BY THE COMPTROLLER GENERAL

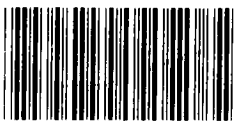
Report To The Congress

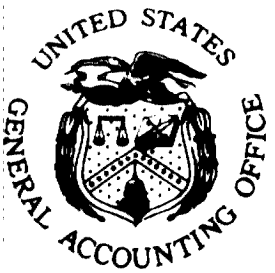
OF THE UNITED STATES

A Federal Strategy Is Needed To Help Improve Medical And Dental Care In Prisons And Jails

The health care delivery systems of most prisons and jails are inadequate because of deficiencies in assuring adequate levels of care, physical examinations, medical records, staffing, facilities, and equipment. Officials said they lacked funds to make improvements. Should those needs continue to be underfunded, it is critical that ways to improve utilization of all available resources be examined.

The Federal Government has made commitments to improve both health care and correctional programs through the U.S. Public Health Service, the Law Enforcement Assistance Administration, and other agencies. These commitments should be combined into a Federal strategy that will improve the health care delivery systems of prisons and jails, and make better use of available health care resources.





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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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To the President of the Senate and the
Speaker of the House of Representatives

This report discusses inadequacies in inmate health care delivery systems in Federal and State prisons and local jails. It makes certain recommendations for improving inmate medical and dental care in Federal prisons and recommends a Federal strategy to help improve medical and dental care in State and local correctional institutions.

This review was made because of concern expressed by the Congress and others about the adequacy of health care provided to inmates of prisons and jails. It is the initial report of an ongoing review of health care systems in prisons and jails.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget; the Attorney General; and the Secretary of Health, Education, and Welfare.

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

A FEDERAL STRATEGY IS NEEDED TO HELP IMPROVE MEDICAL AND DENTAL CARE IN PRISONS AND JAILS

D I G E S T

Health care delivery systems of most prisons and jails are inadequate, and many correctional agencies are under increasing pressure, particularly from the courts, to provide more adequate levels of care. Prisons and jails are no longer able to disregard their inmates' health.

This report discusses the problems of providing adequate medical and dental care to inmates and the need for a Federal strategy to help correctional agencies overcome these problems.

INADEQUATE HEALTH CARE DELIVERY IN PRISONS AND JAILS

GAO found that, to varying degrees, Federal and State prisons and local jails do not meet minimum standards for providing adequate levels of care, physical examinations, medical records, staffing, facilities, and equipment.

--Inmates' health needs can only be learned by giving them thorough physical examinations when incarcerated and periodically thereafter. While the prisons visited gave comprehensive entrance physicals, diagnostic testing and dental examinations in State prisons were inadequate. None of the State and Federal prisons gave subsequent physicals unless requested by inmates. Most jails gave no physicals. (See pp. 8 to 12.)

--Medical and dental records must be complete and confidential. The records GAO examined were not always complete, and many State prisons and some Federal institutions assigned inmates to maintain them. Most jails kept no medical records. (See pp. 12 to 17.)

--Sufficient, qualified health staff should be available. Nearly every prison system had

problems attracting and keeping qualified health staff because of unsatisfactory salaries, facilities, job status, personal safety, and protection from potential malpractice suits. Many small jails had no medical staff available to give first aid or entrance physicals. (See pp. 18 to 22.)

--Prisons and jails should meet national medical and dental care standards for the services they provide, or obtain these services in the community. Health units in Federal prisons appeared to meet the standards for services provided, but those in State prisons did not meet all the minimum standards. Most jails had limited facilities and some had none. (See pp. 22 to 24.)

INADEQUATE ASSESSMENT OF HEALTH CARE IN PRISONS AND JAILS

To begin solving the problems GAO found, correctional administrators must determine the medical and dental needs of inmates and the resources required to meet those needs. They should use this information to design and implement adequate health care delivery systems and mechanisms for monitoring their performance. (See ch. 3.)

The health care delivery systems reviewed generally did not have the resources for providing adequate health care or for making improvements. Should they continue to be underfunded, officials must improve their utilization of all available health care resources, particularly those in the community.

Correctional institutions should not duplicate any services economically and conveniently available in the community. Jails especially need help from community health care providers because of the everpresent danger of inmates transmitting communicable diseases which are community health problems.

A FEDERAL STRATEGY IS NEEDED

The Federal Government has given only limited attention to the medical and dental care of

inmates despite its long-standing commitments toward improving (1) health care through the U.S. Public Health Service and (2) correctional programs through the Law Enforcement Assistance Administration and other agencies. GAO believes these commitments need to be combined into a Federal strategy for (1) improving the health care delivery systems of prisons and jails and (2) better utilizing available health care resources.

The Federal strategy GAO envisions would require correctional officials to demonstrate their commitments by

--determining the medical and dental needs of their inmates and

--implementing whatever health standards they can within their existing capabilities.

Remaining problems could then be addressed by applying available Federal resources, technical expertise, and influence.

The Federal Government cannot fully subsidize health care delivery systems in State prisons and local jails; but it can make existing financial and technical assistance programs available to these systems to help support comprehensive studies of the systems and development of management information and review mechanisms. In addition, prison and jail inmates could be served by federally supported State and local health programs where practical.

RECOMMENDATIONS

The Law Enforcement Assistance Administration should develop and implement a Federal strategy to help State and local governments bring their prison and jail health care delivery systems into compliance with standards promulgated by the American Correctional Association and the American Medical Association. It should incorporate into the Federal strategy the appropriate expertise and resources of the U.S. Public Health Service, National Institute of Corrections, and U.S. Marshals Service. To participate, State and local governments should be required to

--determine the medical and dental needs of their inmates and the proper mix of resources to meet those needs and

--implement whatever health care standards they can within their existing resources. (See ch. 5.)

The U.S. Public Health Service should closely monitor its newly initiated Prison Health Program and, if successful, expand it within the Federal strategy. It should provide grants under section 1625 of Public Law 93-641 (the Public Health Service Act) to help State and local correctional institutions bring their medical and dental facilities into compliance with existing standards, and explore the feasibility of utilizing other applicable assistance programs within the Federal strategy. It should also encourage State and local health planning agencies to participate in the Federal strategy by considering inmate populations when planning and programing for community health improvements.

In addition, the U.S. Marshals Service, which contracts with and supervises over 1,000 non-Federal facilities housing about 5,000 Federal prisoners a day, should assist in the Federal strategy by providing technical assistance and funding for improving medical and dental care at those contract facilities.

To upgrade the level of health care in Federal institutions, the Bureau of Prisons should:

--Reexamine its policy on physical examinations to include biennial examinations of all inmates and mandatory examinations of inmates about to be released.

--Replace inmates working in sensitive positions, such as maintaining medical records, with qualified civilian personnel.

--Take appropriate actions to assure 24-hour coverage by qualified medical personnel at all institutions.

AGENCY COMMENTS

The Department of Justice agreed with GAO's conclusion that there is a need to improve medical and dental care services in prisons and jails and noted that the Department is taking a number of actions which are consistent with the recommendations of the report. However, the Department did not specifically state how it will implement the Federal strategy. (See app. I.)

The Department of Health, Education, and Welfare concurred with the findings and is taking certain actions that are consistent with most of GAO's recommendations. However, the Department stated that although it has legal authority to make grants to correctional institutions under section 1625 of the Public Health Service Act, the current funding level makes such grants unlikely. (See app. II.)

In each of the States visited, copies of the draft report were provided to the appropriate correctional agency and to the State planning agency. A copy of the draft was also provided to the American Medical Association. Comments received from these organizations were considered in the report, and changes have been made, where appropriate.

Contents

ABBREVIATIONS

ACA	American Correctional Association
ADA	American Dental Association
AMA	American Medical Association
APHA	American Public Health Association
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
JCAH	Joint Commission on Accreditation of Hospitals
LEAA	Law Enforcement Assistance Administration
PHS	Public Health Service
USMS	U.S. Marshals Service

CHAPTER 1

INTRODUCTION

Federal, State, and local governments are spending about $3 billion annually to house approximately 500,000 inmates in 4,500 institutions--ranging in size from large-walled prisons housing thousands of inmates to small jails housing a few. Aside from finding enough space for them, one of the most pressing problems is providing them with adequate health care.

Proper health care for inmates of correctional institutions has become a major prisoners' rights issue in recent years. Correctional officials, the courts, and the legislatures are all, to varying degrees, concluding that inmates must have access to adequate health care. The elements of what constitutes adequate health care are evolving through the promulgation of professional standards and Federal court decisions. But many correctional facilities still face the problem of how to bring their level of health care to that which is considered adequate.

This report discusses problems that Federal, State, and local governments are having in assuring that adequate medical and dental care is provided to inmates in Federal and State prisons and local jails in 10 States, and the need for a Federal strategy for improving health care assistance. We are conducting a separate review of mental health and drug and alcohol rehabilitation programs.

CONCERN ABOUT MEDICAL AND DENTAL CARE OF INMATES HAS INCREASED

The alleged absence of proper medical and dental care has been one reason for inmate dissatisfaction in recent years and has resulted in countless complaints to lawyers, legislators, and judges. Hundreds of suits have been filed. Court decisions resulting from this dissatisfaction have declared that the unreasonable deprivation of medical and dental care is unconstitutional, and some States have been ordered to take action.

A 1972 U.S. District Court decision, for example, concluded that inmates in one State were deprived of proper and adequate medical treatment guaranteed them under the Constitution. The court found prison medical facilities so grossly understaffed and inadequate that there were frequent shortages of (1) trained medical personnel, (2) sick calls, and (3) basic medical supplies. The court ruled that the failure of the State to provide adequate medical treatment

violated the rights of prisoners by constituting "cruel and unusual" punishment under the Eighth and Fourteenth Amendments to the Constitution. Moreover, the State was ordered to begin making drastic improvements in its prison health care system and to report its progress to the court.

In a more recent class action suit against a prison in another State, a U.S. District Court judge declared the prison conditions unconstitutional. Contributing to the court's decision was the testimony of two experts on delivery of medical services in a correctional setting. They testified that the system of medical care delivery was inadequate by any acceptable standards to meet inmates' routine and emergency health needs. The court concluded that the State consciously disregarded a grave and substantial risk to its inmates' health and well-being and ordered it to bring health care delivery into compliance with minimum standards within 6 months.

DIFFERENT CHARACTERISTICS OF PRISONS AND JAILS CALL FOR DIFFERENT HEALTH CARE DELIVERY SYSTEMS

There are two basic differences between prisons and jails which call for different health care delivery systems:

--Prisons are much larger than jails, with about 590 facilities in the country holding about 250,000 inmates. There are about 3,900 local jails in the country with about 142,000 inmates on any given day; about 75 percent of the jails are small, holding 20 or fewer inmates.

--Prison confinement is for much longer periods than jail confinement, with sentences ranging from 1 year to life. Jail confinement is generally for shorter periods--usually from 24 hours to 1 year--with most inmates being detained less than 1 week, although some may stay much longer, awaiting trial or space in prison.

While prisons and jails are responsible for assuring that adequate medical and dental services are made available to persons in their custody, prisons are expected to have more comprehensive programs.

HEALTH CARE STANDARDS HAVE NOT BEEN NATIONALLY ADOPTED

While hospitals and other health care providers have for many years been required to comply with State licensing

standards and requirements, prison hospitals and infirmaries --with few exceptions--have not been subject to these requirements. Until recently, no health care standards were available for correctional insitutions. Now, however, the American Public Health Association (APHA), the American Correctional Association (ACA), and the American Medical Association (AMA) have promulgated medical and dental standards for prisons and jails 1/ which provide State and local governments with guidance for making needed improvements to health care in prisons and jails. The standards are consistent with those expected of other health care providers.

At the time of our review, State and local governments were just becoming aware of the APHA, ACA, and AMA health standards for prisons and jails. Few were in the process of implementing them.

The APHA standards for health services in correctional institutions are based on the premise that (1) adequate health care for the incarcerated is a public responsibility to be borne jointly by the criminal justice and health care systems and (2) the level of health care services for those incarcerated should be of a comparable standard to that prevailing in the commuunity at large. The standards address

--primary health care services, including entrance and periodic examinations;

--secondary care services;

--dental care;

--pharmacy services;

--health records;

--staffing; and

--other important issues affecting the overall health of inmates.

ACA prison health care standards are part of its overall standards for adult correctional institutions. The standards state that there should be

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1/On June 23, 1978, the U.S. Department of Justice released its "Draft Federal Standards for Corrections" for public comment. The standards cover a broad range of correctional issues but include a number of specific standards for inmate medical and dental care.

---routine physical and dental examinations followed by proper treatment as necessary,

--adequate recording of these examinations and treatments to document the adequacy of care provided,

--medical personnel available to handle emergencies and treat routine needs, and

--hospitals or infirmaries which measure up to acceptable health and environmental standards.

AMA jail health care standards recognize that jails are smaller than prisons, and confinement is generally for short periods. Nevertheless, the standards require provisions for emergency medical and dental care of inmates. In addition, because of the danger jails present for spreading communicable health problems such as body lice, venereal diseases, tuberculosis, and hepatitis, the standards require that, as a minimum, medical screening for health problems requiring immediate treatment be performed on new inmates before they are placed into the general population.

While we included four jails in our study, most of our review work was accomplished at Federal and State prisons. This was done because the AMA had done extensive survey work on jails in developing their jail health care standards. (Ch. 6 discusses in detail the scope of our review.)

THE FEDERAL GOVERNMENT IS INVOLVED IN PROVIDING HEALTH CARE TO INMATES

The Government provides health care to inmates in Federal correctional institutions and also helps State and local governments improve health care to inmates in their prisons and jails. This latter activity is accomplished primarily by providing funds through the Law Enforcement Assistance Administration (LEAA).

The Federal Bureau of Prisons is responsible for providing a comprehensive health program for approximately 29,000 inmates. The program includes preventive medicine, curative medicine, and rehabilitation. In addition, the Bureau's Medical Division is responsible for training and educating inmates and staff in health principles and techniques.

