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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D C 20548

GENERAL GOVERNMENT
DIVISION

August 5, 1977

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Mr. Norman A Carlson, Director
Federal Bureau of Prisons
Department of Justice

Dear Mr. Carlson

The General Accounting Office recently made a limited survey of health care delivery in Bureau of Prisons facilities and is presently conducting a similar survey in State prisons and local jails After we complete the latest survey, we plan to perform an overall review and report on health care delivery in correctional institutions. Before returning to the Bureau as part of our overall review, however, we would like to present to you our observations to date and make some suggestions for your consideration.

The following findings illustrate what we believe are gaps in the Bureau's ability to monitor and evaluate the effectiveness of its health care delivery system. Our survey was performed at the Bureau's headquarters, its Southeast Regional Office, and three facilities within that region--the U.S. Penitentiary in Atlanta, Georgia; the Federal Correctional Institution in Tallahassee, Florida, and the Federal Prison Camp at Eglin, Florida We examined records and procedures on a test basis, and discussed our observations with institutional, regional office, and central office officials. Our field work was performed between September 1975 and August 1976.

INMATE HEALTH NEEDS COULD BE BETTER ASSESSED

Knowing the health needs of the Bureau's inmates is a prerequisite to determining how well health care services are being provided and identifying areas for improvement.

We believe the Bureau's assessment of inmate health needs could be improved by conducting periodic physical

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examinations after the initial commitment examination and including more meaningful information in certain reports.

<u>Periodic physical examinations would improve assessment of inmate health needs</u>

The Medical Division does not require nor provide periodic physical examinations to inmates after their initial examination upon commitment Since inmates generally see a physician only when they have a complaint, no overall assessment can be made of inmate health problems after commitment, and little preventive care can be given. Also, because routine physical examinations are not provided when inmates are released, there is no way to assess changes in their health conditions during their term in prison.

As of January 1, 1978, the Division plans to provide routine physical examinations to older inmates According to the policy manual, every inmate 50 years of age or older will be given an electrocardiogram and offered other tests Those in that same age group who have been institutionalized for at least 2 years will also be offered a biennial physical examination

These procedures will provide the Bureau with better information on inmates over 50, but more could be done, particularly for younger inmates.

In 1975, the State of Michigan Office of Health and Medical Affairs published the results of thorough physical examinations given to 458 randomly selected State prison inmates. The examinations revealed 1.8 health problems per inmate, excluding dental problems. Approximately 5 percent of the men and 29 percent of the women needed urgent medical treatment. An additional 16 percent of the men and 29 percent of the women needed follow-up within 2 weeks of their examination. All of the women and 96 percent of the men examined needed dental services other than simple teeth cleaning.

The study resulted in a recommendation that inmates be given thorough routine periodic health examinations with the following objectives:

--detection of illness and disease for early intervention and treatment,

--prevention of epidemic illness,

--relief of inmates' anxieties about their personal health,

--opportunity for personalized health education,

--provision for considering inmates' health status and needs in determining their classification and assignment, and

--collection of a data base for monitoring health care system effectiveness and allocation of resources, and for research

In order to implement the recommendation, the report called for giving all inmates, subsequent to their initial examination at the time of reception, the opportunity for (1) a biannual thorough screening and physical examination, and (2) an annual thorough dental examination and prophylaxis

We do not suggest that the above findings are illustrative of the Federal prison system. But this example does indicate the need for thorough periodic routine physical examinations for persons living in close conditions such as corrections institutions. Periodic routine examinations could help prevent such situations from occurring and provide better information on inmate health needs.

<u>More meaningful information could make reports more useful to management</u>

Certain reports submitted by the institutions and the regional offices could be made more useful to management. These include quarterly and annual medical/dental reports and cost reports.

For example, the outpatient data reported in the quarterly and annual reports to the Central Office could provide a better indication of trends in workload. The reports now consist of a gross figure showing the number of visits to clinics. It would seem that a more detailed picture of the actual workload at each medical unit would be provided if the number of inmates treated for types of health problems and the number who had no actual medical problem were also reported.

Another example relates to the pharmaceutical cost data reported in fiscal year 1975. Although the Medical Division used this information to determine the total costs per inmate per year for each institution, it did not analyze the costs which comprised the total

Per capita costs for the Bureau's juvenile and youth institutions were generally comparable

Ashland	$12.66
Englewood	12.64
Morgantown	8 72
Pleasanton	12.00

But, when we analyzed the costs within those totals for psychopharmaceuticals, antibiotics, and other drugs, we found that the institutions apparently have widely different usage rates.

