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Follow-Up Report on Inmate Health Services Within the Department of Corrections

Abstract

The department addressed all of OPPAGA's recommendations and potential policy options.

- **The department is implementing a formal health care consolidation plan to contain inmate health care costs. Consolidation efforts will be completed January 1, 2000. Initial consolidation efforts have resulted in a cost avoidance of $4 million.**
- **The department and the Correctional Medical Authority disagree as to whether their inmate health care reviews are duplicative. OPPAGA agrees that there is some duplication, but this is necessary to ensure the department continues to delivery adequate inmate health care.**
- **The department delivered a report to the Legislature outlining several options to recover the cost of medications from inmates. OPPAGA does not recommend pursuing these options.**

Purpose

In accordance with state law, this follow-up report informs the Legislature of actions taken by the Department of Corrections in response to our 1996 report.[1, 2] This report presents our assessment of the extent to which the department has addressed the findings and recommendations included in our report.

Background

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 as inmates age, the number of HIV-positive inmates increases, and costly new drugs are developed.

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 a day. 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.

As a result of 21 years of litigation regarding the provision of inmate health care, the Legislature created the Florida Correctional Medical Authority (CMA) in 1986. The CMA provides independent oversight of the department's provision of health care services.

[1] Section 11.45(7)(f), F.S.

[2] *Review of Inmate Health Services Within the Department of Corrections,* Report No. 96-22, November 22, 1996.

Prior 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 leads the department to provide more medical services than may be necessary and thereby to create higher costs for the state.
- The Legislature and the department have already initiated some cost containment measures that have produced cost savings.
- 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 also pose significant disadvantages.

Current Status

Since our 1996 report, the department has attempted to contain inmate health care costs by assessing the level of care provided inmates, reviewing policies that may provide secondary gains to inmates, and identifying the cost-efficiency of health care delivery methods. In addition, the department is implementing a health care consolidation plan to contain both present and future inmate health care costs. The department is addressing all of OPPAGA's cost-saving recommendations and some of the policy options.

Actions Taken

Consolidation. OPPAGA recommended that the department develop a plan by June 30, 1997, that would include assigning staff on a regional basis and grouping inmates with special needs at selected institutions. The 1997 Legislature directed the department to adopt our recommendations to consolidate health care staff and services and report to the Legislature by January 1998 detailing the consolidations made.

The department has submitted a Health Services Consolidation Plan that outlines the current status of health care consolidation, staffing patterns, impact, potential problems, and the projected completion date of consolidation efforts.

Initial consolidation efforts have resulted in a cost avoidance of $4 million. Pharmacy consolidation, a reduction of dental FTEs, and the consolidation of health care staff at two correctional institutions, resulting in 17 fewer FTEs, have all contributed to the cost avoidance.

Privatization. OPPAGA recommended that the department issue a request for proposals to privatize health services for one of the department's five regions, with the stipulation that the vendor guarantee savings of 10% from the department's annual costs over a period of five years.

The department has only partially addressed this recommendation. It is focusing its efforts on the performance of privatized facilities in fulfilling their current contractual obligations and not on expansion of privatization. The department has issued an Invitation to Bid for the delivery of health care services at Broward Correctional Institution. The department has evaluated the abilities of each bidder to perform the requirements of the RFP but the cost proposals have not yet been opened. As of November 1998, a vendor had not yet been selected. The department reports that due to concerns about poor private vendor performance and cost issues, this is the only privatization initiative it is presently pursuing.

Electronic Medical Records. OPPAGA recommended that the department research the costs of developing an electronic medical records system and propose a cost-effective system that would improve health care management.

In January 1998, the department contracted with the consulting firm of Coopers and Lybrand to work with department staff to identify requirements for such a system. According to the department, the needs assessment and requirements definition have been completed as well as the comparative systems analysis. The contractor is due to make final presentations of the findings to the Office of Health Services prior to the end of 1998. Following this presentation, a specific proposal will be developed to pilot an electronic medical record system at a minimum of three institutions.

Standards of Care. OPPAGA recommended that the department review treatment guidelines to identify policies or procedures that allow inmates to receive

services beyond what is standard for the average citizen.

The department reports that because its goal is to provide only the level of care that is constitutionally required, staff routinely update policies and procedures to ensure that they meet the minimum acceptable levels of health care. In addition, the department reports that it assesses and takes issue with recommendations from Correctional Medical Authority surveys that seem to require care that exceeds minimum standard requirements.

Secondary Gains. OPPAGA recommended that the department reduce the opportunity for secondary gains that can be received by inmates through health services. For example, inmates who declare an after-hours mental health emergency may be transferred to an institution with air conditioning or female staff.