LEAA provides funds in the form of block or discretionary grants to State and local governments for programs and projects to improve and strengthen law enforcement and criminal

justice. Some of these funds have been used in the health care area. For example, Michigan used LEAA funds to study its health care delivery system to determine improvements needed, and New York used them to develop its organizational structure to improve prison health care and to establish a computer system for medical records. Michigan also received $1 million in LEAA funds to develop a health care training program to be used in 10 States.

The Department of Health, Education, and Welfare (HEW) has started a new program to improve health care for inmates of correctional institutions. Recently, HEW began coordinating its efforts with LEAA to gain the expertise of LEAA in State and local criminal justice systems. Some other Federal agencies have provided funds for health care, but their involvement has been limited.

A detailed discussion of Federal involvement in improving inmate health care may be found in chapter 4.

CHAPTER 2

MANY PRISON AND JAIL HEALTH CARE DELIVERY SYSTEMS ARE IN BAD SHAPE

The health care delivery systems of most prisons and jails are inadequate, and although some improvements have been made or attempted in the last few years, progress has been slow. Widespread deficiencies exist in providing adequate levels of care, physical examinations, medical records, staffing, facilities, and equipment.

An adequate medical and dental care system is comprised of many service elements including physical examinations, X-ray and laboratory procedures, daily sick call routines, recordkeeping, and most importantly, medical and dental routines to resolve health problems identified. For prison health care to be considered adequate, there must be sufficient numbers of doctors, dentists, and allied health staff 1/ to provide these services. Of equal importance, the health staff needs space, supplies, and equipment to perform the services. Depending on the levels of care provided in an institution, it needs properly equipped hospitals or infirmaries, X-ray and laboratory units, dental units, and administrative offices in which to prepare and store medical records and perform the numerous other tasks necessary for administering comprehensive health programs.

Since most of the Nation's jails are small, most do not need, nor do they have, elaborate health care facilities and staff. Most small jails rely on adjacent community hospitals to provide health care for people in their custody. In contrast, large city jails have some staff and equipment and, as a result, provide many basic health care services.

Regardless of the method used, there must be access to medically trained staff and proper equipment because jail officials are responsible for providing health care to inmates. Moreover, because of the danger jails present for spreading communicable disease, new inmates must be medically screened for such health problems as body lice, venereal diseases, tuberculosis, and hepatitis.

1/Allied health staff consists of professional, technical, and supportive workers in patient care who assist physicians and dentists and supplement their professional services.

HEALTH CARE DELIVERY SYSTEMS VARY IN DESIGN

Federal and State prisons have similar health care delivery systems; both give physical and dental examinations, maintain health records, hold sick call, distribute medications, and maintain staffed medical and dental units for inmates needing treatment or bed rest for recovering from illnesses or surgical procedures. In our visits to selected Federal and State prisons, however, we noted that methods of delivering health care varied dramatically regarding the use of prison hospitals and health staff and regarding the way services were provided. We noted these variances among States and among prisons in States.

Most State prison systems, for example, recognized they could not afford to comply with State hospital licensing standards and requirements and, therefore, downgraded their hospitals to infirmaries. In these States, prisons performed only minor surgery. 1/ Two States' prisons visited, however, still performed major surgery inside the walls even though we were told the prison hospitals did not meet State licensing standards and requirements.

We also noted that:

--Entrance physicals seemed to be complete except for dental examinations, which ranged from a visual inspection for missing teeth to a full set of X-rays.

--Health records ranged from unsigned and undated hodgepodge administered by untrained clerks to well-organized, documented files administered by trained clerks and Registered Record Administrators.

--Sick call ranged from once a week to daily, and was administered by a wide range of people--from unlicensed/uncertified-allied staff to registered nurses and licensed physicians.

--Prescription medications were sometimes prescribed by unlicensed staff and sometimes by licensed doctors.

1/Minor surgery pertains to relatively simple operations not requiring entry into body cavities or the use of whole blood; for example, removing a callous or stitching a wound.

Health service provided in jails also varies dramatically --ranging from reliance on community resources by small rural jails to the use of well-staffed medical units in larger metropolitan jails.

Descriptions of health services provided in the Federal Bureau of Prisons and those States in which we did detailed audit work are in appendix IV.

PHYSICAL EXAMINATIONS ARE BECOMING MORE THOROUGH BUT PROBLEMS STILL EXIST

Inmates' health can only be learned by giving thorough physical examinations and can only be reassessed if these examinations are conducted periodically before they leave the system. Although the Bureau conducts thorough physical examinations of all new inmates, periodic reexaminations are given only to inmates who have attained the age of 50. In State correctional systems, inmate entrance physicals were not always thorough, and periodic reexaminations were usually not given. In jails, inmates rarely received admission physicals and periodic reexaminations.

Initial screening of inmates

Prisons

ACA standards require that inmates first entering a prison system or jail be given an initial health screening and, within 2 weeks, a comprehensive health examination. The initial screening is a system of structured observations and assessments of inmate health needs and general conditions designed to identify those with communicable disease or other health problems requiring immediate treatment. The comprehensive health evaluation, at a minimum, includes a medical history, physical examination, and prediagnostic tests. Both the initial screening and the comprehensive health evaluation should be completed before new inmates are placed in general prison populations.

Bureau of Prisons' policies require that entrance examinations be sufficiently detailed and given with such care as to permit an appraisal of an inmate's physical and dental condition. In addition, special examinations are performed at the request of proper authorities when medical information is needed or requested. In the six U.S. prisons visited, inmates were given comprehensive examinations when entering the prison system.

Most of the States visited also had policies requiring that medical examinations be given to all new inmates before being assigned to the general prison population, and the physicals seemed sufficiently comprehensive. However, because of an increase in the number of new inmates and shortages of medical staff, the Medical Director in one State said he doubted that all new inmates were getting physicals, and in another State, some new inmates were assigned to the general populations before getting physicals. The policy in all but 3 of the 10 States was that new inmates would get dental examinations; however, these examinations often were not done unless inmates complained and, when they were done, consisted only of visual inspections. Most prison dental units lacked equipment to do full mouth X-rays.

Studies performed by three States on health care provided in their prisons indicated that entrance examinations are more complete now than they were a few years ago.

--A December 1971 report on Massachusetts' prisons noted that systematic procedures for screening for diseases were lacking and, with few exceptions, the quality of intake histories and medical and dental examinations was poor when performed at all. One recommendation called for the establishment of defined and uniform intake medical procedures, including complete physical and laboratory examinations and appropriate immunization procedures. At the time of our visit, comprehensive entrance physicals were being given.

--In a January 1975 study on Michigan prisons, multiphasic health screening and thorough physical and dental examinations were performed on 458 randomly selected inmates already in the system. As discussed below (see p. 11), this indicated that numerous medical and dental problems within the study group went unnoticed during the entrance physicals. One of the report's recommendations was that new inmates should be given the same thorough physical and dental examinations as those given during the study. At the time of our visit, we were told that more comprehensive entrance physicals were being given.

--A 1972 report entitled "Health Care and Conditions in Pennsylvania's State Prisons," reported that cursory entrance physical examinations were given. Comprehensive physicals were being given, however, at the time of our visit.

Jails

In two studies of jails, the AMA found that routine physicals of all inmates upon admission were rarely given. The results of an AMA survey questionnaire from 1,108 jails 1/ revealed that the vast majority of jails examined inmates only if they complained. Only 75 jails indicated that all inmates received an examination.

The percentage of respondents indicating that all inmates received examinations increased as jail size increased. In an in-depth study of 30 jails, 2/ the AMA found that only 4 provided routine physicals of all inmates on admission, and only 2 included any routine screening for communicable diseases.

Three of the four jails visited during our review did not screen inmates before they entered jail. While jail officials acknowledged screening was desirable, they said most jails lacked the funds, staff, and facilities to provide the service. One official, however, was attempting to establish a working agreement with his county health department to obtain staff for screening new inmates. This official said the health department was funded and staffed to provide services to the public, including inmates, and felt that now was the time to begin using their services.

Only one jail visited actually screened inmates before placing them in the general jail population. Upon entering the jail, inmates were first given a cursory screening by a correctional officer and then held separately from the general population until a member of the medical staff gave them a physical examination. The examination consisted of routine medical tests, including blood tests, chest X-rays, serology, urinalysis, etc.

Periodic reexaminations of inmates

The ACA recommends that conditions for periodic health examinations be specified. It believes that (1) persons 50 years of age and over should be given annual physical examinations, (2) all other inmates should receive thorough

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1/Medical Care in U.S. Jails--a 1972 AMA Survey.

2/Final Evaluation Report of the American Medical Association's Program to Improve Health Care in Jails (Year One) February 18, 1977.

physical examinations at least biennially, and (3) all inmates should be examined prior to release to protect both the inmate and society.

One in-depth study 1/ of 458 inmates already in a State prison system demonstrated the need for periodic examinations. The study 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, and an additional 16 percent of the men and 29 percent of the women needed a followup 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. Among other things, the study recommended that inmates be given thorough periodic health examinations for

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

--prevention of epidemic illness, and

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

This example indicates the need for thorough periodic physical examinations for persons living in correctional institutions to provide better information on the status of their health.

The Bureau of Prisons' policy calls only for biennial physical examinations of persons who have attained the age of 50, and examinations of individuals about to be released if they make a specific request. Bureau officials said they did not perform more examinations because they lacked sufficient staff, and they were not convinced that periodic physical examinations were very productive.

At the time of our visits to six Federal prisons, periodic examinations were not given to all inmates. Bureau officials stated that periodic physicals will be given to inmates over 50 years old as staff and resources become available. Inmates under 50 years of age are not regularly scheduled for periodic examinations but may request physicals by attending sick call or being admitted to the prison hospital.

1/"Key to Health for a Padlocked Society," January 1975.

The States had varying policies on periodic examinations. One State's policy was that inmates, regardless of age, should be afforded the opportunity of biennial physicals and annual dental examinations. Another State had a policy whereby physical examinations were to be given once a year to all inmates over 40 years of age, and inmates under 40 were to receive physicals biennially. Five States had no policies regarding physical examinations. But regardless of their policies, officials stated that due to a lack of funds and staff, they were (1) unable to give periodic examinations, (2) only gave them upon request, or (3) only gave them if and when inmates complained at sick call. Also, physicals were not given to inmates leaving the system.

In its study of 30 jails, the AMA found that routine physicals for any category of inmates (e.g., kitchen help) were available in only 11 jails. However, the type and extent of the screening performed varied a great deal among these 11 jails. In some cases, the physical exam consisted only of tuberculosis and/or venereal disease screening for those staying over a certain length of time. In others, full physicals were performed on all long-term inmates (e.g., those staying over 30 days.) Still others gave physical exams only to sentenced inmates.

PATIENTS' RECORDS ARE NEITHER COMPLETE NOR WELL MANAGED

Health care professionals place much emphasis on good medical and dental records which adequately document the conditions of patients and the care provided them at each encounter with health care providers. The ACA standards require that medical and dental personnel maintain complete records of treatment given inmates to ensure continuity of care. The record should list all medical visits, diagnoses made, and treatment prescribed. To maintain confidentiality of information, the responsible physician should control access to records, particularly inmates' access.

Records should be complete

What should the medical record contain? The AMA's Department of Practice Management, in its seminar for new physicians, stresses that the content of individual medical records is totally up to individual physicians. Because of the current malpractice climate, however, physicians are well advised to include as much information as possible, as well as notations regarding place, time and date of medical encounters, and health care provider involved in the episode of care. The AMA and other professionals believe all significant

clinical information pertaining to a patient should be incorporated in the patient's medical record. In fact, the record should be sufficiently detailed to enable

--the practitioner to give effective continuing care to the patient, as well as to enable him/her to determine at a future date, what the patient's condition was at a specific time and what procedures were performed;

--a consultant to give an opinion after his/her examination of the patient; and

--another practitioner to assume the care of the patient at any time.

We believe these requirements should be applicable to the records of a correctional institution's medical unit.

A medical/dental record for all inmates should be opened at the time of their arrival in the correctional system. It should record, at a minimum, inmates' medical history, physical examination, and prediagnostic tests. Each contact of an inmate with the medical/dental services should be entered, as appropriate, in the form of progress notes, nursing notes, laboratory reports, consultants' opinions, diagnoses, orders, and treatment plans.

Bureau policy requires that physical examinations be reported on standard Federal medical and dental examination and history forms. All sick call visits are to be recorded on a standard chronological record of medical care listing the date, nature of complaint given, physical findings, diagnoses, and treatment prescribed. An additional report of injuries is supposed to be filled out on any injury requiring first aid. All standards of the Joint Commission on Accreditation of Hospitals (JCAH) are to followed.

We examined medical records in five of the six Federal institutions visited and obtained copies of regional inspection reports on all six. In the one institution where we did not examine medical records, a recent regional inspection report revealed that medications issued to inmates were not always recorded in their medical records. The report also noted that the records for three inpatients in the hospital disclosed that:

--The entrance physical examination form was grossly inadequate and had not been signed in any of the three cases.

--Admission orders were missing.

--There was no record of the laboratory work.

The medical records examined at four of the five remaining Federal institutions were generally complete and in compliance with Bureau policies; this was substantiated by regional inspection reports. In our August 5, 1977, letter report to the Bureau, we advised it that many records at the remaining institution were missing and incomplete. We reported that:

--Medical record files we selected for 24 of 51 inmates who were recent inpatients at the prison hospital could not be located. Five of the 27 files found contained no indication that the inmates were hospitalized. Many other files were not summarized.

--We also selected medical record files for 17 inmates who were inpatients at outside hospitals. Files for 4 inmates could not be found. Only 2 of the remaining 13 files were summarized.

A subsequent report by Bureau officials indicated that while outpatient records were good, improvements were needed on inpatient records.

The 10 States visited required that medical and dental records be maintained, and officials agreed that good record systems are valuable. Discussions with officials--including a detailed examination of selected records in three States--however, revealed that six States were not keeping adequate records.

In one State, our medical consultant 1/ reviewed 40 medical records. Examination of the 38 files located revealed the following:

--Materials were stapled together in a hodgepodge, making it a formidable task for anyone to review a medical record.

1/We used one staff and two contract medical consultant physicians to help assess the adequacy of medical records, facilities, and staff at selected prisons in three States.