	Psychopharmaceuticals	Antibiotics	Other
Ashland	$9.71	$ 14	$ 2.81
Englewood	1.66	2 24	8.74
Morgantown	17	.26	8.29
Pleasanton	-	-	12.00

This analysis raises questions as to why the per capita purchases for different types of drugs varied so much between institutions with the same type of populations and indicates the need for management review

The Medical Director pointed out that annual purchases do not necessarily reflect annual usage. He also said that it is very difficult to develop accurate usage data. However, the Division might consider having the medical units accumulate usage data from the Monthly Narcotic, Hypnotic, Amphetamine, and Ethyl Alcohol Usage Report (PHS Form 1604) and reporting it in total and on a per capita basis. This would provide the Division with a tool for meeting its oversight responsibilities.

Recommendations

We recommend that the Bureau institute a program to provide periodic physical examinations to all inmates after their initial examination upon commitment.

Also, the Bureau should analyze the formats of its medical reports and make necessary revisions to provide more meaningful information for assessing its health programs.

We also recommend that the Bureau obtain more meaningful information for its managers by obtaining data (1) on the number of inmates treated for different types of health problems and the number who had no actual medical problem, (2) from periodic physical examinations, and (3) on drug usage.

IMPROVEMENTS CAN BE MADE IN HEALTH CARE MONITORING

The Bureau's health care units are not always reviewed as scheduled. The Bureau relies primarily upon reviews by independent accrediting organizations and on annual medical facility surveys conducted by the Regional Administrators of Medical Services (RAMS). However, some units have lost accreditation by failing to reapply and others are not surveyed annually by the RAMS Furthermore, the central office does not maintain an accurate schedule to verify that the reviews are performed when required Thus, it was unaware that some institutions were no longer accredited.

Better control over accreditation efforts is needed

To obtain accreditation for its medical and dental units, the Bureau uses the Joint Commission on Accreditation of Hospitals (JCAH), which is a nationally recognized accrediting authority that reviews health facilities for compliance with certain minimum standards, and the American Dental Association (ADA).

We found that medical units at three facilities--Lompoc, El Reno, and Terminal Island--were listed in the Bureau's December 31, 1975 Selected Medical Activities Summary as accredited, but, on March 15, 1976, central office records indicated their accreditations had expired from 1 to 4 years earlier. Inquiries to the institutions revealed the following

--The report of a recent survey at Lompoc was not finished.

--El Reno had been reaccredited in 1974 and the report was sent to the central office after our inquiry, and given to us on March 30, 1976.

--Terminal Island lost its accreditation in 1972 and had not sought reaccreditation. The central office was unaware of this situation.

The Division central office does not always receive copies of interim self-survey reports required by JCAH or request reports from institutions describing steps taken to comply with JCAH recommendations We asked for any such reports available and only a few were provided.

The Division Director told us that, while their files may have been incomplete and their listings incorrect in certain cases, they are aware of the situation at each unit. Regardless, we believe the central office records should reflect the current situation at each institution

In addition, at Atlanta some deficiencies still existed which were cited in JCAH recommendations. For example, in March 1976 JCAH suggested several corrective changes for medical records handling. However, many of the deficiencies still existed in May 1976. JCAH also proposed that the Atlanta staff develop criteria for use in medical care quality evaluations, but hospital officials could not provide us information demonstrating their compliance

The Medical Division's Dental Director said he prefers that each dental unit submit ADA survey and interim reports so that he can review them But we found in March 1976 that not all institutions send copies, and that the central office did not have accurate records showing which units were certified and when.

Annual surveys can be improved

Although the institutions are to be inspected annually by Bureau personnel, in actual practice

--not all institutions are surveyed, and

--the central office does not have updated information showing when and whether surveys were conducted.

Each of the five Bureau regions has a RAMS who is responsible for conducting the annual health service surveys at institutions in their respective regions. In addition, the Medical Director or the Deputy Medical Director occasionally evaluates an institution's health program during field trips.