According to the department, it has achieved substantial success in this area by revising mental health policy directives to preclude after hour transfers. The department reports it will continue to address secondary gains through regular discussions at regional and central office meetings.

Correctional Medical Authority (CMA). OPPAGA recommended 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.

The department and the CMA disagree over whether the CMA's current review methodology is duplicative of the department's in two main areas: mortality review and surveys.

Both the department and CMA review all inmate deaths. In addition, the CMA has recently implemented a process to review selected deaths to determine the effectiveness of the department's mortality review program. The department believes that the CMA's new process is a suitable alternative to CMA reviewing each death and that CMA should stop reviewing every mortality report.

However, according to CMA, the full review and the sample review are conducted for different reasons. All mortalities are generally reviewed during the CMA survey for standard of care. A smaller sample of randomly selected mortalities is reviewed as part of the CMA's Quality Management program to determine whether the department's peer review process is adequate. CMA states that while standard of care and adequacy of peer review are related, they must both be reviewed to ensure the department is providing constitutional levels of care.

The department also reports that many of the items in its Health Services Quarterly Survey are similar, if not identical, to items reviewed during CMA surveys, but are structured in a more objective and measurable format than the corresponding CMA survey questions. The department provides its survey to CMA. Currently, the department and the CMA are reviewing the CMA survey instrument's validity, objectiveness, and effectiveness.

The Correctional Medical Authority states that "it is our opinion that the CMA reviews do not unnecessarily duplicate the department's quality management efforts" and that the department's quality assessment program is undergoing revisions to assure compliance with health care quality assessment standards. CMA reports that it is presently soliciting comments from a variety of sources, including the Department of Corrections, to improve its survey instrument and ensure objectivity.

The CMA's review of mortalities and the delivery of institutional health care are somewhat duplicative of the department's efforts. We concluded that this duplication is necessary for the CMA to fulfill its mission of independent oversight. We encourage the CMA and department to continue to work cooperatively to reduce duplication where possible, but realize that a minimal level of duplication is necessary to ensure that the department does not fall below the constitutional level of care it is required to provide all inmates.

Policy Options. OPPAGA also identified several policy options for the department and the Legislature to consider. These options include increasing the inmate co-payment for health services, increasing the use of interns and telemedicine, and expanding health education efforts. Each of these options also had potential disadvantages that could limit their usefulness. The department has implemented five of these options.

The Legislature specifically addressed one of OPPAGA's policy options by requiring the department to conduct a study and develop a plan to recover costs associated with over-the-counter and prescription medications for inmates. Accordingly, the department submitted a report to the Legislature in January 1998. According to the report, five other states are charging inmates for prescriptions, and each of these states (Indiana, Louisiana, Oklahoma, Utah, and Virginia) has a much smaller inmate population than Florida.

The report identified three options for recovering inmate medication costs (see Exhibit 1). The department reported that regardless of the option chosen, it has serious concerns about the long-term effects of co-payments. Possible effects include deterring inmates from seeking medical treatment, which would lead to higher long-term health care costs and increase the department's inmate grievance workload.

Exhibit 1
Options for Recovering Inmate Medical Costs

		Possible Assessment	Estimated Cost Recovery for Fiscal Year 1996-97
1.	Charge inmates a **co-payment** for each new non-mental health prescription	$1	$475,000
2.	Charge each inmate prescription user (non-mental health) a **monthly user fee**	1	214,000
3.	Charge every inmate (whether they use a prescription or not) a **monthly surcharge** (or premium)	1	612,000

The report stated that the first two options would increase the department's administrative workload. For example, one health services administrator described problems associated with investigating inmate complaints about improperly assessed co-payments and the need to process refunds to inmates. These problems would be exacerbated by deficiencies in the health services record keeping system noted in our report.

The department's report recommended the third option, a monthly $1 surcharge per inmate, as the best choice for a medication co-payment. The report states that the use of a surcharge is the least complex of the implementation options and would not increase the department's administrative workload as much as the other two options. However, the report acknowledges that this approach probably would not reduce frivolous or questionable attempts to acquire medications.

The department spent approximately $18.6 million on medications in Fiscal Year 1996-97. As Exhibit 1 illustrates, the co-payment options would recover only a small fraction of these costs. Because the third option would not reduce frivolous or questionable attempts to acquire medications, we do not believe it is a good policy choice. There is the potential that this option would increase the consumption of medications since inmates may feel entitled to them due to the charge. If increased use occurred, this would also increase the burden on staff to dispense the medications.

Because the potential cost recovery to be achieved through implementation of a $1 prescription and over-the-counter medication co-payment system is less than 3% of department prescription costs, and such a system may result in higher overall health care costs, we do not recommend the department proceed with such a system at this time.

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