--Many medical reports were unsigned and undated, making it impossible to tell (1) whether an opinion was expressed by a physician or someone other than a physician and (2) when the opinion was expressed.

--Dental cavities were noted on several entry examinations with no notations on dental consultations.

--Records did not always indicate that treatments were fully carried out. In one case, an inmate sustained an injury to his face; X-rays were requested but results were not recorded. Another inmate had evidence of infectious hepatitis, but no blood tests were recorded in the file.

In examining 40 medical records at a prison hospital in another State, our medical consultant found incomplete record because all data on inmates going to the hospital for treatment or evaluation were not sent. For example, initial histories and physical examinations were not part of the hospital records.

In the third State, our medical consultant went to three prisons and found that:

--Twenty files, randomly selected at one prison, contained brief notes of outpatient visits, many of them almost illegible. She also requested cases of epilepsy, diabetes, heart problems, or asthma, which also contained many brief notes that were almost illegible. The files did not contain sufficient information to assess the care given. She also asked for a few old charts, the records of which were in very bad shape.

--Of 40 charts reviewed at a second prison, neither those picked at random nor those picked because they involved epilepsy, diabetes, heart disease, or asthma, contained sufficient information. Many of the entries were illegible.

--At the third prison, records were even less satisfactory than those of the other two.

In another State, the medical association was asked to review a prison hospital. The chairman of the survey committee reported that the prison's medical records were inadequate in terms of content, continuity, currentness, and legibility. Medical record procedures were estimated to be at least 20 years behind the time. Often, a discharge summary was substituted for the documents required in an adequate medical

record, and frequently the initial history and physical record was not included.

While we were not permitted to examine medical records in two States, our conversations with prison officials indicated that they were not well maintained. The medical director of one State correctional system told us the records were in a disastrous condition, and he had not had the opportunity to develop the necessary written policies and procedures to correct the problems nor did he have the money to hire the needed personnel.

In its study of 30 jails, the AMA found that 60 percent of the jails (nine small, eight medium, and one large) did not keep any in-house records regarding inmates' medical histories, or any diagnostic or treatment services given while incarcerated. Of the 12 jails keeping such records in-house, the 1 small jail and 1 of the medium-sized jails kept them in the inmates' regular confinement folder rather than in a separate medical file. In four other jails, regular correctional officers were allowed access to inmates' medical treatment records, under certain circumstances. Thus, only half of the 12 jails maintaining treatment records kept them strictly confidential as called for by AMA standards. Furthermore, 7 of the 12 jails lacked unified medical records systems. 1/ A unified system is highly desirable since it may be important for other health care providers, such as dentists and psychiatrists, to know something of the medical background of a patient, what medications he/she is presently on, etc., before beginning their own treatment program. All four jails visited in our review maintained medical records for their inmates.

Finally, while 8 of the 12 jails indicated that they routinely reactivated old medical records on recidivists, only two stated they automatically sent inmates' medical treatment records if they were transferred to another institution.

Of the three States' jails that we visited, one State correctional department required its jails to keep medical records, the other two did not. In one State conducting training courses for persons handling prisoners, the instructor

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1/A unified medical record system may be defined as one where each inmate has a single folder containing pertinent information from all types of health care providers rather than one where each health care provider maintains individual files on the same inmate.

stressed the need for medical records and suggested that local jails maintain them. Another State has been mandated by law to establish minimum standards for the care and treatment of inmates in its jails. These standards include medical records for inmates.

Medical records should be kept confidential

Medical records, in correctional as in civilian practice, are confidential. This means that, with few exceptions, they should not be available to anyone except the medical staff concerned with an inmate's health care. Inmates, for example, should not be used to transcribe entries into medical records, or have access to medical records. All transcribing and filing should be done by trained employees under the supervision of a trained medical records technician. Also, all medical records should be kept in locked files.

The Bureau's policy is that inmate workers shall not have access to medical records, nor should their assignment be such that unauthorized access is apt to occur. Although many of the States visited had similar policies or beliefs, in 6 of 10 States visited, inmates were directly involved in medical records administration.

At one Federal penitentiary visited, three inmates worked in the medical records department. The other five Federal institutions were maintaining confidentiality of records at the time of our visits. Later, however, a regional medical inspector reported inmates working with medical records at one of these institutions.

In addition to the above, most of the Federal and State prisons lacked a Registered Records Administrator, even on a consulting basis, to train or supervise records clerks and inspect records. Also, many of the records clerks were untrained in medical records administration.

JCAH inspectors reporting on a State prison hospital said that the confidentiality of medical records was discussed at length without resolution. They noted that if true confidentiality is to be maintained, all charting and records must be taken out of the hands of inmates. They also noted that prison hospitals must have rules and regulations ensuring the confidentiality of medical records and there must be adequate supporting staff for medical record services.

SUFFICIENT NUMBERS OF QUALIFIED STAFF ARE UNAVAILABLE

While ACA standards do not mention actual numbers, or inmate/staff ratios, they do require that sufficient numbers of professional staff be available to provide (1) 24-hour care for chronic and convalescent cases and emergency situations and (2) other services on a level comparable to those available to the general public. AMA standards for jails require a written plan specifying the arrangements for obtaining medical and dental care from community facilities. Both sets of standards require that State licensing and certification for health care providers be mandatory and that the providers be subject to professional supervision as they are in the community.

Every prison system--Federal and State--reviewed was, to varying degrees, inadequately staffed with licensed and certified professional staff to meet inmates' medical and dental needs. As a result, 24-hour coverage was not always available to provide nursing care for chronic and convalescent cases or emergency situations; routine followup examinations were, for the most part, done only on request; and medical records administration, X-ray, and laboratory procedures were often controlled by undersupervised and inadequately trained inmates. Regarding dentistry, we were told that dentists were unable to treat all emergencies in a timely manner, and preventive dentistry (X-ray and cleaning teeth on a regular basis) was an impossible task.

Almost every prison system was plagued with the problem of attracting and retaining the professional and allied staff necessary to meet inmates' medical and dental needs. Several States needed significantly more positions to replace all inmate workers and raise their care to acceptable levels. Some Bureau of Prisons institutions also needed more positions to replace all inmate workers and fully comply with Bureau policies.

The problems in attracting licensed physicians are several--low salaries, antiquated facilities, lack of assured malpractice liability protection, and low job status. This has made some systems dependent on a few licensed physicians together with unlicensed foreign doctors, some of whom can hardly speak English.

One State is attempting to alleviate the shortage of physicians, mostly by contracting with physicians from community hospitals to supervise nurses, physician assistants, and other health staff. State officials believe it is

important that doctors do not become prison oriented but maintain their professional standing in the community. Officials also said that hiring and using physicians on an "as needed basis" permits them to attract more highly qualified physicians at substantially lower salaries than would be possible if they were required to work full time. Other States were still attempting to hire full-time prison doctors, even though AMA officials and others agreed that the salaries offered did not assure attracting the most qualified personnel.

California is having fewer problems attracting physicians because it resolved the malpractice issue. This State protects its full-time doctors from financial loss through inmate claims. Since January 1, 1976, the State has paid more than $700,000 on seven out-of-court settlements on medical malpractice claims dating back to 1968.

There are also several problems in hiring allied health staff. The biggest problem seems to be the lack of funds needed to hire enough staff immediately; therefore, new staff must be phased in a little each year. The problems in attracting them include the (1) potential risks to personal safety, (2) lack of opportunities for advancement, and (3) unpleasant environment aggravated by old and inadequate facilities and equipment.

We found different views on the use of allied health staff--nurses, physician assistants, or medical technical assistants--among the States visited. While all the Federal and State prison systems used allied staff to administer sick call and screen inmates before seeing physicians, there were differing opinions on the extent of treatment they could provide.

--In some States, allied health staff could write prescriptions for some prescription drugs--as well as over-the-counter drugs--while this was forbidden in other States. This is permitted in Bureau prisons.

--In some States, allied health staff could stitch wounds and perform other minor surgery. This is permitted in Bureau prisons.

--In some States, allied health staff performed tasks normally performed by physicians in screening inmates at sick call, such as checking eyes and ears. In at least one State prison hospital, this practice was forbidden. This is permitted in Bureau prisons.

--In most State and Federal prisons, allied health staff would refer inmates to doctors when they demanded to see doctors. In one Federal prison, allied health staff said they made the final decision on who sees the doctor.

Even in those institutions where allied health staff was permitted to prescribe prescription drugs, stitch wounds, and perform other functions normally performed by a physician, some officials admitted that if enough licensed doctors were available and willing to work in prisons, allied staff would probably be more restricted in the extent of treatment they could provide.

Problems could also result from situations we noted where untrained and/or unsupervised inmates were performing medical tasks, e.g., working in clinical laboratories. In one State, we were told that inmates were not as trained or as well supervised as they should be and had made some serious diagnostic errors.

State and local officials said that jails were faced with the same problems as prisons in getting medical staff and, in some ways, the problems were more acute because jails had less money with which to hire staff.

In the 1972 AMA survey, 1,159 jails responded to a question concerning the health personnel available to them. Thirty-eight percent of the jails employed one or more physicians, 51 percent had physicians on-call, and only 18 percent provided nursing care. Less than one-half of the jails offered inmates dental services, and these services were usually obtained in the community.

In the in-depth study of 30 jails published in 1977, the AMA found a total of 110 individuals who provided medical and dental services on a regular basis.

Type of staff	Number of jails	Percent of 30 jails	Number of staff
Physicians	26	87	43
Nurses	11	37	31
Other health staff	6	20	25
Dentists	10	33	10
Dental assistants	1	3	1
Total			110

Most of the 30 jails had at least one physician who was a "regular" provider of primary care. Thirty-two of the 43 physicians responding to AMA's questionnaire said they were licensed to practice medicine in the State where they were employed. More than half of the physicians were specialists, while the remainder were general practitioners.

Most physicians in the small jails served on an "as needed" basis. Eight were paid a "fee for service," one received a monthly salary from another agency, and one was not paid for his services since he was the county health officer. In the medium-sized jails, none of the physicians was a full-time employee, although 9 of the 15 responding served on a regular part-time basis. The other six received a "fee for service" or an hourly wage whenever care was provided. Even in the large jails, only one of the eight responding physicians indicated he was employed full time by the jail.

Thirty-seven percent of the jails (11) provided some type of nursing care. Most of the 31 nurses were working in large jails and had at least a 3-year nursing degree. All were licensed or certified to practice in their own State.

The nurse serving the one small jail did so only on an "as needed" basis. She was employed and paid by a county hospital and estimated she spent only about 1 hour per month at the jail. Of the seven nurses serving the five medium-sized facilities

--five worked at the jails full-time,

--one served as a relief nurse and

--one worked full-time for the county health department but spent about 12 hours a month at the jail.

Only 10 of the 30 jails identified any dental personnel. These 10 each had one dentist serving their facilities, and 1 of the large jails had a dental assistant as well. Seven of the 10 dentists responding to AMA's inquiry indicated they were licensed to practice in their respective States. Five were hired by other city/county agencies to serve the jails part-time.

FACILITIES AND EQUIPMENT NEED IMPROVEMENT

ACA standards require prisons to maintain an adequately equipped medical facility which meets the standards for licensed general hospitals. If an institution does not have the resources to meet standards for services it offers, it should provide for outside hospital care.

The six Bureau of Prisons facilities we visited appeared to be adequate for the levels of services provided. Our observations seemed supported by JCAH and regional inspection reports, which noted no major problems with facilities and equipment.

Many of the State prison hospitals and infirmaries visited did not meet all minimum health and environmental standards imposed on other institutions, such as hospitals and nursing homes.

--Prison infirmaries were often as old as the prisons themselves. In some instances, infirmaries were 50 to 100 years old, and could not conform to present-day standards.

--Some infirmaries did not have isolation wards to house patients with communicable diseases even though such diseases were treated there.

--Some infirmary wards did not have toilet facilities or wash basins.

--Dirty and clean laundry was sometimes stored in the same room, which, in itself, is improper.

--One infirmary's X-ray unit did not have a lead-lined door or lead-lined walls.

State officials acknowledged that conditions were bad but usually noted funds to improve the facilities were lacking.

Prison officials readily agreed that their facilities should be required to comply with the same standards as any community hospital providing the same services; in the case of full service hospitals, this could be expensive. In one State, a new hospital in one prison is being considered at an estimated cost of $17 million just for the building; the equipment will be extra.

The 1972 AMA survey of 1,159 jails revealed that about 65 percent of the jails had only first aid facilities for treating inmates; 17 percent had no facilities at all. As shown below, 7 percent had an infirmary, and 8 percent had a clinic dispensary.

Medical facilities available	Number of jails	Percent of 1,159 jails
First aid only	759	65.5
Infirmary	78	6.7
Examining room	161	13.9
Clinic dispensary	91	7.9
Other	72	6.2
None	194	16.7
No response	76	6.6

The more recent AMA study also revealed that some jails lacked facilities and equipment for properly treating inmates. Seven jails had in-house bed care facilities which were not used due to a lack of staff. In 1 of 11 jails with in-house clinics, the clinic consisted of "using the chapel as the examining room and a stretcher as an examining table." Furthermore, eight jails had no emergency equipment, including two which did not even have first aid kits. As shown below, the jails lacked various kinds of emergency equipment.

Type of equipment	Number of jails without equipment	Percent of 30 jails
Litter/stretcher	11	37
Emergency drug box	21	70
Oxygen	17	57
Ambulance bag	19	63
Airway	12	40

CHAPTER 3

CORRECTIONAL ADMINISTRATORS NEED TO BETTER ASSESS THEIR SITUATIONS

Correctional administrators have not systematically determined the medical and dental needs of inmates and the proper mix of resources to meet those needs so they can design and implement adequate health care delivery systems. To do this, they must analyze the inmates' medical and dental needs and determine (1) the level of care needed to meet the needs and (2) the type and amount of resources required. A system can then be designed to include some mix of institutional and community resources.

