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Office of
Program Policy Analysis
And Government Accountability

John W. Turcotte, Director

November 27, 1996

REVIEW OF INMATE HEALTH SERVICES WITHIN THE DEPARTMENT OF CORRECTIONS

REPORT ABSTRACT

- **Inmate health care costs have increased rapidly in recent years due to prison health system reforms and the increasing inmate population. Additionally, inmates frequently access health care services for secondary gains such as avoiding work. Factors such as grievance procedures and Department and Correctional Medical Authority reviews of inmate heath care create an environment that makes it easier to provide requested health services than to deny them. Consequently, inmates use health services more than private citizens.**

- **Nevertheless, Florida's inmate health care costs have risen at a slower rate than overall medical inflation and are comparable to those for private citizens. Florida has initiated several cost-containment efforts that have saved and/or recovered about $16 million annually.**

- **Proposed Department initiatives, combined with additional Department actions can reduce or contain inmate health care costs by at least $4.9 million annually.**

PURPOSE OF REVIEW

Chapter 96-312, Laws of Florida, requires the Office of Program Policy Analysis and Government Accountability to conduct a review of the Department of Corrections' Office of Health Services and the Correctional Medical Authority (CMA) to determine effectiveness and quantify health care cost containment efforts. Our review discusses the factors that affect the delivery of health services to inmates and identifies and discusses various strategies that can be used to further contain the cost of correctional health services.

BACKGROUND

When offenders are sentenced to prison, the state becomes responsible for providing them health care. In fiscal year 1996-97, the Legislature appropriated approximately $213 million for inmate health services, which represented approximately 15 cents of every dollar provided to the Department of Corrections. As the prison system grows, the cost of providing health care to inmates is likely to increase. The Criminal Justice Estimating Conference projects that the number of inmates in the Department's custody will increase from 64,000 in June 1996 to more than 110,000 in June 2001. If the Department's per-inmate health care costs were to increase at 3% per year over this period, annual health care costs will rise to $401 million. In addition, increases in the number of older inmates, the number of inmates who are HIV-positive, and the use of costly new drugs will serve to increase the cost of inmate health care.

Florida's delivery of correctional health care has been largely influenced by 21 years of litigation stemming from the filing of a class action lawsuit by inmates in 1972. In 1985, a court-appointed survey team observed that the Department exhibited "systematic indifference" to inmate medical needs. Citing a pattern of deficiencies in the correctional system, the court appointed a Special Master and a Monitor to oversee health services provided to inmates.

In response to this lawsuit, the Department and Legislature changed the organization of inmate health care to ensure that security staff would no longer make health care decisions and that prisoners were not involved in providing health care services. The Legislature created the position of Assistant Secretary for Health Services, who has line authority over health services staff within the institutions and responsibility for all correctional health care issues. The Assistant Secretary heads the Office of Health Services, which provides administrative support. Within each of the Department's 50 major correctional institutions, Chief Health Officers are responsible for delivering health care services to inmates.[1] In addition, each of the Department's five regions has medical staff that monitor the delivery of inmate health services and serve as consultants to institutional health care staff.

To provide independent oversight of the Department's provision of health care services, the Legislature created the State of Florida Correctional Medical Authority (CMA) in 1986. The CMA consists of a nine-member board of physicians and health care specialists who are appointed by the Governor and confirmed by the Senate. CMA has 14 staff members who, together with teams of community health care consultants, conduct periodic surveys of health services at the Department's major correctional institutions. The consultants review inmate health care files and institutional policies and procedures, interview staff and inmates, and generally assess the appropriateness of the care provided. Deficiencies are reported to the Department, which must take corrective action. CMA is to conduct surveys at each institution at least once every three years.

The Department's reorganization and the establishment of CMA enabled Florida to enter into a settlement agreement with the plaintiff attorneys that terminated the federal court's oversight in 1993. A key to the final court settlement was recognition that the CMA would continue to monitor the Department's health care delivery system. At the time the settlement agreement was approved, the court expressed concern that, without an entity such as the CMA, the correctional system might again allow inmate health care to fall below acceptable standards.

Currently, inmate health care includes physical, dental, and mental health services that inmates receive upon admission to the Department of Corrections and throughout their incarceration. When they enter the Department's reception centers, inmates receive a number of health care examinations conducted by health services staff. Inmates receive a complete physical, including any needed laboratory tests and X-rays. They receive a visual dental examination and, when determined necessary by a dentist, X-rays and treatment to correct existing problems. Additionally, inmates receive a mental health examination, which includes testing and an interview by mental health staff, to determine their current psychological functioning level. As a result of these examinations, health services staff assign each inmate a medical classification status that indicates his or her physical and mental capability for institutional and work assignments. Inmates who have been identified as having a chronic medical condition, such as diabetes, asthma, hypertension, or seizures, are to be scheduled for routine follow-up visits with doctors at intervals not to exceed 90 days once they reach their assigned institutions.

At each major correctional institution, on-site health care staff provide primary health care services to inmates. Health care staff are available or on call 24 hours per day. Some reception centers have staffing and equipment to provide some specialty procedures, such as kidney dialysis. Inmates who require consultations with medical specialists or tertiary care not readily available within the Department are transported to community physicians or hospitals for treatment. When necessary, emergency care is provided by the closest hospital emergency room.

