger policy, protocol or training adjustments.
DOC should ensure that the internal clinical review "patient safety" reviews are rigorous and that it involves external participation to ensure that any and all lapses are discovered, examined, and necessary improvements are implemented.	The Department of Corrections Health Services Division has recently hired a Medical Director for Quality Care Management who will review the Patient Safety Review (PSR) and Mortality Review Committee (MRC) processes and provide recommendations for updating and efficiency. Once the agency has received these recommendations, appropriate staff will work to implement new procedures to create rigorous responses. Additionally, the chief medical officer will follow up with the external doctor involved in the MRC for being included in the PSR process.

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,

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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