The three basic mechanisms for assessing, controlling, and planning for adequate health care are:

1. Comprehensive studies of health care delivery systems.

2. Management information systems providing data from each institution for analysis.

3. Audit, review, and accreditation programs.

Each of these mechanisms, individually or combined, can be used to help administrators and health care providers (1) assess the quality of care, (2) control services and costs, and (3) identify and plan for the needs of their health care delivery systems. However, before any of these mechanisms can be used effectively, there must be an assurance that each inmate has had a thorough physical examination and that the medical records are current, accurate, and complete as discussed in chapter 2.

PROPER MIX OF RESOURCES NEEDS TO BE DETERMINED

The health care delivery systems in the agencies we examined generally did not have the resources for providing adequate health care. Officials frequently told us they lacked the necessary funding to make improvements. However, given the likelihood that correctional institutions will generally continue to be underfunded, it is critical that they examine ways of improving their utilization of all existing health care resources.

The AMA and other professionals we interviewed agreed that medical and dental programs should be tailored to meet

the needs of the population served. For example, young people may have different problems than old people and people of one race may have problems different than those of another--sickle-cell anemia being one example. Only after corrections administrators learn what manner of care is needed and what is actually being delivered in the institutions under their direction, can they make effective decisions about staffing, facilities, equipment, and, possibly most important, which health care services to provide using institutional versus community resources.

Community resources should be used more

AMA officials and other professionals in prison health care generally agreed that correctional institutions should not duplicate any services economically and conveniently available in the community. We also believe that building and staffing prison hospitals and infirmaries in areas with community hospitals and clinics is uneconomical and, perhaps, not possible in view of the problems involved in hiring doctors, nurses, and allied health staff to work in correctional institutions. As discussed on page 7, two States visited were performing major surgery in prison hospitals, even though one State apparently lacked the professional staff needed to meet State licensing requirements and the other lacked adequate staff and facilities.

AMA officials and other professionals, including officials of LEAA and HEW, stated that several alternatives need to be explored. They have said that State and local health planning agencies should include prison and jail populations in their statistics when considering programs for community health needs. The following are examples of alternatives considered.

--New community hospitals might be designed to include provisions for treating prison and jail inmates, e.g., in secure wings. (An alternative might be for a prison hospital to be constructed outside the walls so people from the community could be treated in unsecured areas.)

--A community health center might be planned in such a way that a satellite clinic could be located in a prison or jail. The satellite clinic could be served by health care personnel from the health center, or main clinic, located in the community. (In practice, this might also answer the problem--at least partly--of finding physicians to work in prison.)

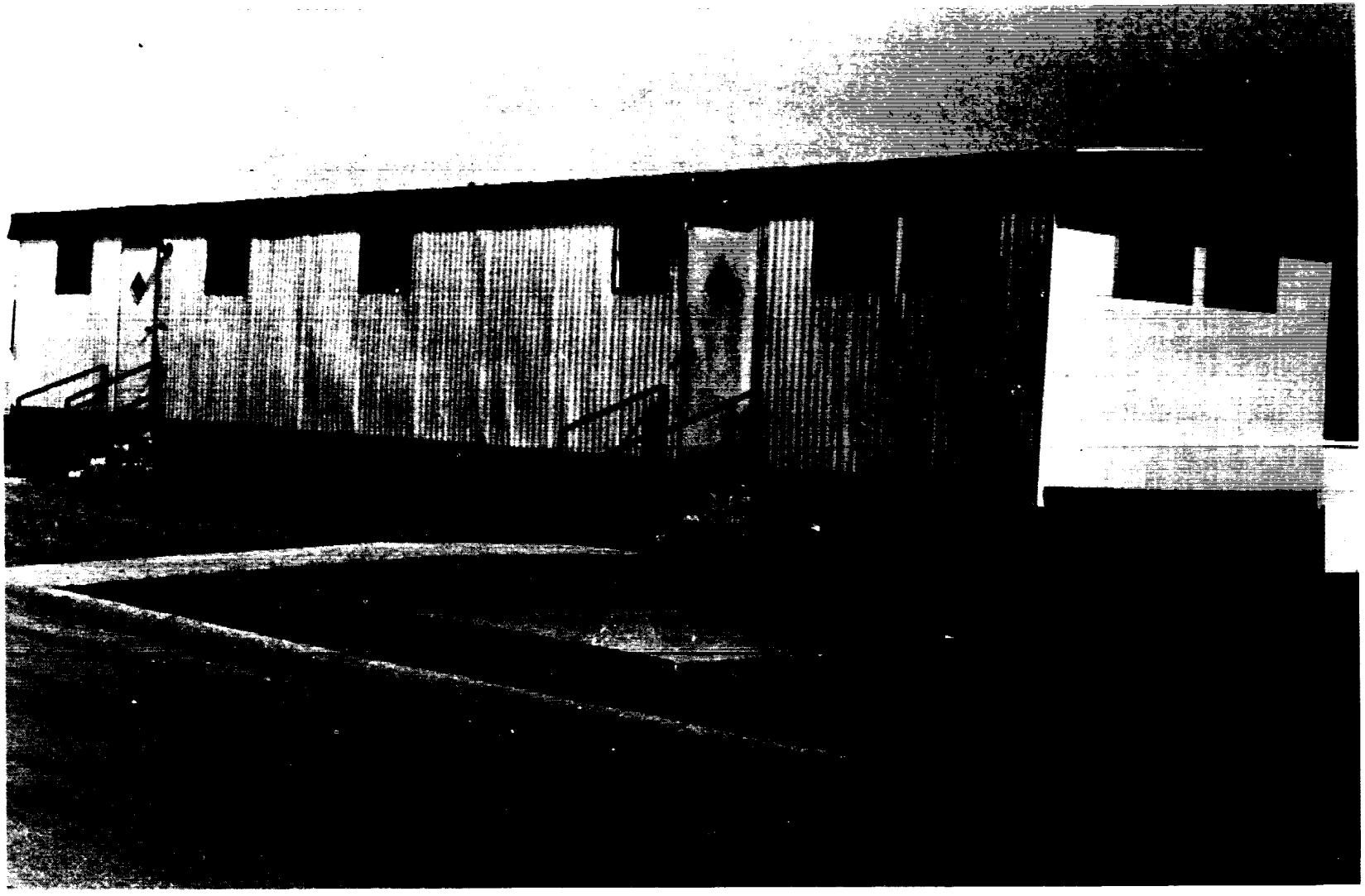
The use of mobile health clinics might be a possibility. For example, dental facilities at one North Carolina prison are housed in a mobile trailer. (See pp. 28 and 29.) Such a facility is less expensive than a permanent one, and it gives correction officials flexibility because it could be moved to other prisons. The trailer has wall paneling similar to that found in homes and presents a pleasing, non-prison atmosphere for the inmates. This approach to providing dental services for inmates has worked so well that North Carolina is planning to purchase two more trailers for housing dental facilities at other prisons.

Jails especially need the help of community health services, since many of them have no medical personnel available to even screen new inmates. Local community health authorities could become responsible for admission screening since communicable diseases--an everpresent danger in jails--are actually community health problems. For example, one jail has a physician, but he is too busy with other medical problems to personally screen all incoming inmates. As a result, jail officials are attempting to reach an agreement with the county health department whereby it would provide staff for the daily screening of new inmates. Furthermore, the same jail has equipped a dental clinic in the jail and is trying to get the county health department to provide a dentist part-time each week. Some State personnel said that their local public health services--perhaps with Federal assistance --could help them by performing some services, e.g., screening new inmates.

COMPREHENSIVE STUDIES CAN TELL ADMINISTRATORS WHAT THEIR NEEDS ARE

In October 1978, the Bureau of Prisons announced that a private consulting agency will be performing an in-depth study of medical care in its institutions. The contractor plans to evaluate medical care utilization and unmet health care needs in the Federal prison system, and make suggestions for improvement. The contract for the 1-year study was awarded by Health Services Administration of the U.S. Public Health Service (PHS).

Several States had made studies of their inmate health care systems and found the studies to be useful management tools toward making improvements. Other States had not made studies and, as a result, seemed less certain of what they needed or how they intended to implement improvements.



DENTAL FACILITY AT NORTH CAROLINA PRISON: EXTERIOR.

DENTAL FACILITY AT NORTH CAROLINA PRISON: INTERIOR.

Michigan's "Key to Health For a Padlocked Society"

Because of an inmate riot at Michigan's major prison and court decisions on the right of prisoners to receive necessary health services, the Governor in 1974 commissioned a study of health care in the State's prisons. The study was funded by an LEAA grant for $110,582. A nine-member Governor's Advisory Committee for State Correctional Health Care was appointed to oversee the project, and the current Associate Director of the Office of Health Care, Department of Corrections, was named as Executive Director for the study.

The study incorporated five principal elements:

--Development of a set of standards for correctional health care.

--Description of existing arrangements for health care and detailed documentation of inadequacies.

--Assessment of health status of resident population, through extensive physical examination of a stratified random sample of the residents.

--Design of a new health care system, with a series of proposed recommendations.

--Preparation of a set of supportive analyses including legal dimensions such as budget and utilization data, resident opinion survey, and demographic data.

Completion of the tasks required nearly a year and involved numerous professional and technical consultants. The final report, "Key to Health for a Padlocked Society," was published in January 1975.

The report formed the framework for short- and long-range plans to improve health care in Michigan's prisons, and the Associate Director, Office of Health Care, was using it as a guide to judge improvements. For example, one major recommendation was that acute hospital care be provided in community facilities rather than in a prison hospital. In an April 1, 1977, accomplishment report, the Associate Director noted that current data still tended to support that recommendation and, on that basis, the new major health facility at a major prison would be an infirmary and not an acute-care hospital.

Reports on Massachusetts' prisons

In 1971 a riot took place in the maximum security prison at Walpole, Massachusetts, culminating in a series of demands by the inmates, chief of which was the request for better medical care. In response to this, the Secretary of the Office of Human Services appointed a committee from various fields in health and penology to study the matter. In its December 1971 report, the committee made 48 recommendations for improving the quality of health care provided in the Massachusetts State prisons. The recommendations were grouped according to the following problem areas:

--General medical and surgical care.

--Occupational and environmental health.

--Medical training and health careers for inmates.

--Treatment.

--Medical experimentation in prisons.

--Blood donation programs.

Based on the findings and recommendations of the report, the Departments of Correction and Public Health received funding from the Federal Office of Economic Opportunity for a project subsequently called the Prison Health Project.

The Prison Health Project began November 1972; one of its primary objectives was developing and planning a model health care system for State prisons which could be adopted by other States and possibly the Federal Government. In December 1974, the Project was concluded with the issuance of a Final Report containing a list of 21 accomplishments and 24 recommendations based on the work performed within the Massachusetts State Prison system. The following are examples of accomplishments cited in the 1974, Prison Health Project's Final Report:

--Establishment of an office to deliver health care within the Department of Corrections.

--Development of a working relationship between the Departments of Correction and Public Health.

--Development of a system involving a group of acute, general care private hospitals for backup use.

--Introduction of use of medics in two major prisons.

The Department still has not solved some of its problems. For example, recommendations which were first cited in the committee's 1971 Report, and again in the Prison Health Project's 1974 Final Report, were also identified as problem areas during our review--there is still a need for

--improved pay for full-time health professionals,

--greater use of allied health professionals,

--greater community involvement in delivery of health care to inmates, and

--closer involvement of the medical community, with a special emphasis to involve teaching institutions.

But such problems were also noted in other States.

Reports on Pennsylvania's State correctional institutions

A 1972 report entitled "Health Care and Conditions in Pennsylvania's State Prisons," prepared by the Health Law Project of the University of Pennsylvania Law School (partly funded by the U.S. Office of Economic Opportunity), identified major health care delivery problems in prisons and added impetus to the movement for improved conditions. Some of the major problems cited were (1) cursory entrance physical examinations, (2) uncoordinated allocation of equipment and resources, and (3) little physican guidance to civilians and inmates who deliver health care. Our review indicated that cursory examinations were no longer a problem because comprehensive entrance examinations were being given.

The Chief of the Office of Health Care Services was instrumental in performing two reviews of the health care delivery systems. The first review was a 1976 internal management survey of the prison infirmary we visited, which noted many significant problems regarding communication, organization, personnel, and space allocation and equipment. Some of the findings were:

--The prison medical staff showed a lack of concern for the inmates' medical problems and more concern for their own safety.

--Crowded space on the first floor of the building.

--Inmates arrived at the infirmary at all hours of the day for diagnosis and treatment.

--1:00 p.m. sick lines could be eliminated since most inmates come to the infirmary at 1:00 p.m. for medicine only.

--Need to update medical records.

--No drug inventory control.

--Heavy concentration of medical employees working between 6:00 a.m. and 4:00 p.m. with no coverage between 11:00 p.m. and 6:00 a.m.

--Corrections officers did not receive first aid instruction.

--One part-time physician, with an outside practice, did not conduct sick call at a standard time each day.

--Physicians did not write and sign prescriptions for medicines and drugs.

--Inadequate infirmary layout: about 3,000 of the 12,000 total square feet was for the visiting room. This caused disturbances, distractions and increased security problems.

Except for the space allocation and equipment problems, which were affected by past and present capital budget constraints, several improvements were made in these areas.

The second review was a comparison of the conditions in each of the eight correctional institutions with the American Public Health Association standards. A March 1977 report to the Governor stated that $11.8 million was needed for health systems improvement, $11.1 million of which was for nonrecurring building renovation, construction, and medical equipment. It is unlikely that much funding will be received because (1) there is a State-wide budget crisis, (2) none of the funds requested for capital budget items over the past 5 years were received, and (3) the total annual budget for health care is only $4.3 million. Nevertheless, being on record is an important first step toward improvements.

AMA in-depth study of 30 jails

To develop a program to improve health care in the Nation's jails, the AMA obtained an LEAA grant in 1975 for $448,000 and solicited proposals from all States interested in gathering data on jails. Six States were selected for the project--Georgia, Indiana, Maryland, Michigan, Washington, and Wisconsin.

In-depth data was gathered on health care delivery systems for 30 jails. The 3-year AMA program consisted of three phases:

--Development of model health care delivery systems.

--Construction of minimum standards and implementation of a national certification program.

--Establishment of a national clearinghouse on jail health care.

Each State gathered data on its jails, identified deficiencies in its health care delivery systems, and designed a corrective action program to overcome these deficiencies.