Florida's efforts to improve the inmate health care delivery system have increased inmate health care expenditures. Between fiscal years 1986-87 and 1990-91, the number of correctional health services staff increased by 37%, and appropriations for inmate health care increased by 111%. For the 1996-97 fiscal year, the Legislature appropriated $213.7 million and authorized 3,076 positions for the Office of Health Services. This total includes an allocation of $1.3 million for the Correctional Medical Authority.

FINDINGS

The use of health care by inmates for secondary gain and the prospect that health care decisions will be questioned through grievances or other reviews lead to the Department's providing more medical services than may be necessary, and thus to higher costs to the state.

[1] This does not include prisons operated by private vendors.

Two factors drive up inmate health care costs. First, inmates seek health care services not only for medical needs but also to achieve secondary gains. Second, the Legislature and Department created grievance and quality review procedures that sometimes make it difficult or expensive for health care workers to deny the health care services that inmates request but may not need. As a consequence, inmates access health care services more frequently than do average citizens. This increases the cost of correctional health care.

As in the rest of society, the delivery of health services in prisons is generally based on a patient requesting services, describing symptoms, and following the doctor's instructions. However, in prison, health services is a primary means by which inmates can achieve secondary gains, such as avoiding work, relieving boredom, talking to nurses and other medical staff, or being transported out of the institution to a community hospital or to another institution. Inmates may describe false or exaggerated symptoms in an attempt to achieve such secondary gains. For example:

- An inmate who complains of foot pain may be accurately describing a medical problem or may simply be trying to obtain a medical exemption that would allow him to wear softer shoes than the Department's regulation footwear;

- An inmate who visits sick call complaining of lower back pain may be feigning symptoms in hopes of obtaining an assignment to a lower rather than an upper bunk; or

- An inmate who declares a mental health emergency (such as displaying self-injurious behavior) may be seeking to be moved to a crisis stabilization unit or to a different institution for some other gain, such as air conditioning, television, or interaction with nurses.

When inmates request unnecessary health care services, correctional medical staff may have difficulty denying their requests. First, medical staff may not always be able to readily determine whether or not an inmate is seeking a service for secondary gain. In addition, the Legislature and Department have implemented grievance and quality review procedures that increase the likelihood that even routine medical decisions will be challenged. These procedures include a federally-accredited grievance procedure and medical record reviews by Department staff and the Correctional Medical Authority (CMA). Although needed to ensure that inmate health care is not again characterized by "systematic indifference," these procedures create a situation in which medical staff may find it expeditious to provide more treatment than necessary than to build a case for denying an inmate's request for medical care.

For example, one doctor cited a dilemma in the treatment of inmates. An inmate may complain of a condition that the doctor is unable to verify through an office examination. If the doctor denies a readily available treatment for the condition, such as a prescription, the inmate is likely to file a grievance. In responding to the grievance, the doctor may be advised to provide the inmate with the prescription or to refer the inmate to a specialist for a second opinion. Such a referral may require the inmate to be transported to a community doctor. The most expeditious solution, and perhaps the least costly, may be to provide the inmate with the prescription.

Inmate use of health care for secondary gains and the hesitancy of health care workers to deny requested care increases the number of times that inmates seek correctional health care.[2] Available data shows that inmates make more frequent visits to sick call and to the prison emergency rooms than average citizens make to their doctors and to hospital emergency rooms. In 1994 United States males between the ages of 15 and 44 years of age averaged less than four doctor visits annually, while inmates averaged 26 non-emergency clinic visits in fiscal year 1995-96. (See Exhibit 1.) Similarly, inmates visited prison emergency rooms at a substantially higher rate than citizens go to hospital emergency rooms.

Despite factors that tend to increase the cost of inmate health care, inmate health care costs have grown at a slower rate than overall medical costs. While the Department's annual cost of providing each inmate with health care services has increased over the last five years, these costs have increased at a slower rate than Florida's medical care inflation rate. (See Exhibit 2.)

[2] Inmates do not have routine access to many over-the-counter medications that citizens can purchase from a drug store. Although the Department makes acetaminophen, antihistamine, antacids, and throat lozenges available to inmates through the security officers in the housing units, other over-the-counter medications can only be obtained through a visit to sick call or the emergency room.

Exhibit 1

On Average, Inmates Make More Doctor Visits Annually Than Do Private Citizens

Average Annual Medical Service		
Non-Emergency Visits	U.S. Males (1994)[1] Ages 15-44 = 3.7 Ages 45-64 = 6.3	Department (FY 1995-96) [3] 26 per Inmate
Emergency Visits	Florida Statewide (1994) [2] 350 per 1,000 persons in Florida	Department (FY 1994-95) [4] 2,380 per 1,000 inmates (visits to prison emergency room)[1]

[1]Visits to the prison emergency room include inmate-declared emergencies, both founded and unfounded. For fiscal year 1994-95, the Department reported visits to community hospital emergency rooms at a rate of 46 per 1,000 inmates.

