October 17,2023

Dear Legislators,

I am writing to you concerning the ongoing unmonitered health care that our incarcerated population is receiving, or in many cases, not. I Freedom Of Information Act requested the healthcare policies from the DOC and I was told they were online. The online information for healthcare is a mission statement and sparse at best. Christopher Antoine also told me that Wellpath provides the National Commission on Correctional Health Care Standards. There is no copy of this on the DOC Policies and Procedures. I have FOIA requested that from Mr. Antoine as well.

There seems to be a discrepency in our state law V.S.A 28 { 801 which states "the department will provide the prevailing standard of care" and the DOC website states they will provide the "prevailing standard of corrections care." Is the corrections standard of care what the legislators meant when they wrote this law? Has Mr. Deml reviewed the NCCHC Standards? Why are these standards not available on the website? Are these standards congruent with Vermont State law?

This creates an ambiguity. As an RN of 46 years we don't provide one iota of care that is not the policy and procedure to do so. We actively know what the policies are that we follow. How does the DOC know what care needs to be provided when there are no true standards available on the website? When Mr. Deml or Mr. Titus sign an upper level greivance denying healthcare, do they do so with the prevailing medical standard of care that the legislators have signed into law to allow such care? On the website it states all care is done by qualified health care providers. Are Mr. Deml and Mr. Titus these qualified providers so they actually know all about the healthcare denial they are signing?

Additionally, and there is no written mention of this on the DOC website, detainees are not given a warm handshake, or a prescription for lifesaving meds, or any meds. Our Mr. DA was booted out with none of the above and if he had not had his endocrinologist at DH (and had recommended the prevailing standard of care insulin pump.) who wrote the insulin prescription when called by DA, not the DOC discharge planner. Without his own MD, Mr. DA would be presenting himself to the emergency room. His diabetic sister was able to provide him with the immediate insulin needed before he could get this filled. Why are detainees not given the prescriptions they have been on?

Will Hunter provided plenty of information about the incarcerated individual who was

released without his case worker on duty, the psychiatric meds not called in and his living arrangement also not ready. It took hours of phone calls by Mr. Hunter to straighten this out and keep this individual safe. The DOC policy for these releases are vague, and apparently noone is held accountable, or cares.

Imagine if an individual was on MAT meds and began withdrawing immediately,with no DOC arranged community provider. Relapse and recidivism come to mind. Are we proud of our high recidivism in this state? Is this our purpose? Incarceration, recidivism, incarceration recidivism more police, more probation and parole officers? Or, do we need meaningful weekly oversight with accountability?

Those incarcerated continue to receive less than the prevailing standard of care. Ask Mr. Deml or Mr. Titus how often someone gets referred for an MRI, or to a real psychiatrist when the individual has been a guinea pig for every psych med known to man, with zero result.

There are no group therapy programs. An accurate guestimate is that 50% of our incarcerated loved ones suffer from mental health issues, ADHD, Adverse Childhoood Events, no high school diploma, young offender incarceration, substance use disorders, and anger problems manifested by all of the above. Handing out medications is half the equation. The other half is groups of all different varieties.

There is a man who was released from Marble Valley and the Rutland the Turning Point goes in to this facility and establishes relationships. This same man built a relationship and upon release has maintained sobriety through the support of the Turning Point and group work. He has accepted the loss of his family due to his drinking and anger and is working hard mentally and physically to save money to pay his fines and to get his license reinstated. His first incarceration was at 16, and he never graduated from high school. He managed his emotions with alcohol. Why doesn't SSCF utilize the Turning Point in Springfield? Why isn't there continuity of care in each facility throughout the state?

This is not rocket science. This is common sense science. As legislators you have budgeted millions upon millions of dollars to try to solve our "public safety" issues. Our incarcerated folks need to be treated like real people with real problems. We can make this better. We need supervisors whose job is to make sure the work is getting done. Why are there no case workers on Saturday when someone is leaving to a living arrangement that is not ready? Why are we allowed to throw people in the holding cell for 8 days without the basics to appear in court disheveled and ill? Who is allowing this?

In conclusion I recommend weekly health care oversight by a number of outside providers. They could review the care at home remotely. We need to know what standards of care Wellpath is using. Specifically when outside consultation is needed. These healthcare providers manage all care with prescriptions remotely, telehealth. There is no outside specialty consultations when the prescriptions fail. That is not the prevailing standard of care.

I recommend someone go over the standards of care as written in the NCCHC and decide, is that the level of care we want here? Or should we go by medicaid standards of care. It seems like discrimination to have a prison set of standards. Health care is health care.

Take away the power of non medical people like Mr. Deml and Mr. Titus to sign denials for healthcare. Mr. Deml is a lawyer and has zero knowledge to sign his name on a healthcare denial form.

Institute group therapy for many topics. Reach out to the Restorative Justice Centers to bring in restorative circles.

We can't let another David Mitchell happen. He absolutely died because when they could not manage his breathing difficulties they did not get him to a pulmonologist. His care was managed by NP's and PA's, all remotely. What expert listened to his lungs and took his history? No expert. All the inhalers in the world did not change what he needed as the prevailing standard of care. When a treatment fails, or continues to fail over multiple months it is more than time to take the care to a specialist. There is no doubt the remote healthcare providers of the for profit Vitalcore were active participants in his untimely and unnecessary death.

We need independent oversight of healthcare, and oversight of everything else with accountability.

Thank you

Leslie M Thorsen RN BBA

DOC:

POLICY (Healthcare Services) Effective 11/28/17

PG 1:

It is the policy of the DOC to provide healthcare services to meet the medical, mental health, and dental needs of all inmates in accordance with the **prevailing medical standards**. Unreasonable barriers to inmates' access to healthcare services shall be avoided. All clinical decisions and actions pertaining to an inmate's healthcare shall be made by a QHCP, in accordance with prevailing medical standards for correctional environments.

National Commission on Correctional Healthcare (NCCHC) accreditation for the **provision of healthcare services in correctional facilities shall be maintained.**

PG 2:

Healthcare services provided in correctional facilities are designed to achieve high standards regarding the following factors:

• Continuity of care, with regard to providing ongoing treatment for individuals that are admitted to, and released from, DOC custody;

• Care planning, which aids the ability to coordinate and manage care for individuals as they transition between the community and correctional facilities;