As a result of the work in the six States, the AMA formulated 43 standards for jail health care services. As of February 1978, 22 of the 30 jails met the newly established standards and were fully accredited by the AMA.

A national clearinghouse for information on jail health care was also established in 1975. This portion of the AMA's effort was designed to (1) stimulate interest nationwide in jail health care and (2) help upgrade health care delivery systems by gathering, developing, and disseminating information on various aspects of jail health.

MANAGEMENT INFORMATION SYSTEMS CAN HELP MONITOR ACTIVITIES

Management information systems, whether manual or computerized, are an invaluable aid to administrators in monitoring and planning the activities of their health care delivery systems. The health problems of people entering correctional institutions and the problems they develop while there are largely unknown. Consequently, assessing the changes in their health status, contacts with the system by inmates with chronic problems, and the efficiency of the existing allocation of resources is unknown.

The ACA recommends that institutions use an organized system of information retrieval and review because it facilitates decisionmaking, research, and timely response to offender needs. It also points out that such systems help ensure protection of the public and efficient and effective use of resources.

We found little demographic data on medical and dental needs of inmates entering prisons and jails. While everyone

generally agreed that inmates entering their systems were in poorer health than people in the community, few had any statistical data to support their viewpoint.

In our inquiries into the use of medical records data, we found that only 3 of the 10 States visited consolidated some data from the records for planning and control purposes. New York used LEAA funds to establish a State-wide computerized medical/dental records system. This system is based on medical complaints made by inmates during the daily sick call routine. Officials of this State said the system was useful for:

--Determining the volume and type of services provided. Reports on monthly visits, broken down by prison and medical staff members providing the care--doctors, dentists, or other allied staff--is a necessary part of the required information. Planning for each prison is enhanced by this data because it reveals such things as staff shortages and overall health problems.

--Assessing the underutilization of medical care by those inmates who need treatment and observation for serious illnesses. The chronic disease report, which lists inmates with important chronic conditions such as hypertension and diabetes and their monthly encounters with the health care system, is valuable here.

--Auditing the quality of care by using explicit criteria for assessment and management of specified diseases. This is possible because lists of all inmates with specific diseases are available, and each individual medical record can be located and examined.

Pennsylvania was using similar information gathered at each prison to manually prepare quarterly reports. Among other things, these reports were used to make budget projections, analyze staffing levels, compare cost data, and monitor sick call activities. A State official told us the system was working so well that he was considering switching from a quarterly to a monthly basis.

North Carolina was developing a system to determine overall health needs by gathering information from inmates' physical examinations. This data allows officials to see the problems of inmates entering the system. At the time of our visit, they had not reached the point where they could tell which health needs had been treated and which had not been. Officials hoped to expand their system to enable them to evaluate additional staffing needs.

Although other States were not using medical/dental record data for planning or control purposes, officials could see the need for and benefit of such data. Without such data, they realized they could not (1) assess overall changes in health status, (2) assure efficient use and allocation of resources, or (3) demonstrate overall improvements in health care. Officials in one State believed that given a totally operational system, health needs and related staffing needs could be statistically predicted, which would assist greatly in preparing budget projections and allocating resources.

We found that the Bureau of Prisons had been entering data from physical examinations on the computer for some time, and accumulating other health data manually--such as the number of sick call visits, x-rays, and dental procedures. At the time of our review, Bureau officials did not feel that the information was as complete or accurate as it should be. They said they recognized the importance of a good management information system for the health area, and were in the process of developing their system. They also said that eventually, all the data will be computerized.

Of the 30 jails in the AMA in-depth study, 3 of the 10 small jails and 5 of the 12 medium-sized jails did not keep any management records which reflected medical activities. In other words, 26.6 percent of the jails did not keep track of the number and types of drugs being dispensed, the number of inmates receiving health care, etc.

Of the seven small jails keeping management records, three only logged medications, while the other four logged any health treatment given as well. In six of the jails, these records were kept by the corrections officer, while in the other jail, both the correctional officer and the physician made entries as needed.

The medium-sized jails keeping management records and all of the large jails tended to keep full tallies of the jails' medical activities. These records were usually completed by a correctional officer, a nurse, or both, with occasional physician input.

AUDIT, REVIEW, AND ACCREDITATION PROGRAMS CAN KEEP EVERYONE HONEST

Programs for auditing, reviewing, and accrediting the delivery of health care services are common in the community but not in corrections. Community hospitals undergo periodic internal audits and reviews by medical audit commitees and utilization committees plus external reviews by the JCAH,

Medicare, Medicaid, and commerical insurance companies. With the exception of JCAH accreditation of some prison hospitals, most correctional systems do not have effective audit and review mechanisms to asses the quality of care they are providing.

The Bureau has an audit and review system consisting of

--visits to major facilities by the director and deputy director of the medical division,

--semiannual audits of all medical and dental facilities by the regional administrators of medical services, and

--JCAH and American Dental Association (ADA) accreditation of major medical and dental units.

Our discussions with top Bureau headquarters and regional officials, examination of reports, and visits to six Bureau prisons, revealed that the Bureau's audit, review, and accreditation programs were moving toward compliance with the Bureau's health policies. A major reason for this was that the review, audit, and accreditation processes alerted the Bureau to health care deficiencies. Once these areas were identified, each institution addressed how it proposed to alleviate each deficiency. Followup reviews were conducted to assess corrective actions.

Deficiencies existed that could not be easily corrected, such as the lack of qualified people and additional funds for needed staff positions. However, knowing their deficiencies allows each health unit to appropriately budget for corrective actions and inform headquarters of their problems in complying with policies. The Bureau's policy that major prison health units be inspected by the JCAH and ADA and meet their standards also goes a long way toward improving health care. Regional inspectors get JCAH and ADA requirements in advance, help prison health unit administrators understand the requirements, and make necessary improvements. While some units are given only limited accreditation and others are refused accreditation from time to time, Bureau administrators are provided JCAH and ADA reports which give the reasons for this and the corrective action needed.

None of the States had programs to audit and review their correctional health systems' compliance with policies and procedures. As a result, top officials could not assess their health care systems, and medical staff at the individual prisons seemed at a loss over what was expected of them. For example, the Registered Record Administrator at one of the

prisons where we made a study of medical records asked us to tell him our findings because such a review had never been made before.

State prison medical units and clinical laboratories are not periodically inspected by outsiders, because their facilities are generally not subject to State licensing standards and requirements. Although correctional officials have invited licensing inspectors to inspect their health units and help them identify areas needing improvements, this was not routinely done in most States. One exception was Maryland, where the Department of Health and Mental Hygiene inspects medical facilities in State correctional institutions and has undertaken a joint study with the Division of Correction to develop licensing standards for such facilities. While JCAH inspectors have also inspected some State prison medical units--and accredited some in the past--few could meet accreditation requirements and few were being inspected at the time of our review.

All States visited had standards for their jails, including a few general standards for health care. All States had authority to inspect jails for compliance with the standards, and most States had authority to enforce them. However, no jails were closed for failure to comply with health care standards.

Most States were aware of the AMA standards for health care in jails but at the time of our review, few States planned to implement them. Two States were upgrading their health care delivery systems in jails to meet or exceed AMA's standards. Some States intended to implement their own jail health standards rather than AMA's.

AMA's program is now nearing the end of its second year, and already 22 jails have received full accreditation. Additional jails within the initial six pilot States are applying for accreditation. During the third program year, the six original pilot States will expand their activities to process a total of 50 new jails for accreditation. In addition, AMA proposes that the Accreditation Program for Medical Care and Health Services in Jails be expanded to 10 new pilot States during the third year. The same approach for accreditation for the original six pilot States will be used. LEAA approval and funding for the third year of operations began on April 2, 1978.

CHAPTER 4

A FEDERAL STRATEGY IS NEEDED FOR IMPROVING HEALTH CARE ASSISTANCE

The Federal Government, together with State and local governments, has made commitments to improve health care through the U.S. Public Health Service and correctional programs through LEAA. These commitments need to be combined into a Federal strategy which will better address the medical and dental needs of prison and jail inmates and improve the utilization of existing health care resources.

Such a strategy would require that the Bureau of Prisons and State and local correctional officials implement those ACA and AMA standards that they can to demonstrate their commitment to making improvements. Remaining problems could then be addressed by applying available Federal resources, technical expertise, and influence.

The Federal Government cannot fully subsidize the operation of State and local health care delivery systems. However, Federal financial and technical assistance programs exist which States and localities could use to (1) support comprehensive studies of systems and (2) help establish management information and review mechanisms. In addition, prison and jail inmates could be served by federally supported State and local health programs.

INITIATIVES BY CORRECTIONAL AUTHORITIES SHOULD BE A KEY COMPONENT OF THE FEDERAL STRATEGY

For any form of Federal aid to result in a long-term improvement in inmates' medical and dental care, correctional authorities must be committed to making improvements. This commitment can be enhanced by making the initiatives of correctional authorities an integral part of the Federal strategy to assist in improving inmates' medical and dental care.

Correctional authorities should undertake several initiatives as part of the Federal strategy. One initiative would be a comprehensive study of inmates' medical and dental care within their jurisdictions. Such a study could provide a firm basis for making improvements. It could identify (1) inmates' health care needs, (2) inadequacies in health care delivery systems, and (3) where additional resources are needed for an effective delivery system. Some states have undertaken comprehensive studies of their inmate health care systems and have found those studies to be useful.

management tools. LEAA block grant funds and Federal technical assistance could be used to make such a study.

Another intiative would involve implementing inmate health care standards to the extent possible under existing circumstances. Many health care standards require little or no expenditure of funds but can be implemented through policy changes. For example, each institution could be required to make an arrangement with an outside licensed medical facility to provide emergency services and major surgical services on a 24-hour-a-day basis. Before the Federal Government makes a significant investment in helping a correctional agency upgrade its inmate health care system to meet all standards, the agency should demonstrate a commitment to the standards by adopting those it can.

An additional initiative is greater use of community health care resources. Inmates are traditionally outside of State and local health authorities' area of responsibility. While the Federal Government provides many of the resources used by State and local health authorities, much of the decisionmaking as to how those resources are used is left to the State or local government. As discussed above, we feel there could be greater use of community resources. For all practical purposes, this cannot be accomplished without a State commitment to encourage greater cooperation between State and local health authorities and correctional officials.

LEAA SHOULD BE USED TO IMPLEMENT THE FEDERAL STRATEGY

LEAA has been assisting State and local governments to improve prison and jail conditions for 10 years. LEAA's legislation provides funds to State and local governments for programs and projects to improve and strengthen law enforcement and criminal justice. Although LEAA has not been able to invest a large amount of its resources in specific problem areas--such as inmate health care--because of its broad mandate, it is in the best position to develop and implement a Federal strategy.

Past LEAA efforts

LEAA has invested in some programs which could help improve inmate health care. In 1974 LEAA funded a project for the development of correctional standards by the ACA which would serve as a basis for accrediting various types of correctional facilities and programs. The ACA established a Commission on Accreditation for Corrections to develop and test the standards and implement a nationwide program of

correctional accreditation. These standards, where appropriate include standards for inmate health care. A series of standards manuals have been published for adult and juvenile long-term and short-term correctional facilities.

In 1975 LEAA funded the AMA's project to develop medical and dental standards for local jails. The AMA developed specific standards and tested them in jails in six States across the Nation. The AMA standards were incorporated by the ACA in its standards for adult local detention facilities.

In addition to funding the development of standards efforts, LEAA has provided block grant funds to States, which have used these funds to

--study the problems of their correctional health system and make recommendations as to how these problems can be overcome,

--develop an organization structure that would allow a better health care delivery program,

--develop management information systems to better assess the needs and quality of health care given, and

--establish a system of providing physical examinations and obtaining the needed medical staff.

Current LEAA efforts

LEAA recently awarded a $1 million grant to the Michigan Department of Corrections to improve medical and health care services in correctional institutions. The Department will develop and implement a training and technical assistance program for correctional health care delivery personnel. The program will involve 10 State correctional systems and will focus on training correctional health care personnel and providing technical assistance. As a part of the project, the AMA will be developing detailed prison medical and dental standards.

In addition to the grant awarded to Michigan, LEAA has planned two grant programs for fiscal year 1978 to assist correctional facilities. The grant programs are designed to encourage the adoption and implementation of correctional facility and program standards. Each will involve a number of grants to prisons and jails. Neither program is directed specifically at health care standards, but they could be included.

Some LEAA staff are hoping to implement a more comprehensive correctional standards grant program in the future. This program would involve a comprehensive strategy to assist all States in meeting and adopting all correctional standards. The ACA accreditation process is envisioned as a vehicle for this program. LEAA's staff estimates the program would require one-time appropriations of $300 million for each of 3 years to help implement all standards.

We believe that LEAA should take a leadership role in a Federal strategy to improve medical and dental conditions in correctional institutions. For example, LEAA is involved in standards development and implementation and correctional accreditation activities, has State correctional systems contacts, is aware of some State needs, and has experience in Federal grant programs and influencing improvement in State and local criminal justice programs. Based on its experience, LEAA could serve as a focal point for Federal efforts to assist States in upgrading inmate medical and dental care.

NATIONAL INSTITUTE OF CORRECTIONS' JAIL TRAINING PROJECT SHOULD BE PART OF THE STRATEGY

In 1977 the National Institute of Corrections created a national jail center at Boulder, Colorado, to serve as a focal point for coordinating State, Federal, and private efforts to improve jails. The overall objectives of the center are to

--upgrade jail staff through training;

--provide information services for jail administrators, elected officials, and concerned citizens; and

--provide technical assistance to State and local jails in a variety of areas.

One of the technical assistance programs includes providing support for the development and implementation of medical services inside jails. One component is a program the AMA developed to provide health education and screening techniques to jailers.

THE PUBLIC HEALTH SERVICE CAN PROVIDE ASSISTANCE THROUGH EXISTING PROGRAMS WITHIN THE FEDERAL STRATEGY

The Public Health Service is HEW's principal health component, and its basic mission is to protect and advance our Nation's health.