Sources: [1] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; [2] Local Health Councils of Florida, 1996 Florida Health Data Sourcebook; [3] Department of Corrections, Office of Health Services, Management Report Supplement, June 30, 1996; [4] OPPAGA analysis of Department of Corrections, Office of Health Services, Monthly Work Utilization Reports.

Exhibit 2

Increases in Inmate Health Expenditures Have Been Less Than Medical Inflation For Five Consecutive Years

Fiscal Year	Annual Cost Per Inmate	Department Inflation Rate	Florida Medical Inflation Rate
1990-91	$2,923		9.4%
1991-92	3,080	5.3%	8.0%
1992-93	3,147	2.2%	6.6%
1993-94	3,163	0.5%	5.3%
1994-95	3,040	-3.9%	4.7%
1995-96	3,148	3.5%	4.0%

Source: Compiled by OPPAGA from U.S. Department of Commerce; Bureau of Labor Statistics; and Department of Corrections, Office of Health Services, Management Report Supplement, June 30, 1996 .

Florida's average costs for inmate health care are slightly lower than costs of health care for the average citizen in Florida. The most recently reported average health care cost for Florida citizens was $3,227 per person in 1993. This was approximately 2% higher than the state's average cost of $3,163 cost per inmate in the 1993-94 fiscal year. [3] While this comparison is informative, differences in the two populations limit the usefulness of the comparison.

The Legislature and the Department have already initiated some cost containment measures that have produced cost savings.

The Legislature and the Department have initiated cost containment efforts that have been effective in reducing inmate health care costs. In addition, the Legislature and the Department have partially implemented some other efforts that have the potential to further decrease the cost of inmate health care services. These measures include:

- Establishing an inmate co-payment system, whereby inmates pay $3 per inmate-initiated, non-emergency medical, dental or mental health care visit. Inmates paid $358,934 in co-payments in fiscal year 1995-96. The Department has estimated that inmate visits to sick call decreased by approximately 22% during the first year (1995) that the co-payment was implemented;

- Negotiating contracts with community hospitals and specialists, and scheduling specialty consultations and procedures through the reception centers whenever possible. The Department estimated that it avoided additional hospital charges of approximately $11.5 million in fiscal year 1995-96 through negotiated fees;

- Establishing a utilization review system to reduce the number of inmates referred to more costly outside hospitals and to reduce the length of hospital stays. After this process was established, the Department estimates costs avoided of $2.1 million in the first seven months of 1996 (annualized to $3.6 million); and

- Combining pharmacy staffing for institutions that are close to one another during fiscal year 1996-97. The Department estimates this clustering will produce cost avoidance of approximately $1 million for the year.

[3] We obtained data from 19 other states in an attempt to compare the costs of correctional health care in Florida with similar costs in other states. It was not possible to make direct comparisons of health care costs due to variations resulting from differences in how medical costs were calculated and factors such as the size of the inmate population, the number and size of the institutions, the distance between those institutions, the type of health problems and care rendered to inmates, the use of private vendors, and the proportion of public to private care.

The combined effect of these four measures already implemented by the Department could result in cost recovery of approximately $350,000 and cost avoidance of approximately $16 million for the 1996-97 fiscal year.

In addition, the Legislature and Department have partially implemented several measures that have the potential to further decrease the cost of providing inmate health services. These measures include privatizing the delivery of health services in four institutions,[4] using telemedicine (providing a video link between inmates and medical specialists), using conditional medical releases to relieve the Department of the cost of care for terminally ill and incapacitated patients, monitoring bills from outside providers for overcharges, using interns from Florida medical schools to assist medical staff, and implementing preventative health care measures. The advantages and disadvantages of increasing the use of these measures is discussed in Appendix A.

To avoid substantial funding increases for inmate health care the Department could implement six key strategies. Other options could lead to further savings but these options pose significant disadvantages.

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Our review of Department operations and research on cost-containment efforts by the federal government and other states identified six basic strategies that can help limit the rate of increase in health care cost as the prison system grows. These strategies include:

- Consolidating the delivery of health services;
- Privatizing the delivery of health services for a region;
- Improving data that can be used to contain health care costs;
- Reviewing health service guidelines to make services more cost-effective;
- Reducing the availability of secondary gains for inmates; and
- Streamlining CMA's review of inmate health services.

While the Department may not be able to significantly reduce the current $213 million correctional health budget, these strategies should provide a more cost-effective managed inmate health care system. We identified additional strategies that can reduce inmate costs; however, the savings provided may not be significant or the strategies may pose implementation problems.

Strategy No. 1: Consolidate Health Services

Since salaries and benefits comprise the greatest portion of health services expenditures, reducing or containing personnel costs is a key means of reducing increases in the health care budget. Approximately 55% of the Department's health services expenses in fiscal year 1995-96 were spent on employee salaries and benefits. In comparison with the number of health care professionals in Florida, the Department generally has a higher ratio of medical professionals per inmate than exists in the community. (See Exhibit 3.) Historically, the Department has allocated health care staff to each institution, without allowing for economies of scale. Because it is necessary to have some health care staff at each institution, the Department will continue to have higher ratios of medical professionals than exist in the community. However, consolidating the delivery of health services should allow the Department to more closely approximate community ratios.