The Medical Division's fiscal year 1977 Health Services Program Narratives states that RAMS health service surveys are performed at least annually at each facility. Although there is no policy statement concerning survey frequency,

Division officials expect the RAMS to visit each facility at least annually and perferably twice each year

We found that the central office did not have updated information concerning when RAMS surveys were performed, if at all Records obtained by the central office from the RAMS at our request showed that annual survey schedules were not maintained for all institutions

--The Medical Center at Springfield, Illinois had not been surveyed since 1972

--Leavenworth's hospital had not been surveyed since August 1972.

--The health unit at Sandstone was last surveyed in November 1974.

--The Milan health facility was surveyed in April 1976, however, the previous survey was performed in September 1972.

--The health care facility at Terre Haute was surveyed in March 1976 but the last survey had been June 1972.

--The Tallahassee facility received a "Familiarization Visit" by the Southeast RAMS in September 1974.

We asked the Bureau Medical Director why these delays had occurred, especially for Springfield since it is a Medical Center. He stated that formal RAMS and Bureau official surveys of Springfield and Leavenworth are operated by experienced Chief Medical Officers and accredited by the JCAH and therefore treated as independent hospitals. The Director said he reviewed the Springfield hospital in 1975, but no audit or trip report was filed.

The Medical Director also said that, as far as he knew, the RAMS had visited the other institutions considerably more than one time in the 18 months prior to April 1976. He said that it is possible the reports either were not written or were not forwarded to the central office.

Dental program surveys are inadequate

Although the dental program receives a large portion of Bureau resources and is an important part of an inmate's

health care, it appears that the RAMS are not surveying these services in-depth Several survey reports do not include any mention of a survey of the dental program, and the majority contain only very brief statements

One possible reason for this situation is that the RAMS are not well trained in dentistry At the August 1975 South Central Regional Dental meeting, it was suggested that the RAMS should use a dentist from the region to help perform future dental surveys because the RAMS lack dentistry training

Follow-up reports not available at central office

After the RAMS complete their survey they send a report to the Chief Medical Officer at the institution. He is requested to submit a report describing actions taken to implement survey recommendations These responses are not always sent to the central office Consequently, headquarters does not know if the reviews are having the desired effect.

Recommendations

We recommend that the Division central office update its list of accredited medical and dental units and insure that facilities apply for review when they are due.

We recommend that the Medical Division develop and enforce a policy which requires annual RAMS inspections of all Bureau medical facilities. Such a system of independent internal review of the Medical Division's operations, methods, systems, procedures, and practices would be an important mechanism for providing management officials with information as a basis for management action We believe that this form of independent internal review is needed to provide an appraisal of all other elements of control and to supplement and reinforce those controls.

Further, the question of whether RAMS can adequately perform dental inspections should be resolved.

PLANNING CRITERIA FOR EQUIPPING MEDICAL FACILITIES ARE LACKING

The regional offices and wardens make the procurement decisions for medical equipment, but there are no written criteria for equipping medical units.

We noted that when the Miami Federal Youth Center was being equipped with major medical equipment, the following information and instructions were sent to it from the Division central office·

--Review purchase order copies for major medical items ordered for the Butner Federal Correctional Institution and the Chicago Metropolitan Corrections Center, the Bureau Medical Director would review the X-ray machine before it was ordered

--Discuss needs with a person who is responsible for purchasing major medical equipment for all future new institutions.

--Confer with the central office, Office of Facilities Development person responsible for the Miami Federal Youth Center.

--Read information about the major medical dental equipment purchased for the Pleasanton Federal Youth Center

--Coordinate major dental equipment purchases with the Division Dental Director.

--Inspect xeroxed copies of the floor plans for Miami and Pleasanton.

The purchase orders from Butner and Chicago were of questionable value to Miami because those facilities contain prison populations with age ranges which differ from the Federal Youth Center and thus presumably could have different equipment requirements.

The Medical Director agreed that criteria are desirable but have not been thought to be necessary because most institutions have the same basic equipment and the staff who choose the equipment for new institutions are experienced people who should know what is needed.

Recommendations

To minimize any possibility of error, we recommend that the Bureau develop formal standards for purchasing medical equipment.

MATTERS IN NEED OF ATTENTION AT INSTITUTIONS WE VISITED

At the institutions visited, we identified several operational areas in need of attention.