One of the important activities that PHS carries out is awarding and administering a diverse array of grant and assistance programs which cover the whole spectrum of health care concerns. The 6 PHS agencies and the 10 PHS regional offices are responsible for the award, administration, and monitoring of these grant programs.

During our review, we were unable to find any major programs within PHS providing Federal assistance for inmate medical and dental care in State or local correctional institutions. One notable exception was the Prison Health Program, a pilot program which is discussed below. In addition to the Prison Health Program, we identified other PHS programs which could potentially assist State and local authorities to improve medical and dental care of prison and jail inmates. All of these programs are within two administrations of PHS --the Health Services Administration and the Health Resources Administration. Each has a number of grant or assistance programs, and together they have a broad mandate to help improve the availability and delivery of health care across the Nation. We believe that these programs could be utilized in a Federal strategy to assist State and local officials to improve inmate and, in some cases, community health care.

Health Services Administration

The Health Services Administration provides funds in the form of formula or direct grants to State and local governments to improve health care. Many of the assistance programs are targeted at communities or population groups that are "medically underserved." These communities do not have adequate health care professionals or medical facilities to provide primary health care services to all members of the community. Inmates should be considered in the target populations for these programs, since they are part of the community. Some of these programs are described below.

Comprehensive health services

In fiscal year 1978, $90 million was appropriated for formula grants for comprehensive health services to assist States in establishing and maintaining adequate public health services. The formula grant awards are considered an entitlement to the States. Except for having an approved State plan, few restrictions are placed on States as to how these funds are used. Whether or not these funds assist in providing inmate health care depends largely on whether the State and local health departments receiving the funds provide services to inmates within these districts. Besides making clear to States that this usage is allowable under current legislation,

HEW can do little to encourage that these funds be used in part to provide services to inmates.

Community health centers

The Community Health Centers grant program, costing $247 million in fiscal year 1978, supports the development and operation of community health centers to provide health services to medically underserved populations. HEW officials stated that since community health centers should serve the community as a whole, there is no reason why they could not provide services to a local inmate population.

National Health Service Corps

The National Health Service Corps is a program by which PHS may assign health care professionals to communities in areas critically short of health personnel. Applications for assistance under this program may be coordinated so that a community health center established with PHS grant funds and serving inmates could then be staffed by Corps health personnel. In its report on HEW's fiscal year 1979 appropriations bill, the House Committee on Appropriations stated that HEW should explore the feasibility of placing National Health Service Corps personnel in Federal and State prisons.

Prison Health Program

The Health Services Administration has recently established the Prison Health Program to explore the feasibility of using the former's assistance programs to aid correctional officials in improving the health care delivery systems in their institutions. At this point, the program is a relatively small effort.

The program's director has traveled extensively throughout the country and met with correctional officials and authorities to determine prison and jail health care needs. He has developed a conceptual plan for placing National Health Service Corps staff in correctional institutions, while at the same time serving in other community health systems. He has also established contact with correctional experts at LEAA to (1) identify prisons and jails that could potentially benefit from PHS programs and (2) explore future LEAA and PHS cooperation in efforts to improve inmate health care.

At the time of our review, the program was about to establish its first project at the Mississippi State Prison at Parchman, Mississippi, using the National Health Service Corps and other communtiy health delivery systems. PHS

plans to assign six physicians and six physician assistants to this project. They will rotate between two local PHS-funded community health centers and the State prison providing the health personnel coverage needed at all three places. Similar projects for correctional facilities in Florida, Michigan, and Tennessee are currently under consideration.

Health Resources Administration

Health care planning

Several programs within the Health Resources Administration could assist in improving health care for prison and jail inmates. These programs are designed to promote systematic health care planning at the State and local level and to develop appropriate health care facilities where they are needed.

Under the provisions of the National Health Planning and Resources Development Act of 1974 (Public Law 93-641), the country has been divided into 205 health service areas. The Secretary, HEW, has designated a Health Systems Agency within each area. The agencies are generally responsible for preparing and implementing plans designed to improve the health of the residents of the health service area and preventing unnecessary duplication of health resources. Among other things, the act requires that each agency review and approve or disapprove applications for Federal funds for health programs within the health service area.

The act also provides Federal grants for State agencies that are responsible for health planning activities at the State level. In addition, the act created Statewide Health Coordinating Councils which are responsible for developing a final, overall State health plan based on State and local health planning efforts.

Neither the authorizing legislation nor HEW guidelines give any specific guidance as to whether inmates of correctional institutions should be considered in these planning efforts, although consideration of inmate health needs is not specifically excluded. With the exception of "medically underserved populations," no specific population group is mentioned in the legislation. As a result, the various planning entities decide whether the inmates within their jurisdiction are part of the overall population for which they plan.

Since there is little or no interaction between local planners and Federal officials at the Health Resources Administration headquarters, the Federal officials did not know of

any planning agency which had considered inmates as part of their population. Officials doubted that this was happening since inmates' health needs are usually outside the responsibility of traditional State or local public health departments. Officials did, however, state that obtaining Health Systems Agency or State agency approval was needed for many of the PHS grant programs which might provide assistance in meeting inmate health care needs.

Medical facilities construction

The Health Resources Administration administers several loan, loan guarantee, and grant programs for medical facilities construction. Each of the programs requires a showing of need for the proposed facility which is determined at the State level.

Again, the Health Resources Administration officials contacted were unaware of any HEW facilities construction funds that may have been used for facilities that provide services to inmates.

One medical facilities grant program is administered directly by Health Resources Administration personnel. This program, authorized by section 1625 of Public Law 93-641, makes grants to publicly owned medical facilities for modernization projects to prevent safety hazards or avoid noncompliance by such facilities with licensing or accreditation standards. This section, however, has received only limited funding, and only a few grants have been made under its authority. None have gone to medical facilities in correctional institutions. An HEW official stated that prison or jail medical facilities could be considered as potential grant recipients under this section if the Congress appropriates additional funds under the section.

Other HEW programs

We did not examine in detail additional HEW programs which could possibly provide direct assistance. For example, assistance might be available in some circumstances from Appalachian health programs and emergency medical services programs.

In addition, HEW programs could be utilized to provide indirect improvements to inmate health care. State and local governments could, in some circumstances, make greater use of HEW assisted community health facilities for inmate health care. For example, health care programs supported by funds available under Title XX of the Social Security Act, might be used to provide some inmate services.

THE U.S. MARSHALS SERVICE COULD PROVIDE AID TO JAILS HOUSING FEDERAL PRISONERS

We recently reported 1/ that the Federal Government faces problems in finding and contracting for sufficient and suitable space for Federal prisoners detained in non-Federal institutions. An average of 5,000 Federal prisoners a day are housed in over 1,000 non-Federal facilities--primarily local jails--the majority of which do not meet minimum detention standards for such things as health care services. Many jails are under court orders to reduce inmate populations and improve facilities and services. They have often responded to these court orders by (1) refusing to contract with the Federal Government, (2) canceling existing contracts, or (3) reducing the number of available spaces for Federal prisoners. This has forced the Federal Government to contract for space with jails outside the area in which it was needed or to build costly Federal facilities in major metropolitan areas.

One of the alternatives discussed in our report for alleviating deficiencies in contract facilities was the provision of Federal assistance to them. This would benefit both the Federal and local governments because the Federal Government could get guaranteed adequate and sufficient space for its prisoners in return for badly needed improvements in the local jails.

The U.S. Marshals Service (USMS), which is now primarily responsible for contracting with local jails, is in a position to provide management assistance and funds for improving the medical and dental care in contract local jails. The USMS has 92 district detention specialists who will be conducting detailed surveys of contract jails just prior to negotiating 3-year contracts and every 3 months thereafter. The purpose of these surveys is to identify substandard conditions based on Department of Justice and ACA standards. In negotiating contracts with local jails, USMS could incorporate a program of improvement to meet the standards as a condition of the contract work statement. USMS could agree to provide partial funding for the full or part-time employment of medical and dental staff and services, and for the acquisition of new or replacement equipment and supplies. Such funds, however, should not be used for major construction or renovation projects. USMS could also

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1/"Housing Federal Prisoners in Non-Federal Facilities Is Becoming More Difficult," GGD-77-92 (Feb. 23, 1978).

encourage and aid local jails to obtain other available Federal, State, and local resources which could be used in improving medical and dental services.

A program to help fund improvements in contract local jails would

--provide an incentive for them to continue housing Federal prisoners;

--provide for the safe, sanitary, and humane detention of Federal prisoners; and

--serve as a catalyst to encourage local governments to improve conditions in their jails.

The program would complement, but not overlap, other Federal, State, and local programs.

CHAPTER 5

CONCLUSIONS, RECOMMENDATIONS, AND AGENCY COMMENTS

CONCLUSIONS

The health care delivery systems of most prisons and jails are inadequate. To varying degrees, they do not meet minimal standards for providing adequate levels of care, physical examinations, medical records, staffing, facilities, equipment, and assessments of their performance. In addition, many of these systems are under increasing pressure from the courts to upgrade the health care they provide so as not to violate the constitutional ban against cruel and unusual punishment.

Correctional officials are faced with severe constraints in improving the delivery of medical and dental care in their prisons and jails, such as a lack of resources and/or knowledge about ways to make effective changes. However, given the likelihood that most correctional agencies will continue to be underfunded, it is critical that they, with the help of the Federal Government, examine ways of improving the utilization of all their existing health care resources.

The Federal Government has given only limited attention to the medical and dental care of inmates despite its long-standing commitments to improving health care through PHS and correctional programs through LEAA and other agencies. We believe these commitments need to be combined into a Federal strategy that will improve the health care delivery systems of prisons and jails and the utilization of available health care resources.

The strategy we envision would require that correctional officials demonstrate the strength of their own commitment to making improvements by (1) determining the medical and dental needs of their inmates and the proper mix of resources to meet those needs and (2) implementing the health standards they can within their existing capabilities. Remaining problems could then be addressed by applying available Federal resources, technical expertise, and influence.

While the Federal Government cannot fully subsidize health care delivery systems in prisons and jails, it can make available to these systems (1) existing financial and technical assistance programs to help support comprehensive studies of the systems and (2) development of management information and review mechanisms. In addition, inmates in prisons and jails could be served by federally supported State

and local health programs where practical. Because of its experience, LEAA should develop and implement the Federal strategy utilizing the appropriate expertise and resources of the National Institute of Corrections, USMS, and PHS.

RECOMMENDATIONS

We recommend that the Attorney General:

1. Require the Administrator of the Law Enforcement Assistance Administration to:

   --Develop and implement a Federal strategy to help State and local governments bring their prison and jail health care delivery systems into compliance with ACA and AMA standards.

   --Incorporate the appropriate expertise and resources of the National Institute of Corrections, USMS, and PHS into the Federal strategy.

   --Require that State and local governments, in order to participate in the Federal strategy, determine the medical and dental needs of their inmates and the proper mix of resources to meet those needs, and implement the health standards they can within their existing resources.

2. Require the Director of the U.S. Marshals Service to:

   --Provide funding for improving the medical/dental equipment, services, staff, and facilities of contract jails which fall below ACA and AMA standards.

   --Coordinate USMS' efforts with those of LEAA and PHS, and with State and local health authorities.

3. Require the Director of the Bureau of Prisons to:

   --Reexamine the policy on physical examinations to include biennial examinations of all inmates and mandatory examinations of inmates about to be released, unless they have had recent physicals.

   --Replace inmates working in sensitive positions, such as maintaining medical records, with qualified civilian personnel.

--Take appropriate actions to assure 24-hour coverage by qualified medical personnel at all institutions.

We also recommend that the Secretary of Health, Education, and Welfare direct the Assistant Secretary for Health to:

--Monitor the newly initiated Public Health Service Prison Health Program and, if successful, expand it within the Federal strategy.

--Provide grants under Public Law 93-641, Sec. 1625 within the Federal strategy to help State and local correctional institutions bring their medical and dental facilities into compliance with ACA and AMA standards.

--Explore the feasibility of utilizing other applicable assistance programs within the Federal strategy.

--Encourage the State and local health planning agencies established under the Public Health Service Act to consider inmate populations in their planning and programing for community health improvements.

AGENCY COMMENTS

The Department of Justice agreed with GAO's conclusion that there is a need to improve medical and dental care services in prisons and jails and noted that the Department is taking a number of actions which are consistent with the recommendations of the report. However, the Department did not specifically state how it will implement the Federal Strategy. The Department's comments are included as appendix I.

It noted that LEAA has been active in funding pilot projects in the prisons medical care area for several years and is considering an additional program designed to encourage the implementation of ACA and AMA standards. It also pointed out that medical and dental needs are well-documented by the courts and cited a recent listing of pertinent court orders prepared by LEAA.

The Department stated that the USMS was recently authorized to expend funds to correct deficiencies and upgrade facilities at non-Federal institutions housing U.S. prisoners. USMS expects to begin this program by January 1, 1979.

The Department stated that the program can later include medical and dental treatment problems.

The Department questioned the importance of periodic physical examinations for Bureau inmates since (1) there is considerable controversy as to their value and (2) inmates are examined carefully on admission and most are seen frequently while incarcerated. It stated that the Bureau has been taking action on replacing inmates working in sensitive positions and hopes to have 24-hour medical coverage by fiscal year 1980 or 1981.

We support LEAA's proposed program to encourage the implementation of ACA and AMA standards. But, while court orders have given some correctional administrators a good idea of what is expected of their system, they have not documented the needs in all prisons and jails. We continue to believe that administrators should determine (1) how their individual health care delivery systems compare with standards and (2) what resources are available to them from the community as a prerequisite to a Federal commitment for assistance.

We also support the USMS' program to upgrade non-Federal contract facilities and encourage USMS to include health care delivery system standards in its program.

The Department's questioning of the importance of periodic physical examinations for Bureau inmates is suprising since the ACA standards recommend periodic physicals and the Department in its draft Federal Standards for Corrections recommends "medical preventive maintenance" which includes "medical services provided to take advance measures against disease." It would seem rather difficult to take advance measures without having advance knowledge gained through periodic physical examinations, particularly for those inmates who attend sick call infrequently. Our recommdendation was made because of the increased health risks inherent in an institutional setting.