Exhibit 3

Medical Practitioner to Patient Ratios Are Higher for Florida's Inmates Than for Florida's Citizens

Practitioner Category	Florida Citizens for Each Practitioner	Inmates for Each Practitioner
General Care Physician	1,293	432
Dentist	1,337	788
Mental Health Specialist	1,227	454
Pharmacist	730	1,482
Nurse (Registered and Licensed Practical Nurses)	54	52

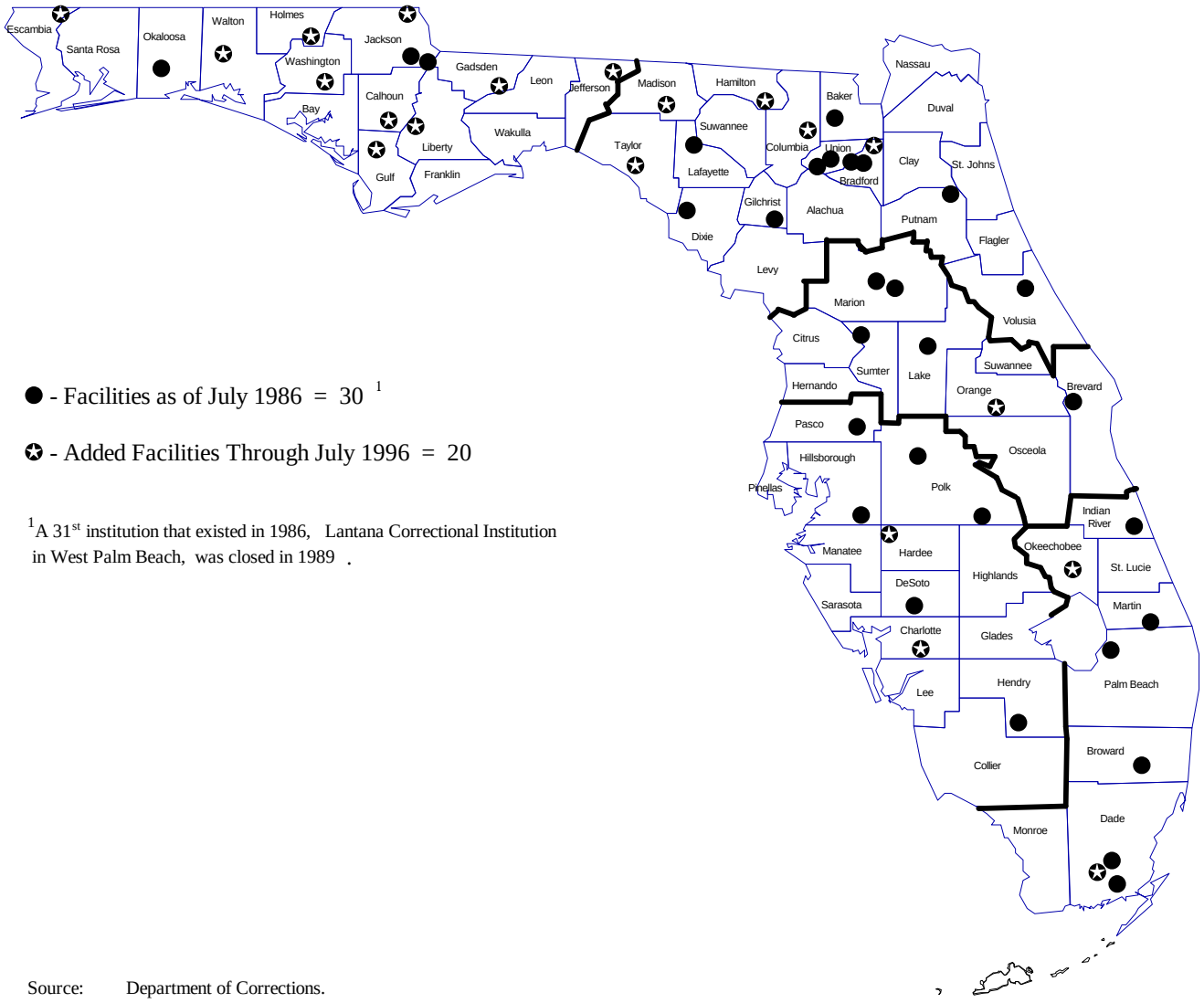
Source: Compiled by OPPAGA from Florida Statistical Abstract, 1995; Florida Department of Business and Professional Regulation; Florida Hospital Association, Healthcare in the Sunshine State, 1996; and the Department of Corrections, Office of Health Services.

[4] These four privately run health services operations do not include the health services operations at the institutions in which the whole correctional operation is privatized. The four institutions with private health services operations are South Florida Reception Center, Taylor Correctional Institution, Okeechobee Correctional Institution, and Everglades Correctional Institution.

Over the past ten years, the number of correctional institutions has increased from 31 to 50, and some new institutions are located in close proximity to other institutions. (See Exhibit 4.) This creates an opportunity for the Department to save personnel costs by shifting from an institution-based approach to determining its need for health care staff to a more regional approach. Thus, as new institutions come into operation, the Department could assign staff to serve more than one institution, perhaps alternating days between institutions, or rotating staff to fill in for absent staff. The Department could also assign inmates with special health care needs to institutions or reception centers that are staffed to meet these special needs, thereby reducing its referrals to more expensive external providers.

