House Sub-Committee on
Immigration, Citizenship, Refugees, Border Security, and International Law

Hearing on: Problems with Immigration Detainee Medical Care

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Testimony of
Edward Harrison, President
National Commission on Correctional Health Care

Members of the committee, my name is Edward Harrison and I am the President of the National Commission on Correctional Health Care (NCCHC). We accredit health services in some of the detention centers that house detainees of Immigration and Customs Enforcement. I am pleased to be with you today to describe our organization's standards-setting and accreditation processes.

The National Commission is a non-for-profit organization that grew out of a project begun at the American Medical Association (AMA) in the early 1970s. Our board of directors is made up of representatives of thirty-eight major supporting organizations, including the AMA, the American College of Physicians, the American Nurses Association, the National Association of Counties, the American Dental Association, the American Bar Association, the American Public Health Association, and the National Sheriffs' Association (see attached list). We are solely and completely dedicated to improving health services in our nation's jails, prisons, and juvenile confinement facilities. Our pioneering work began even before the Supreme Court's ruling in *Estelle v. Gamble* that an inmate has a constitutional right to health care. So we have watched this field evolve and improve over time, and have helped correctional systems and health care professionals adapt to new challenges that were unheard of 30 years ago.

Our standards are based on three basic principles: that inmates should have access to necessary medical and mental health care, that assessment and treatment should be done by competent health care professionals, and that health care ordered by clinicians should be delivered without undue delay or interference. These principles may seem obvious and simple, but adhering to the standards is often complicated by the institutional nature of corrections.

The NCCHC standards, or some adapted form of them, are used by detention and correctional systems throughout the country, but not by everyone. Adherence to the standards in most cases is voluntary (exceptions being, for example, when federal or state courts have required compliance, or when the standards have been stipulated in a contract between the government agency and a third party that provides the health

care services on site). Thus, in most cases, including with ICE facilities, we enter the premises as the guests of the legal authority.

Our standards are available to anyone. They have been used by state medical societies that have been contracted to review local correctional health care services, by the Department of Justice in its investigations into civil rights violations in correctional facilities, and by numerous consultants hired by correctional systems to help evaluate and improve the quality of their care. Even correctional systems accredited by other organizations, when confronted with growing problems, have asked us to conduct our own review of their facilities and to make recommendations for improvement based on the NCCHC standards. So I can state to the committee that our standards are widely recognized as the best standards for facilities that house ICE detainees to follow.

When we are asked to accredit a facility's adherence to the standards, we bring on site a skilled team of correctional health care clinicians and experts, who use a set of tools we have developed to ascertain and measure compliance. For an average size jail we might have three people on site for 2 or 3 days. The team always includes at least one physician.

We look to see if an appropriate system for the proper delivery of health care is in place. Prior to our visit we require the facility to post a notice of our upcoming review that encourages patients, staff, or visitors to contact us directly with any concerns they may have. We look at active medical records going back to the initial time of confinement to ensure that the quality of care we see when we are on site is typical of what the facility staff have been providing over time. We interview health staff, custody staff, and administrators as well as detainees and patients. We thoroughly review the facility's policies and procedures to see if there are any flaws in their system or if any component is missing. Then we look at the staff's performance in carrying out those policies, and verify that staff are credentialed and trained appropriately. When deficiencies are found, they are reported to the administrator and health authority, who must submit evidence of corrective action.

Our organization advocates continuous quality improvement (CQI) as a great way for correctional systems to improve their operations. CQI, one of our standards, dictates that facility staff actively seek out areas in need of improvement. The model embraces the discovery of problems as an opportunity to improve. From the thousands of correctional system reviews we have done over the past 30 years, I can say that what distinguishes the best systems from the mediocre is this culture of quality.

Patient safety in this country — not just in corrections — is a huge problem. The Institute for Healthcare Improvement estimates that each year as many as 15 million patient injuries occur in health care settings, and between 100,000 to 200,000 deaths from unintended injury. This is more deaths than would occur if a 747 jumbo jet crashed each day. So within the profession of health care, we are well aware that unintended problems arise when treating patients. And within the world of corrections,

as I mentioned earlier, treatment can be more complicated, and therefore more susceptible to problems, than in the community.

The National Commission on Correctional Health Care is a totally independent, unbiased organization obligated only to its mission to improve correctional health care. We have no "membership," do not collect dues. Furthermore, our volunteer leadership have been board members, on average, for over 9 years, and staff members, on average, have also been with us for that long.

I have read a number of press reports about medical problems in some ICE detention facilities. It is always deeply troubling to hear about neglect and suboptimal patient care. Reports of these kind require careful investigation and, when warranted, changes to improve the system. Some of the reported problems had to do with custody staff action or inaction, which is not my organization's area of expertise. But where clinical performance may be involved we are very concerned.

While we recognize that not every problem can be anticipated, we strongly believe that a correctional facility should be proactive in implementing patient safety systems to prevent adverse and "near-miss" clinical events. There should be an error reporting system for health staff to voluntarily report, in a nonpunitive environment, errors that affect patient safety.

All deaths should be promptly reviewed, both administratively and clinically. In the case of a suicide, a psychological autopsy should also be conducted. Importantly, treating staff should be informed of any review findings, and necessary corrective actions need to be implemented and monitored.

Our usual process is to conduct an on-site review once every three years. These reviews could be done more frequently, and it is my understanding that ICE does this through a third party using a modified form of our standards. We would encourage ICE to review its contracts and the contractors' performance to ensure it is getting the quality review necessary to meet its needs.

For security reasons our visits are planned well in advance and the facility staff are aware we are coming, although at some sites (none of them ICE), with the cooperation of the legal authority, we have also conducted unannounced, surprise accreditation visits. I would suggest that unannounced on-site reviews be considered at ICE facilities, as well.

I encourage members of the committee to refamiliarize themselves with our 2002 report to Congress, done at Congress' request, on the Health Status of Soon-To-Be-Released Inmates, available on the websites of the National Criminal Justice Reference Center, the National Institute of Corrections, or our own website at www.ncchc.org. Members may want to read our position statement on inmate abuse, also available on our website. And to see a sample of the type of thorough evaluation that is possible, I

would suggest committee members look for a copy of our report posted on the website of the Michigan Department of Corrections.

Thank you.

Contact Information:
Edward Harrison, President
National Commission on Correctional Health Care
1145 W. Diversey Parkway
Chicago, Illinois 60614
(773) 880-1460 x290
EdwardHarrison@ncchc.org

NCCHC Supporting Organizations

Academy of Correctional Health Professionals
American Academy of Child and Adolescent Psychiatry
American Academy of Pediatrics
American Academy of Physician Assistants
American Academy of Psychiatry and the Law
American Association of Public Health Physicians
American Bar Association
American College of Emergency Physicians
American College of Healthcare Executives
American College of Neuropsychiatrists
American College of Physicians
American College of Preventive Medicine
American Correctional Health Services Association
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American Diabetes Association
American Dietetic Association
American Health Information Management Association
American Jail Association
American Medical Association
American Nurses Association
American Osteopathic Association
American Pharmacists Association
American Psychiatric Association
American Psychological Association
American Public Health Association
American Society of Addiction Medicine
International Association for Correctional and Forensic Psychology
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