HEW concurred with our recommendation to monitor the Prison Health Program for possible expansion within the Federal strategy. It also concurred with our recommendations to explore the use of other assistance programs to upgrade inmate medical and dental care and to encourage State and local planning agencies to consider inmate populations in their planning efforts. Concerning our recommendation that section 1625 (Public Law 93-641) grants be used to help correctional institutions bring their medical and dental facilities into compliance with standards, HEW agreed that legal

authority exists for such grants. However, it stated that given the current level of resources, it is not reasonable to expect grants to jails and prisons. HEW's comments are included as appendix II.

HEW agreed that there are potential benefits in combining the efforts and expertise of Federal, State, and local governments, but noted that it would be desirable to have a more detailed explanation of how we intend that LEAA should interact with HEW in this process. It also stated that the strategy might be best developed with LEAA's assuming primary responsibility for coordination and implementation and with HEW's acting as primary consultant on health related issues. We have no problems with this approach.

HEW also made several technical comments. These have been considered, and changes were made to our report where appropriate. Several of the technical comments requested information which was beyond the scope of our review. Since we agree that the information requested would be useful, perhaps it could be gathered as part of initial Federal efforts within the Federal strategy.

In each of the States we visited, copies of the draft report were provided to the appropriate correctional agency and to the State criminal justice planning agency. A copy of the draft was also provided to the AMA. Comments received from these organizations were considered in the report, and changes have been made where appropriate.

CHAPTER 6

SCOPE OF REVIEW

To determine the adequacy of correctional health care nationally, we made literature searches, examined court decisions, and reviewed reports and studies published by professional groups such as the American Correctional Association, American Medical Association, American Public Health Association, and the National Sheriffs Association. We also interviewed representatives of the American Bar Association, American Correctional Association, American Dental Association, American Medical Association, National Sheriffs Association, and the American Civil Liberties Union.

To determine the adequacy of health care in Federal institutions, we interviewed Bureau of Prison headquarters officials and reviewed policies and procedures for providing medical and dental services. In addition, we reviewed Joint Commission on Accreditation of Hospitals inspection reports on Federal prisons. To observe the actual delivery of health care, we visited six Federal prisons. (See app. III.) We interviewed correction and medical/dental staffs, observed sick-call activities, and inspected the medical/dental facilities and equipment.

To determine the adequacy of health care in State and local institutions, we interviewed State correctional officials and reviewed policies and procedures for providing medical and dental services in 10 selected States having 39 percent of the non-Federal inmates. (See app. III.) To observe the actual delivery of health care, we visited 23 prisons and 4 jails in the 10 selected States. Because of the American Medical Association's extensive coverage of medical and dental care in jails, we limited our onsite coverage to only four jails. At the prisons and jails, we interviewed correction and medical/dental staffs, observed sick-call activities, and inspected the medical/dental facilities and equipment. In addition, a medical consultant accompanied us on visits to three prisons to inspect the medical/dental facilities, determine the adequacy of the medical/dental staffs, and review medical records to determine the adequacy of the medical records and the quality of care provided.

We also interviewed HEW, PHS, Department of Justice, and LEAA officials to (1) assess their role in helping States

provide medical/dental care in correctional institutions, (2) determine what Federal programs are available and being used by the States, and (3) determine what the Federal role should be in assisting the States to meet inmate health care needs.

The primary reason for our visits to the States was to identify ways in which the Federal Government could improve its health care assistance to them. The States in our review were selected on the basis of their geographic location and are not considered by us to be better -- or worse -- than those we did not visit. Because the focus of this report is not on evaluating the specific health care problems of individual States, they generally have not been identified unless they seemed to be making headway in solving certain problems. This was done so that other States might be able to contact them to obtain additional information.

Our review was performed primarily between September 1977 and April 1978.

APPENDIX I

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20530

Address Reply to the
Division Indicated
and Refer to Initials and Number

OCT 23 1978

Mr. Allen R. Voss
Director
General Government Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Voss:

This letter is in response to your request for comments on the draft report entitled "A Federal Strategy Is Needed to Help Improve Medical and Dental Care in Prisons and Jails."

We agree that there is a need to improve medical and dental care services in prisons and jails at all government levels and the Department is taking a number of actions which are consistent with the recommendations of the report. In some instances, the strategies recommended in the report are well along in their implementation.

The report recommends that the Law Enforcement Assistance Administration (LEAA) "develop and implement a Federal strategy to help State and local governments bring their prison and jail health care delivery systems into compliance with ACA and AMA standards." LEAA has been active in funding projects in the prisons medical care area for several years. The standards issued by the American Medical Association (AMA) and the American Correctional Association (ACA) were funded by LEAA. These standards have been incorporated into the ACA guidebook and the most recent draft of the "Federal Standards for Corrections." The latter effort is supported by the Attorney General's Federal Corrections Policy Task Force, which is working to incorporate the standards into an overall Federal corrections strategy.

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During fiscal year 1978, LEAA awarded over $1.9 million in a discretionary grant program to improve medical programs at selected sites. Furthermore, a new incentives program, for which $3 million has been allocated in fiscal year 1979, will be instituted to enhance the use of block grant funds for implementation of ACA and AMA standards. Initially, this program will be concentrated in selected States demonstrating their willingness to commit substantial block grant funds as well as State funds.

The report further recommends that LEAA "require that State and local governments in order to participate in the Federal strategy, determine the medical and dental needs of their inmates and the proper mix of resources to meet those needs, and implement the health standards they can within their existing resources." The medical and dental needs of inmates are well documented by the courts, and a recent listing of pertinent Court Orders prepared by LEAA includes 113 cases. Contact with law enforcement personnel across the country indicates that the list of Court Orders is due to increase and focus on additional areas such as sanitation, fire safety, legal rights, medical care and overcrowding. Also, under an LEAA project funded by the National Institute of Law Enforcement and Criminal Justice, Abt Associates, as part of the Survey of Correctional Facilities and Assessment of Needs, is collecting information on the medical diagnostic facilities in the nation's prisons. At such time as the data on health care facilities currently in use is available, LEAA will be better able to determine what specific follow-up surveys would be most useful. This information will be available in March 1979, and will be used in planning and implementing LEAA's strategy to improve medical care in prisons and jails.

With respect to the recommendation to improve medical/dental equipment, services, staff and facilities of contract jails, the U.S. Marshals Service (USMS) will be addressing these matters in accordance with its new mandate under DOJ Order No. 777-78, effective April 27, 1978, which authorizes the USMS to expend funds to correct deficiencies and upgrade facilities under contracts with non-federal institutions for the care and custody of U.S. prisoners. Through the jail contracting program, the USMS may provide funds under

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the contract to include "contracting for such physical improvements as may be required" in order to bring the facility to a level of acceptable standards. All the USMS contract improvements will be based upon those deficiencies identified in a comprehensive jail survey derived from ACA and AMA standards. A comprehensive evaluation of the options available will be carried out before specific action is undertaken.

The USMS plans to have 92 trained and dedicated personnel recruited and operational in 92 field offices by January 1, 1979, to begin the program. These specialists will receive advanced training from the National Institute of Corrections in jail operations and administration. Later, the training schedule can be expanded to include a course in medical care administration developed by AMA in conjunction with the National Institute for Corrections. Given this highly specialized field staff, the USMS can conduct on-site surveys of all jails under Federal contract, identify areas of substandard medical or dental treatment and take immediate initiatives to upgrade medical services.

With respect to the recommendations made pertaining to the Bureau of Prisons (BOP), we are in general agreement with the suggested actions, although we do believe that the frequency with which periodic physical examinations should be performed has been overemphasized by listing it as a primary recommendation. Although we have included periodic examinations in our plans, there is considerable controversy today among health care providers about the value and cost benefit of periodic examinations. Since each inmate is examined carefully on admission and most inmates are seen with considerable frequency throughout incarceration, the need for periodic examination is further reduced.

As for the recommendation that BOP replace inmates working in sensitive positions with qualified civilian personnel, BOP has been taking action on this matter and has, in all but a few instances, replaced inmates working as medical record clerks with qualified civilians.

Although BOP hopes to have 24-hour medical coverage for all Federal prisons, it is difficult to project a definite target date for completing this program in light of current budgetary constraints. There are also some problems as to how to best provide this service. We feel there is considerable merit to the viewpoint that many health professionals,

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particularly physicians, should not be utilized in prisons on a full time, permanent basis. These jobs offer a dearth of professional challenge and stimulation and an excess of frustration. Some physicians who stay for an extended period of time tend to become stale and bitter and considerably less effective. Utilization of Public Health Service (PHS) physicians and other PHS medical professionals has permitted rotation through various assignments, including the Federal Bureau of Prisons, and the utilization of National Health Service Corps physicians in State and local systems will permit a similar rotation plan. Utilization of older physicians who are near or past their usual retirement age has been quite effective, but there are obviously problems with this concept.

A major recommendation of the report points out the need for LEAA, USMS, and BOP to coordinate their efforts with each other and with the PHS and State and local health authorities. We fully recognize the importance for all planning done at the Federal level to be closely coordinated with all State efforts so that the final plan will be one that is acceptable and useful at the State and local level and can be integrated with their planning efforts. It is also essential that planning include interfacing with the various groups and organizations throughout the country who are working very actively at this time in the area of improvement of health care in jails and prisons. It would be a mistake to duplicate or to work at cross purposes with these organizations.

The improvement of health care delivery is a major undertaking, and despite the efforts of the Department of Justice to improve health care services at all government levels, more resources will be needed before the nation's correctional organizations can meet the AMA/ACA standards.

We appreciate the opportunity to comment on the draft report. Should you desire any additional information, please feel free to contact us.

Sincerely

for Kevin D. Rooney
acting Assistant Attorney General
for Administration

APPENDIX II

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

NOV 9 1978

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "A Federal Strategy is Needed to Help Improve Medical and Dental Care in Prisons and Jails." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

APPENDIX II

THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE (DHEW) COMMENTS TO THE GENERAL ACCOUNTING OFFICE (GAO) DRAFT REPORT ENTITLED "A FEDERAL STRATEGY IS NEEDED TO HELP IMPROVE MEDICAL AND DENTAL CARE IN PRISONS AND JAILS"

General Comments

While we agree that there are potential benefits in combining the efforts and expertise of the Federal, State and Local Governments, it would be desirable to have a more detailed explanation of how GAO intends that LEAA should interact with HEW in this process. As documented in part by the GAO study, the medical care problems confronting correctional institutions are of such magnitude and complexity that the solutions require management systems and experience in all aspects of health care delivery and evaluation. We believe that the strategy might be best developed with LEAA assuming the primary responsibility for coordination and implementation of the strategy and with HEW acting as the primary consultant on health related issues.

GAO Recommendation

We recommend that the Secretary of Health, Education and Welfare direct the Assistant Secretary for Health to:

-- Monitor the newly initiated Public Health Service Prison Health Program and, if successful, expand it within the Federal strategy.

Department Comments

We concur. The Department will closely monitor the Health Services Administration's Prison Health Initiative.

GAO Recommendation

We recommend that the Secretary of Health, Education and Welfare direct the Assistant Secretary for Health to:

-- Provide grants under P.L. 93-641, Sec. 1625 within the Federal strategy to help state and local correctional institutions bring their medical and dental facilities in compliance with ACA and AMA standards.

Department Comments

Legal authority now exists for the Department to make such grants. (See 42 CFR Section 124.3, published December 9, 1977 at 42 FR 62271). However, given the current level of available resources for this activity it is not reasonable to expect grants to jails and prisons. Consequently, the near-term implementation of this recommendation seems rather unlikely.

GAO Recommendations

We recommend that the Secretary of Health, Education and Welfare direct the Assistant Secretary for Health to:

-- Explore the feasibility of utilizing other applicable assistance programs within the Federal strategy.

Department Comments

We concur. The Public Health Service's (PHS) Health Services Administration (HSA), will explore the feasibility of utilizing the Community Health Center and National Health Service Corps legislative authorities to assist state and local officials in improving inmate health care. In addition, HSA will make it clear to the states that the PHS Act Section 314(d) formula grant funds awarded to the states in order to assist them in establishing and maintaining adequate services can be used to provide inmate health care.

GAO Recommendation

We recommend that the Secretary of Health, Education and Welfare direct the Assistant Secretary for Health to:

-- Encourage the state and local health planning agencies established under the Public Health Service Act to consider inmate populations in their planning and programming for community health improvements.

Department Comments

We concur. The Public Health Service's (PHS), Health Resources Administration is developing methods for encouraging the state and local health planning agencies to recognize the inmate populations in their planning and programming for community health improvements.

Technical Comments

GAO notes on page 3 that "prisons are expected to have more comprehensive programs." However, the report should also emphasize the anomaly of large, urban jails which may hold thousands of pre-trial detainees and have a ten-fold turnover rate annually. Health care programs in such facilities must be highly comprehensive in order to meet adequate medical and public health standards. (The medical costs per year of inmate occupancy may easily exceed $1,000 for ambulatory care alone; e.g., the Monefiore Rikers Island Program).

The GAO report mentions and summarizes the recently promulgated standards of the American Correctional Association (ACA) and the American Medical Association (AMA). Omitted, however, are the standards of the American Public Health Association (APHA, Washington, D.C., 1976). The APHA standards are noteworthy for their emphasis upon the necessity of an adequate health

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care system in correctional institutions and for standards that include key aspects of environmental health. The task force which prepared the APHA standards was of extraordinary interdisciplinary quality, including physicians and other health professionals with vast experience in correctional institutions. In Federal Court decisions in both Rhode Island and Oklahoma, the APHA standards have been specifically cited as a standard to be met by State prisons. Therefore, the importance and usefulness of the APHA standards should not be omitted from the GAO report.

It would be useful if the report's section dealing with physician staffing would include more specific data on the salaries that are currently being budgeted for physician services, at least in those facilities where the reviewers site-visited. One could then compare these salaries with per capita physician figures (both salaried and self-employed) and thereby derive a better understanding of the actual dollar gap. More analysis should also be devoted to the issue of whether recruitment of physicians and other health personnel for correctional institutions could be improved by various administrative changes such as direct employment by a health agency or a direct line of authority with a State director of medical services rather than the warden or director of the local institution.