In 1995, the Office of Health Services proposed using a regional approach to health care staffing coupled with grouping inmates with special health care needs at select institutions. Implementing this proposal can achieve a cost-avoidance of approximately $2.4 million to $3.9 million year, with a potential reduction of between 58 and 92 positions. Over the long run, a regional rather than institutional staffing strategy should enable the Department to limit increases in the health services budget as more institutions come into operation.

Exhibit 4
Consolidation of Health Services is Possible Because Major Correctional Facilities Have Been Located Closer Together Over the Past Ten Years



[1] A 31st institution that existed in 1986, Lantana Correctional Institution in West Palm Beach, was closed in 1989 .

Source: Department of Corrections.

Strategy No. 2: Privatize a Region

The privatization of correctional health services, appears to offer potential for savings that could exceed 10%. No data is currently available on savings that may have resulted from the four institutions for which the Department already has contracted with private health care providers. [5] Seven of the 22 states that we contacted have privatized health services operations statewide. States' experiences with privatization have not, however, been universally positive. Some jurisdictions have terminated contracts with private vendors due to performance and accountability considerations. As a result, the best alternative in Florida may be to expand the experiment with privatization to a regional rather than statewide level. Privatizing a whole region would enable the Department to get additional data regarding the potential cost savings of privatization. If privatization provides a 10% cost savings from Department costs, privatization of one of the Department's regions would result in an annual savings of approximately $2.5 million.

Strategy No. 3: Improve Data for Effective Health Care Cost Containment

Other states we contacted and private-sector managed health care organizations have found that information management is an important tool for containing health care costs. The Department relies upon a paper-based medical records system that limits the availability of data for making good managed health care decisions. Data that would be useful to the Department is often not readily available from its management information system. For example, without additional programming, the Department cannot determine the frequency of various reasons for attending sick call; the number of inmates diagnosed with specific medical conditions such as cancer; the frequency and cost of various procedures provided statewide; changes in the health conditions of new inmates; the health care costs for individual inmates; the number of sick call visits that result in specialist referrals, surgery, or community treatment; the outcomes of treatment provided; and the relationship of cost and medical classification.

An electronic records system that includes improved data and analysis abilities could help Department staff make better informed health care decisions. An improved system would require additional expenditures for hardware, software, and training, but these costs should be offset by long-term savings. The development and implementation of an electronic records system with enhanced data and analysis abilities should result in increased efficiencies of operations by enabling medical staff to better manage inmates who move between institutions. An improved system would also allow Department managers to use the data to identify changes that can lead to reduced costs.

Strategy No. 4: Review Health Services Guidelines

The Department's health services bulletins, administrative memorandums, and standards may require correctional staff to provide services to inmates that exceed the level of care deemed necessary by current medical practices. For example, the Department requires doctors to examine inmates with certain chronic illnesses such as asthma, hypertension, or diabetes at intervals not to exceed 90 days. However, some of these examinations may be performed effectively by nurses, whose services cost much less than the services provided by doctors. The Department could reduce costs by periodically reviewing medical practice guidelines to insure that the guidelines provide for the cost-effective delivery of medical care.

Strategy No. 5: Reduce Secondary Gains Available to Inmates Whenever Possible

As noted previously, inmates seek access to health services in order to achieve secondary gains such as avoiding work, getting attention from medical staff, or getting a trip out of the institution. If the Department can reduce the availability of secondary gains that encourage inmates to use health services, then the Department will be better able to reduce its costs. For example, one secondary gain, a transfer out of the institution, results when inmates declare mental health emergencies through self-injurious behaviors when all the harm-avoidance cells are already occupied. Reducing inmate access to these transfers could be facilitated by converting existing cells to increase the number of harm-avoidance cells available. The Department does not maintain data needed to determine how much cost-savings this specific change would produce. A systematic effort to reduce secondary gains would reduce inmate use of health care services and thereby enable the Department to further reduce costs.

[5] These four privately run health services operations do not include the health services operations at the institutions in which the whole correctional operation is privatized. The four institutions with private health services operations are South Florida Reception Center, Taylor Correctional Institution, Okeechobee Correctional Institution, and Everglades Correctional Institution.

Strategy No. 6: Streamline CMA's Review of Health Services

The Correctional Medical Authority conducts independent reviews that help protect the state from further litigation regarding the delivery of inmate health care. CMA surveys medical practices at individual institutions and identifies deficiencies and concerns related to the delivery of health care at the various institutions. For example, for fiscal year 1994-95, the CMA reported that it had clinical or operational concerns that adversely affected physical health care at 13 of the 22 institutions surveyed and that adversely affected mental health care at 8 of the 22 institutions surveyed.

Since CMA was created in 1986, the Department of Corrections has been consistently improving its health services operations. The Department is developing procedures, such as inmate medical file reviews, to evaluate the quality of its services and identify and correct internal deficiencies prior to any external review. CMA may be able to streamline its reviews by using the information collected in the Department's internal reviews. By building its external reviews upon the findings of the internal reviews, CMA can reduce the level of redundancy in the review of the Department's health services and thereby reduce costs.