Medical recordkeeping and handling could be improved at Atlanta

In our survey of inmate medical jackets at the Atlanta Penitentiary, we found that many were missing and incomplete

We selected 25 inmates who were in-patients at the penitentiary hospital and found that the medical narratives summarizing their hospital stays were not all filed in the medical jackets Jackets were located for only 14 patients (of the 11 remaining patients, 4 were still at the institution). In five cases there was no information in the folders to even show that the inmates had been hospitalized.

To examine this aspect further, 26 additional patients were selected who had been discharged much earlier from the penitentiary hospital (from 2 1/2 to 8 months) Of these, we located the medical folders for 13. Six of the jackets, or about 46 percent, contained no medical summaries. The hospital post orders require that medical narrative summaries be dictated within 48 hours after the patient's discharge and that the completed medical record be filed within 15 days. During a March 5, 1976 Atlanta Penitentiary staff meeting, it was stated that in-patient medical charts, including narrative summaries, should be completed by the attending physician and transferred to the medical records section within 8 days after discharge.

We also selected 17 inmates who had been patients in outside hospitals, but could locate medical record jackets for only 13 of them (1 inmate had died 6 months before). Of the 13 jackets, only 2 actually contained medical summaries.

A number of prescriptions for eye glasses had not been filed in the medical record jackets.

At Atlanta, three inmates worked in the medical records department. They had access to the confidential records, a situation which violates the JCAH standard that medical records be confidential, the National Institute of Law Enforcement and Criminal Justice prescriptive package recommendations, and Medical Division policies.

We were told that one possible reason for the problem at Atlanta was the shortage of properly trained medical records technicians and clerical staffs which forced the hospital to use untrained inmates to relieve the burden The Medical Division Director told us that more medical records technicians will be hired but that budgetary restraints have limited the acquisition of enough staff.

The medical records examined at Tallahassee and Eglin were generally complete, but some medical narrative summaries at both of these institutions were not signed by the attending physician

Pharmaceutical controls need strengthening

Several areas were noted at the three institutions where deficiencies existed in pharmaceutical controls.

Controlled drugs not audited regularly

While Tallahassee and Eglin maintained perpetual inventory counts on controlled drugs, they did not prepare the required monthly and quarterly audit reports. Neither institution maintained the Monthly Narcotic, Hypnotic, Amphetamine, and Ethyl Alcohol Usage Report (PHS Form 1604). There were no quarterly audit reports at Tallahassee, and none for Schedule V 1/ drugs at Eglin. In addition, Tallahassee did not have a Narcotics Auditing Officer.

Differences between inventory counts and perpetual balances

Stock record cards could not be used to monitor non-controlled drugs and medical items because physical inventory counts and perpetual inventory balances on the cards did not agree for a large number of items at Tallahassee and Eglin. At Tallahassee, we checked 72 stock record cards and found that 50 (about 69 percent) had differences between the physical inventory counts and the perpetual inventory balances. At Tallahassee and Eglin there were differences between the physical inventory counts and the pharmacy log book inventory counts, which are used to record issues to individual

1/ Includes Valium, Librium, and Thorazine

patients There was no evidence that officials made any attempt to reconcile these differences Discrepancies such as these can be caused by erroneous inventory counts, failure to record receipts and issuances, mathematical and posting errors, loss or theft of drugs, or some combination of these factors. But without reviews and reconciliations, the causes cannot be determined and the records are unreliable for control purposes

No record kept of used needles and syringes

The Bureau believes that it is important to control needles and syringes so that they do not become available to inmates who may use them for illegal purposes. Although all three institutions maintained records of new needles and syringes, none of them kept inventories of used items Institutions should keep accurate schedules of all syringes and needles, new and used, to control them until destroyed.

U S. Marshals' authorizations for drugs not retained

Eglin did not retain copies of the authorizations to give drugs to U S. Marshals to dispense to prisoners under their supervision. The hospital administrator said that copies of the authorizations will be retained in the future. We did not inquire about this procedure at the other institutions Although not required at the time of our survey, it is now Medical Division policy.

Drug retention procedures

Eglin had drugs on hand that had very little or no demand As of May 3, 1976, 25 of the 33 items on the quarterly controlled drug reports had not been dispensed since January 1975. Five of the drugs had been there for at least 5 years.

Such unused drugs should be disposed of to decrease the costs of administration, control and reporting, and to reduce the potential for abuse. The hospital administrative officer said that actions would be taken to remove the controlled drugs which have little demand.