It would be desirable for the GAO to include some current data on the relative national availability of physician assistants, nurse practitioners, and medical technicians. The draft report takes note of some of the variations in utilization of such personnel from one institution to another. The GAO should add that one of the most essential aspects of such utilization is continuous written documentation of licensed physician review of job descriptions, standing orders, in-service training sessions, and periodic evaluation. If such measures are taken seriously, these physician extenders can do much to upgrade the quality of health services in correctional institutions. As with qualified physicians, however, the correctional system must still provide competitive salaries and benefits as well as frequent opportunities for professional experiences and continuing education in other less stressful environments than the jail or prison.

The GAO notes that Federal prisons provide far more adequate health care than do most jails and State prisons. However, the report also should include budgetary information on the actual per-capita personal health services expenditures of the Bureau of Prisons (about $570.00 per year of inmate occupancy). It is only realistic to note that State prison systems having less than one-half of this amount budgeted are extremely unlikely to achieve minimally acceptable health care standards. Michigan is one State where a figure approaching that of the Bureau of Prisons has recently been budgeted and where great progress is being made.

The CHC program cost stated in the first sentence on page 63 reads $427 million. The correct amount is $247 million. In addition, a $6 million appropriation amendment was approved on September 8, 1978 (P.L. 95-355 Section 330 of CHCs) increasing the CHC program cost to $253 million.

APPENDIX III

LOCATIONS VISITED

STATE AND LOCAL INSTITUTIONS VISITED

States Visited	State Institutions Visited	Jails Visited
California	Correctional Medical Facility California State Prison	
Connecticut	Somers Correctional Institute	
Indiana	Indiana Reformatory	
Maryland	Maryland State Penitentiary Maryland House of Corrections	
Massachusetts	Norfolk State Prison Walpole State Prison Concord State Prison	
Michigan	State Prison of Southern Michigan Michigan Reformatory	Ingham County Jail
New York	Elmira State Prison Green Haven State Prison Great Meadow State Prison Coxsockie State Prison	Schenectady County Jail Albany County Jail
North Carolina	Central Prison Polk Youth Services Complex Johnston Youth Field Unit Vance County Adult Field Unit Currituck County Adult Field Unit	Wake County Jail
Pennsylvania	Camp Hill State Prison	
South Carolina	Kirkland State Prison Central Correction Institute	

FEDERAL BUREAU OF PRISONS

REGIONS AND INSTITUTIONS VISITED

North Central Region

U.S. Penitentiary	Marion, Illinois

Northeast Region

Federal Correctional Institution	Danbury, Connecticut
Federal Correctional Institution	Butner, North Carolina

Southeast Region

U.S. Penitentiary	Atlanta, Georgia
Federal Correctional Institution	Tallahassee, Florida
Federal Prison Camp	Eglin, Florida

DESCRIPTION OF HEALTH SERVICES PROVIDED IN THE FEDERAL BUREAU OF PRISONS AND THOSE STATES IN WHICH WE DID DETAILED AUDIT WORK

FEDERAL BUREAU OF PRISONS

As of March 31, 1978, the Bureau of Prisons had 579 permanent health services personnel 1/ serving at headquarters, 5 regional offices, and 38 medical facilities in institutions. These facilities consist of 1 accredited 2/ medical center, 5 medical referral centers (4 accredited, 1 not), 4 accredited hospitals, and 28 medical stations. In fiscal year 1977, the Bureau spent approximately $17.5 million (an average of $600 per inmate) for health care services to approximately 29,000 inmates. This included $1.5 million for contract medical and dental services, and $2.5 million for outside hospitalization.

The Bureau's health care delivery system provided the following services in fiscal year 1977:

--755,813 outpatient and 9,939 inpatient medical contacts in institutional hospitals and clinics.

--41,697 physical examinations. 3/

--550,015 clinical laboratory procedures.

--82,293 X-rays.

--4,931 surgical operations.

1/These personnel consisted of 62 doctors, 49 dentists, 76 nurses, 278 physician assistants, 7 pharmacists, 24 laboratory or X-ray technicians, 15 dental technicians or dental assistants, and 68 others.

2/The Bureau uses the Joint Commission on Accreditation of Hospitals, a nationally recognized accrediting authority that reviews health facilities for compliance with certain minimum standards, and the American Dental Association.

3/Of the 41,697 physical examinations, 25,924 were of inmates. The remaining 15,773 were of U.S. Marshals, institutional employees, civil service applicants, and others.

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--18,652 consultant visits.

--149,659 dental visits.

--25,757 dental examinations.

--93,181 dental procedures.

Each institution offers a basic package of medical services regardless of what types of facilities and services are available in the surrounding community. Cases which cannot be handled at an institution are referred to better equipped Bureau institutions or community physicians and hospitals. In fiscal year 1977, there were 1,495 medical transfers.

Health care statistics for fiscal year 1977 on the six Federal institutions visited were as follows:

	Butner, N.C.	Danbury, Conn.	Tallahassee, Fla.	Atlanta, Ga.	Marion, Ill.	Eglin, Fla.
Capacity	500	650	550	2,100	500	450
Number of permanent health personnel	27	14	8	28	13	2
JCAH accredited	No	No	No	Yes	Yes	No
Health services allocation	$358,298	$340,794	$175,597	$712,196	$325,564	$81,899
Cost per inmate	$ 717	$ 524	$ 319	$ 339	$ 651	$ 182
Outpatient contacts	9,211	21,523	14,401	33,984	29,480	9,262
Inpatient contacts	180	145	-	454	97	11
Physical examinations	517	1,936	1,119	801	299	1,079
Eye refractions	73	608	211	642	175	192
Clinical lab. procedures	1,654	6,809	1,712	28,106	18,852	4,031
X-rays	825	2,513	1,121	3,313	2,833	1,784
Surgical operations	56	207	130	365	63	25
Consultant visits	419	93	222	442	61	131
Dental visits	2,397	9,236	2,320	7,281	1,669	1,557
Complete dental examinations	338	918	526	508	173	465

APPENDIX IV

CALIFORNIA

For fiscal year 1977, the California Department of Corrections had 498 medical and dental personnel serving at the Department and its 12 major institutions. These institutions housed 19,365 inmates on January 11, 1978. Fiscal year 1977 expenditures for medical and dental services totaled about $14.9 million or about $770 per inmate. Of the medical units at the 12 institutions, 6 were considered acute care hospitals and 6 were considered infirmaries.

The Department maintained 509 medical and surgical beds and provided outpatient and inpatient care and treatment for nearly any medical or dental problem arising in the inmate population. The Department had a major surgical hospital at San Quentin. In addition, the hospitals at the California Men's Colony and California Medical Facility were used for medical and surgical referral patients. Outside facilities, as well as medical consultants, are used for highly specialized medical and surgical procedures.

We visited the California Medical Facility in Vacaville and the California State Prison in San Quentin. They housed 1,860 and 2,090 inmates respectively, on January 11, 1978. Both had acute care prison hospitals, with 83 beds at Vacaville and 60 at San Quentin. Medical and dental services provided by the Department, and at Vacaville and San Quentin in fiscal year 1977 were as follows:

Medical	Total	Vacaville	San Quentin
Total number of hospital patients	11,114	2,282	1,016
Average daily sick line	2,980	35	413
Total complete physical examinations, inmates and staff	31,858	4,715	1,580
Total surgical operations	4,918	542	469
Dental			
Total surgery procedures	13,716	1,234	631
Total fillings	93,648	10,367	6,892
Total dentures, full and partial	4,798	327	239
Total repair of dentures	2,258	187	187
Total number of treatments	34,733	12,731	6,669

MARYLAND

The Maryland Division of Correction supervises the operation of five major and seven smaller correctional facilities, housing about 6,800 State inmates. In fiscal year 1978, the total budget for clinical and hospital services was about $2.1 million, or about $300 per inmate. 1/ The Division had 83 medical and dental personnel.

The Division's Assistant Director, Clinical and Hospital Services, provided the following information on medical and dental services provided in fiscal year 1977:

Number of outpatient visits	2,312
Number of inpatients	152
Number of inpatient days	1,402
Estimated number of entrance physicals	6,800
Laboratory procedures (Maryland Penitentiary Hospital only)	1,620
X-rays (Maryland Penitentiary Hospital only)	7,750
Surgical procedures	120
Consultant visits	492
Dental visits	3,450
Dental procedures	1,602
Eye examinations	327

MASSACHUSETTS

The Massachusetts Department of Corrections is responsible for five major institutions, three forestry camps, and a number of pre-release centers. The total inmate population on June 20, 1977 was 3,688. Appropriations for the Department's Division of Health Services for fiscal year 1977 totaled about $2.6 million, or about $700 per inmate. The Department had 68 medical and dental personnel.

We visited three of Massachusetts' correctional institutions: Concord, with 298 inmates, Norfolk with 746 inmates, and Walpole with 684 inmates. Medical and dental

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1/The cost per inmate figure was relatively low since the University of Maryland Hospital in Baltimore was providing a large amount of free services. Beginning July 1, 1978, the Division of Correction was to reimburse the hospital for medical services.

services provided by these institutions in fiscal year 1977 were as follows:

	Concord	Norfolk	Walpole
Outpatient contacts within the institution	14,000	7,000	10,400
Physical exams	800	1,200	448
Medical transfers for in-patient stays	65	200	55
Clinical lab tests	2,000	21,056	Not available
X-rays	470	4,613	1,100
Consultant visits	0	225	60
Dental visits	2,693	3,150	3,380
Dental procedures	2,930	4,300	2,860
Inmate visits to outside hospitals	600	1,074	1,050

MICHIGAN

On October 4, 1977, the Michigan Department of Corrections had 337 health services personnel serving at the Department and its 20 institutions--7 institutions for men, 1 women's prison, and 12 correctional camps. For fiscal year 1977, the average inmate population was 13,054, and the Department spent about $8.2 million on health care or about $625 per inmate.

We visited the Department's State Prison of Southern Michigan and the Michigan Reformatory. The State Prison, with a population of about 5,800, had 96 inpatient infirmary beds and the Reformatory, with a population of about 1,480, had 22 inpatient infirmary beds. For the year ended December 31, 1977, the following health services were provided by the Department's six major institutions:

Services	Total for all six	State Prison	Reformatory
On-site inpatient visits	2,548	1,574	484
On-site outpatient visits	223,641	82,296	27,375
Off-site inpatient admissions	732	400	91
Off-site outpatient visits	4,840	1,893	534
Support services			
X-ray procedures	17,339	13,955	1,011
Lab procedures	30,088	20,702	680
Prescriptions	556,309	389,280	Not available
Dental visits	30,513	8,533	3,918

NEW YORK

The New York State Department of Correctional Services is responsible for the custody of about 19,400 inmates sentenced to terms of imprisonment in 24 general confinement facilities, 4 camps, 6 community-based male facilities, and 3 community-based female facilities. The Department had 333 medical and dental personnel on January 18, 1978. In fiscal year 1978, the Department's health budget was about $8.4 million, or about $435 per inmate.

According to a January 4, 1978, memorandum prepared by the Department's Assistant Commissioner for Health Services, the health care delivery system provided the following services to inmates:

--400,000 ambulatory health visits recorded per year.

--13,000 patient days of care in community general hospitals per year.

--13,000 outside public health referrals to specialists per year.

--140,000 dental procedures per year.

--350 reconstructive surgery procedures within correctional facilities per year.

NORTH CAROLINA

The North Carolina Department of Corrections had a prison population of about 14,300 inmates on January 1, 1978. The Department's 79 prisons include 6 major adult institutions, 7 youth services complexes, and 66 field units. In December 1977, the Department had 200 medical and dental staff members.

Acute medical and surgical hospitalization is provided to all adult male inmates in the prison system at a 92-bed hospital in Central Prison. The hospital has two surgical suites, an intensive care unit, inhalation therapy service and a renal dialysis capability. It also contains a comprehensive radiological service, a laboratory service, and a pharmacy service. Specialty hospitalization to treat unique conditions, such as neurosurgery and open heart surgery, is obtained from local community hospitals.

Expenditures for medical and dental care in fiscal year 1977 were as follows:

	Total	Average per inmate
Expenditures for direct care	$4,864,581	$292
Expenditures for outside care	$ 851,344	$ 61

The following services were provided:	Number of services
Estimated number of initial intake physical examinations	13,000
Clinical laboratory procedures (Central Prison only)	148,045
X-rays (Central Prison only)	62,312
Surgical operations (Central Prison only)	923
Consultation visits (Central Prison only)	14,828
Estimated dental examinations (all prison dental units)	15,575
Estimated dental procedures (all prison dental units)	38,940
Estimated outpatient visits	600,000
Inpatient hospital admissions (Central Prison only)	1,291
Estimated medical transfers (Central Prison only)	7,500

PENNSYLVANIA

The Pennsylvania Bureau of Corrections is responsible for 8 felony State correctional institutions and 15 community service centers. The total inmate population is approximately 7,500, of which about 300 are in the community service centers. The Bureau had 127 health personnel--including part-time staff--at the time of our visit. The Bureau's annual budget for health care was about $3.4 million, or about $453 per inmate.

The Health Care Services' Program Division Report for fiscal year 1977 showed the following medical services were provided by the correctional institutions:

Sick call visits, medication line, and emergency medical services	1,953,721
Physical examinations	7,775
Laboratory tests	35,203
X-rays	17,746
Special testing procedures (EKG's, etc.)	21,669
Major and minor surgical procedures	470
Consultant visits	33,563
Physical therapy procedures	1,104
Institution and community hospitalizations:	
Number of patients	2,577
Hospital days	18,959

SOUTH CAROLINA

The South Carolina Department of Corrections provided us with the following statistics for fiscal year 1978:

	Total
Expenditures for in-house direct care	$1,152,942
Expenditures for outside direct health services	346,284
Estimated total direct expenditures, fiscal year 1979	1,656,943
Average expenditures per inmate per year--outside	49
Average expenditures per inmate per year--in-house	165

Services provided	Number
Physical examinations	5,689
Eye refractions	1,437
Dental examinations	1,542
Outpatient contacts	1,522
Inpatient hospital contacts	11,000
Patients sent to outside hospitals	173

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