Other Options

In addition to these six strategies, our research identified a number of other options for reducing the cost of inmate health care. These options include increasing or expanding some measures that have been partially implemented by the Legislature and the Department. Each of these options has advantages. However, each option also has disadvantages that could either create implementation problems or would minimize its cost savings potential. (See Appendix A.) One alternative we identified was to replace CMA with an accrediting agency such as the National Commission on Correctional Health Care, or by some other agency conducting independent reviews. Although these services could be obtained at less than the annual CMA cost of $1.3 million, CMA currently provides more in-depth reviews than those that are offered by other entities, and provides services in addition to the external reviews. For example, CMA has responsibilities related to the review of the Department's health services budget, the review of the Department's quality management efforts, and the preparation of an annual report to the Legislature. Accordingly, we do not recommend this alternative.

The remaining options involved recovering costs from inmates by increasing their co-payments, requiring co-payments for prescription drugs, or charging them for over-the-counter medications. The primary advantage of co-payments is that they tend to deter unnecessary use of health care services. However, increasing or expanding the co-payment requirement may offer limited cost recovery while raising legal issues concerning inmate access to health care. Changes in the co-payment requirements should only be implemented if the Department can administer the changes cost-effectively without impeding inmate access to health care.

CONCLUSIONS AND RECOMMENDATIONS

Inmates often access health care services to achieve secondary gains. Although necessary to prevent the state from future lawsuits, the Department's grievance and quality control procedures sometimes make it difficult or expensive for health care workers to deny inmate requests for health care services that may be unnecessary. Consequently inmates use health care services more frequently than the private citizens. This serves to drive up the cost of inmate health care.

The Legislature and Department have initiated some cost containment efforts that have already achieved some savings, and the Department is exploring other potentially cost-saving measures. However, we identified six additional strategies that would be useful in limiting future cost increases for inmate health care. We recommend that the Department:

- Proceed with its consolidation initiative by adopting a formal health care plan by June 30, 1997. This plan should include provisions for assigning staff on a regional basis and for grouping inmates with special health care needs at select institutions;

- Issue a request for proposals to privatize health services for one of the Department's five regions, with the stipulation that the vendor be able to guarantee savings of 10% from Department of Corrections annual costs over a period of five years. Privatization should include monitoring by the Department to assure satisfactory vendor performance and calculations of cost savings should include the Department's contract monitoring costs;

- Research the costs of developing an electronic medical records system and propose a cost-effective system that could be used to improve the data available for effective health care management;

- Review treatment guidelines to identify policies or procedures that lead to inmates receiving services that exceed that which is standard for the average citizen; and

- Reduce the availability of secondary gains that can be received by inmates through health services, such as the prospect of being transferred to a different institution when declaring a mental health emergency after hours.

In addition, we recommend that the Correctional Medical Authority and the Department of Corrections work together to ensure that CMA's reviews do not unnecessarily duplicate the Department's quality management efforts.

AGENCY RESPONSES

STATE OF FLORIDA
DEPARTMENT OF CORRECTIONS

OFFICE OF THE SECRETARY

MEMO TO: John W. Turcotte, Director

FROM: Bill Thurber

DATE: November 25, 1996

SUBJECT: Response to OPPAGA Report

The following is a response to the five recommendations listed in the Conclusion and Recommendations section of the *REVIEW OF INMATE HEALTH SERVICES WITHIN THE DEPARTMENT OF CORRECTIONS* recently completed by the Office of Program Policy Analysis and Government Accountability.

- **As indicated in the report narrative, the Office of Health Services has previously proposed a regional approach to health care staffing and the select grouping of inmates. Additionally, the consolidation of pharmacy and dental services is ongoing. We agree that the prospect for future consolidation should be an integral part of formal health care planning.**

- **We do not agree with the recommendation to privatize an entire region. The assertion on the part of would-be vendors that they can provide ALL required inmate health care services at less cost remains unproved. The few reported positive outcomes appear tenuous and directly at odds with an increasing number of negative experiences. We do agree with that part of the recommendation requiring any privatization initiative to guarantee a 10 percent cost savings calculated on a future five year projection of health service costs, and the inclusion of contract monitoring costs in the savings. Ideally, a negotiated Request for Offers process would be the method of choice. This would provide leverage through DC knowledge of the inmate population, known health statistics, and comparison of competitive pricing of expensive health service components.**

- **The Office of Health Services is currently pursuing the establishment of an electronic medical records system. We agree that improved health care data management and, when available, the electronic capability would contribute to limiting future costs.**

- **All treatment guidelines are reviewed annually. Most receive much more frequent scrutiny. Treatment guidelines are based on responding to an inmate's health presentation in the manner most medically appropriate. It should be noted that when considering the requirement for chronic illness clinics and the suggestion for nurses to perform the examination instead of doctors, that nurses are not licensed to provide the level of care required. Nurses cannot order lab tests or x-rays nor prescribe or renew medications, all of which are necessary in chronic illness clinics.**

- **We agree with the proposal to reduce secondary gains sought by prisoners. A recent initiative to reduce mental health transfers was implemented by the Office of Health Services. Preliminary indications of a 95 percent reduction in mental health transfer have been noted. We will continue to monitor and address the provision of physical health while minimizing inmate opportunities for secondary gains**

This report was well presented and we are especially grateful to the project staff for their diligence and professional effort in compiling the information contained therein.