Also, Eglin was receiving from military, Veterans Administration (VA), and Public Health Service supply depots some drugs without expiration dates and others which had limited remaining shelf life.

Lack of drug formularies

None of the three units had a drug formulary at the time of our survey. A formulary is a list of drugs which the doctors and pharmacist agree will be required to meet a wide range of therapeutic needs. The physicians then prescribe from the drugs listed in the formulary, which should be stocked at the pharmacy and readily available. The institution pharmacy should stock only drugs listed in the formulary, since these would be the ones appropriate for the levels of care available at the institution.

Atlanta and Tallahassee officials stated that they were establishing a formulary. But the Eglin administrative officer said that his institution did not need one In our view, establishing and periodically updating a drug formulary helps insure that only needed items are stocked and unnecessary items are not retained.

Identification procedures for inmates receiving medication are inadequate

Because of the identification procedures at Atlanta and Tallahassee, it is possible for an imposter to receive medication when unit medicine doses are dispensed by the pill line At Atlanta, medication is given when the inmate presents a treatment card. These cards can be misused, since the pharmacist or pharmacy physician assistant cannot recognize all inmates requesting medicine. Similarly at Tallahassee, an inmate appears at the treatment window and identifies himself by name. The attendant checks to see if he is to receive medication and then issues it. There is no procedure for verifying the identity of inmates at the institutions.

Recommendation

We recommend that the Bureau review institution pharmaceutical controls and make corrections by

--preparing standard operating procedures for storing, handling, and ordering pharmaceuticals;

--accounting for pharmaceutical inventories; and

--periodically monitoring pharmacy operations to insure conformity with prescribed procedures

Medical service contracts need more attention

At Atlanta and Tallahassee, the reasonableness of charges by hospitals and doctors were not always verified In some cases, charges were paid without bills being submitted, and in others, the payments exceeded the contracted prices. The files were not documented to support the reasonableness of the established charges or of the amounts billed.

For example, in July 1975, one optometrist charged Atlanta $300 per inmate for contact lenses In September 1975, for contact lenses correcting the same type of visual impairments, Atlanta was changed $400 per inmate There was no explanation by the optometrist on the voucher for the 33 percent price increase and evidence to show that an explanation was requested.

At Tallahassee, private doctors were paid for services without submitting bills. The payments were approved based on verbal information obtained when the visit was made or later through telephone calls. The hospital administrative officer stated that in the future they will try to obtain the doctor's bill before paying.

Tallahassee and Atlanta did not identify inmates receiving contract services. At Tallahassee the payment vouchers, supporting documentation, and surgery log did not identify five inmates who each received minor surgery from the consulting physician at a cost of $100 each. Several Atlanta inmates who received consulting services were not identified in the contract and payment files.

At both Atlanta and Tallahassee, there was evidence that some payments exceeded contracted prices For example, the Atlanta prison hospital did not refer to its contract with an outside hospital before approving bills for payment. We determined that the prices in the contract were different from those being paid.

Recommendation

These units should take steps to check that billings and payments are correct and that charges are supported.

Medical staff not receiving required training

The Medical Services Quarterly Reports showed that neither doctors nor medical technical assistants were receiving the required outside education at Atlanta and Tallahassee facilities. The physician assistants were not getting minimal professional refresher training Lack of funds was cited as the primary reason for these conditions.

Our survey of the Southeast region revealed that physician assistants and medical technical assistants were not receiving formalized in-service training at the Atlanta Penitentiary Hospital However, the Tallahassee and Eglin units were providing such training.

REIMBURSEMENTS TO VETERANS ADMINISTRATION HOSPITALS FOR INMATE VETERANS

At the time of our survey, the Bureau was reimbursing the Veterans Administration for costs incurred by inmate veterans who were treated at VA hospitals

Our Office of General Counsel prepared a draft opinion stating that it is improper for the Bureau to reimburse the VA for such services. No recommendation is being made since the Bureau and VA General Counsels have both concurred with that opinion.

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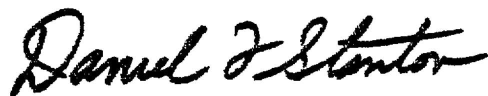
We appreciate the cooperation and courtesy extended to us by central office, Southeast region, and institutional officials during our survey Please inform us about any action taken on the recommendations contained in this letter

Sincerely yours,



Daniel F. Stanton
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