***/s/* Bill Thurber**
Deputy Secretary

BT/JGB/llp
cc/att: Harry K. Singletary, Jr., Secretary
Charles R. Mathews, M.D.,
Assistant Secretary for Health Services
Fred Schuknecht, Inspector General
Richard Dolan, Project Director

STATE OF FLORIDA
CORRECTIONAL MEDICAL AUTHORITY

November 26, 1996

John W. Turcotte, Director
Office of Program Policy Analysis and
Government Accountability
P.O. Box 1735
Tallahassee, FL 32302

Dear Mr. Turcotte:

Thank you for providing the Correctional Medical Authority (CMA) the opportunity to respond to your report on inmate health services. The Office of Health Services (OHS) has shown initiative in implementing many CMA recommended cost containment recommendations, as well as many OHS initiated efforts. These efforts have been successful. For more specific information on these activities, please see the CMA November 15, 1996, Annual Report.

In response to the recommendation that the CMA's review of health services be streamlined, we offer the following comments. The OPPAGA report recommends that the CMA limit its reviews and rely instead on OHS data. In our opinion, the OHS quality management program does not yet produce data sufficient to allow CMA to alter its current survey process (refer to CMA November 1996 Annual Report). Furthermore, OHS does not provide the CMA results of its self-audits at this time. Therefore, the CMA is aware of no redundancy in data collection between the CMA and the OHS. Finally, while self-monitoring is important to identify quality problems, the CMA believes that it does not replace an independent external review.

The CMA provides the following additional comments on the remaining recommendations regarding inmate health care.

Strategy/Recommendation #1 - Consolidate Health Services
The CMA supports this recommendation. The Department has already consolidated some health services with resultant cost avoidance, and minimal disruption of care. More consolidation is planned. Consolidation should proceed carefully in order to avoid restricting access to health care, which can result in increased health care costs and litigation. Our experience indicates that applying community practitioner to patient ratios is probably not achievable without adversely impacting health care because of inmate medical needs (i.e. medically needy, medically indigent). In addition, Department regulations require that inmates use the health care system to obtain many over-the-counter drugs and administrative waivers (for example, hemorrhoid cream and soft-soled shoes). Thus, inmates will continue to have higher utilization rates of health services than private citizens, and require more health care providers.

Strategy/Recommendation #2 - Privatize One Region
In its Annual Report, published November 15, 1996, the CMA recommended that the OHS reconsider a previous recommendation to privatize an entire region's health care services. If health care services are privatized regionally, then objective, external monitoring to determine the adequacy of those services will be extremely important to protect the State's interest.

Strategy/Recommendation #3 - Improve Data for Effective Health Care Cost Containment
The CMA agrees with OPPAGA's recommendations to expand the Department's capability to record and analyze medical data.

Strategy/Recommendation #4 - Review Health Services Guidelines
The CMA supports cost-effective delivery of medical care and the continued review of Health Services Bulletins, administrative memoranda and standards to ensure that adequate services are provided to inmates.

Strategy/Recommendation #5 - Reduce Secondary Gains Available to Inmates
The CMA recognizes that some inmates may access health care for secondary gain. The Department reports that it is attempting to address this difficult issue.

Sincerely,

/s/ Linda A. Keen, R.N., J.D.
Executive Director

LAK/aa
c: CMA Board Members
Harry Singletary, Jr., Secretary of Corrections

This project was conducted in accordance with applicable evaluation standards. Copies of this report may be obtained by telephone (904/488-1023 or 800/531-2477), by FAX (904/487-3804), in person (Claude Pepper Building, Room 312, 111 W. Madison St.), or by mail (OPPAGA Report Production, P.O. Box 1735, Tallahassee, FL 32302). Web site: http://www.state.fl.us/oppaga/

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Appendix A
Advantages and Disadvantages of Policy Options

Option	Pros	Cons	Comment(s)
Sell over-the-counter (OTC) drugs such as aspirin, acetaminophen, antacids, and throat lozenges through the canteen rather than making them available for free in the housing units.	• Reduce overall cost of OTCs; $353,000 in fiscal year 1994-95; • Saves officer time in the Dorm; • Instills financial responsibility/management in inmates; • Presently implemented in two (California and Louisiana) other states contacted.	• Raises potential questions of fair access and problems with administration; • May lead to increased sick call visits, especially from indigent inmates; • Grievances likely to increase, requiring more staff time to handle them; • Administrative costs may offset savings achieved.	Medications are very inexpensive to Department; one option that might be easier to administer would be to charge all inmates a $5 annual over-the-counter medication fee.
Increase the inmate health care co-payment, for example to $5 from current $3.	• Instituting co-payment recovered $358,934 in fiscal year 1995-96, a $2 increase could recover an additional $200,000; • Further reduce unnecessary sick call visits; • The Department collected 72% of assessed co-pays in fiscal year 1994-95.	• Increase in grievances and staff time to handle them; • May drive up long-term treatment costs if inmates refuse to go to sick call when ill; • May be viewed as an access impediment; • In general, inmates have no means of earning money.	Increasing co-payment would produce a tradeoff - slightly greater cost recovery versus prospect that co-payment may discourage inmates from seeking needed medical care.
Institute an inmate co-payment for prescription medications.	• Recover a portion of drug costs, which were $12 million in fiscal year 1994-95; • Increase inmate fiscal responsibility/management.	• Inmates may resist cooperating with treatment by refusing to purchase and take medications; • Administrative resources time/required to implement and track a collection system; • Increased grievances and the time and staff required to handle them; • Could place greater burden on chronically ill inmates and inmates who require more medications.	If prescriptions are medically necessary, then it is not in the Department's interest to impede inmates from obtaining and taking those medications.
Increase the use of medical/mental health interns working as correctional medical staff in the institutions.	• Interns are cheaper than fully trained professional staff; • May act as in-service training/recruitment for future employees; • Reduce use of outside services with ability to deliver more in-house.	• Interns require strict supervision, will not decrease overall staff; • Interns limited in availability and services that can be provided; • Requires Department to negotiate/enter into an agreement with schools.	Due to supervision requirements and service limitations, the use of interns may not represent an overall savings.
Increase the use of the conditional medical release provision for terminally ill inmates unable to re-offend.	• Reduce the high cost of treating terminally ill inmates for the Department; • Increase number of Department of Corrections' beds available to ill inmates; • Estimated savings of up to $500,000 annually.	• Difficult to define life expectancy and inmate's ability to re-offend; • Shifts the financial burden to other state agencies, e.g., Medicaid/Medicare; • Allows offenders to leave prison before sentence has been completed.	In many cases, release of terminally ill inmates will save health care dollars, but such releases raise concerns about possible effect on victims and families and the inmate's ability to reoffend.

Option	Pros	Cons	Comment(s)
Increase the use of telemedicine, a form of videoconferencing between the inmate and a medical specialist.	• Reduce transport and security costs; • May provide for cheaper continuity of care, since inmates may not have to be physically seen by medical/mental health staff for follow-up care and/or assessment.	• Practitioner resistance to use of the technology; • May not serve to reduce treatment costs; the individual may need to be seen in addition to the telemedicine conference; • Cost required to install telemedicine equipment at institutions statewide.	Telemedicine is useful for some medical and mental health consultations. However, it is not clear whether doctors will use it enough to produce overall cost savings.
Increase the use of peer review for medical/mental health cases. Peer review could decrease the treatment costs by curbing or eliminating treatment.	• Ensures periodic review of health care/mental health decisions as a quality control issue; • Allows for review by more than 1 professional - doesn't come down to one opinion against another; • May reduce overall treatment costs if prescribed medications/treatment are curbed/eliminated.	• May be difficult to obtain and organize medical/mental health professionals that are familiar with the correctional setting to serve as peer review; • Takes doctors away from patient care; • Does not necessary lead to reduction in treatment - could lead to increases in treatment.	Difficult to reduce costs by having more doctors look at a case; second opinions are available internally when needed.
Increase the monitoring of community treatment billing for overcharges.	• Identifying and collecting overcharges will reduce overall costs; • Vigilance likely to lead to fewer overcharges by community providers.	• Increasing in-house reviews may require additional staff and additional training; • Emphasis on negotiated fees has decreased the number of bills for which over-billing is a concern.	Information not available on the number of bills not reviewed for overcharges. Monitoring and identifying outside care overcharges will save money and encourage providers to bill accurately.
Implement additional preventative health care measures, e.g., smoking cessation program. The Department has begun a wellness program.	• Reduction in long term treatment costs as inmates maintain their health; • Program(s) act to occupy inmates, reducing idleness; • Educate and instill inmate responsibility for their health.	• Additional staff required to develop and implement programs; • Cost of program implementation; • Institutional space limitations; • May not achieve measurable cost savings, or even effect inmate behavior.	While prevention is a key cost-containment strategy, efforts in the prison setting should be closely monitoring to ensure that outcomes justify the cost of implementation.
Replace the CMA and its institutional surveys with accreditation reviews of the National Commission on Correctional Health Care (NCCHC) or with monitoring by the Agency on Health Care Administration or the Department of Health.	• Projected cost savings range from $250,000 per year to $1 million per year; • NCCHC uses surveyors with specific training in correctional health services as opposed to CMA and other entities that use community consultants without specific corrections related training; • Other entities would not have a separate administration as CMA does, thus reducing some costs.	• Reviews by other agencies may not be as thorough as the CMA reviews; • CMA provides additional services, e.g., quality management, budget review, annual report to the Legislature.	While another monitoring body may provide services at a lower overall cost, the CMA provides the Legislature with a range of services that are generally beyond other monitoring bodies. If the CMA cooperates with OHS and utilizes the Department's QM program to assist in monitoring efforts, overall monitoring costs should be reduced.