PRISON MEDICAL CARE: SPECIAL NEEDS POPULATIONS AND COST CONTROL

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Introduction

Corrections agencies are currently providing many specialized medical services to individuals in their inmate populations who require more extensive care than that provided to most inmates. One result is rising medical care costs for state corrections agencies. It is in this context that the NIC Prisons Division and Information Center initiated a national survey on special issues in prison medical services.

The project was intended:

- To explore how corrections agencies are providing medical care to three inmate populations with special needs: the elderly, the terminally ill, and the chronically ill, particularly the degree to which DOCs have consolidated specialized services at one or more facilities; and

- To assess the use of cost management initiatives in the medical division of each prison system.

NIC distributed a survey instrument to departments of corrections (DOCs) nationwide in May 1997. Staff made follow-up contacts among the DOCs during the summer to promote a high response rate. Completed surveys were returned by 46 states; the District of Columbia; New York City, New York; the Virgin Islands; and the Federal Bureau of Prisons. A list of agency respondents is provided as an appendix to this report.

Findings in Brief

Results of the survey demonstrate that DOCs have devoted considerable effort toward service efficiencies and cost reduction.

- At least 27 DOCs have consolidated-at one or more sites-their specialized medical care for populations targeted by the survey. Consolidation of services is prevalent for terminally ill populations (23 DOCs) and somewhat less common for elderly inmates (15 DOCs). It is rarely used as an approach for chronic care.

- The numbers of DOCs using telemedicine, inmate fees for medical care, and use of computers to manage medical services are increasing rapidly.

- More than 40 of the DOCs are now using or planning to implement managed care, privatization of medical services, and/or centralization or regionalization of medical services.

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PART 1: Care for Populations with Specialized Medical Care Needs

Part 1 of the survey addressed provision of medical care for three populations with specialized needs: elderly inmates, terminally ill inmates, and inmates with chronic illness.

Among the 50 DOCs responding to the survey, 16 indicated that they provide special training for security staff on working with chronically ill, terminally ill, and/or elderly inmates. These agencies include the DOCs in Colorado (limited training), Delaware, Florida, Idaho, Illinois, Indiana, Louisiana, Maryland, Minnesota, Nevada (training related to chronically ill inmates only), Oregon, South Dakota, Texas, Utah, Wyoming, and the U.S. Bureau of Prisons.

Medical Care for Elderly Inmates

Consolidation of specialized care. Most corrections agencies provide specialized medical care to elderly inmates at several facilities; 23 DOCs indicated that these services are provided throughout their systems. In 15 DOCs, however, medical care for elderly inmates has been consolidated at one or more main sites. Table 1, page 3, lists these DOCs and the facilities where specialized care is provided.

Agency respondents noted several approaches to providing health care for elderly inmates:

- Iowa's elderly inmates are "mainstreamed" in the prison population and receive specialized care based on specific needs rather than age. The DOC conducts routine health reassessment tests and procedures consistent with age. Similarly, the New Jersey DOC provides medically indicated care as needed, at each institution or through regional clinics.
- Tennessee has a 40-bed unit for elderly inmates in good health; those with special medical care needs are housed in a 104-bed health care center.
- The Maine DOC uses nursing home beds for very frail and medically compromised elderly inmates.
- Assisted living units are available in 20 agencies and often house both elderly inmates and others needing special care. While the Colorado DOC provides specialized medical care for elderly inmates at several sites, it houses those that need moderate assistance at two particular facilities.
- Other DOCs house elderly inmates who have specialized medical care needs in an infirmary setting together with other acute and chronic care inmates.

Responses to elderly inmates' medical needs. The most common approaches used to provide specialized medical care for elderly inmates include chronic care clinics (42 DOCs), preventive care (41 DOCs), and increased frequency of physical examinations (35 DOCs). In addition, more than half the DOCs reported the availability of special nutrition/dietary care, special housing, and the use of inmate aides to provide non-medical assistance (e.g., reading, pushing wheelchairs) to the elderly.

Compassionate release is available (sometimes through executive clemency provisions) in 22 state DOCs as well as corrections agencies in New York City and the Virgin Islands. Seven DOCs that normally charge inmates fees for medical services provide fee-exempt services for elderly inmates with special medical care needs.

Table 2 lists the agencies that use selected additional approaches to respond to the medical care needs of elderly inmates. Examples include physical therapy, special visitation policies, and special recreation or work opportunities. Other responses noted by respondents include 24-hour physician access and orderlies in the Massachusetts DOC and delivery of medications to reduce ambulation in the New York City DOC.

Table 1. Main Facilities Housing Elderly Inmates with Special Medical Needs

	Facility Name and Location	Number of Beds Available for Elderly Inmates
Alabama	Hamilton Aged and Infirm, Hamilton	(Number not available)
Arizona	Arizona State Prison Complex, Florence	40
	Arizona State Prison Complex, Tucson	30
Connecticut	Osborn Correctional Institution, Somers	48
Idaho	Idaho State Correctional Institution (infirmary), Boise	13
Kentucky	(Facility not identified)	(Number not available)
Louisiana	Louisiana State Penitentiary, Angola	120
	Hunt Correctional Center, St. Gabriel	70
	Dixon Correctional Institute, Jackson	30
	Louisiana Correctional Institute for Women, St. Gabriel	20
Massachusetts	(Assisted living unit, facility not identified)	36
Minnesota	Minnesota Correctional Facility, Faribault	100
Nevada	Northern Nevada Correctional Center, Carson City	75
	Southern Nevada Correctional Center, North Las Vegas	100
New Mexico	Central New Mexico Correctional Facility (chronic care unit), Los Lunas	50
Ohio	Hocking Correctional Facility, Nelsonville	340
	Orient Correctional Institution, Columbus	232
Pennsylvania	State Correctional Institution at Laurel Highlands, Somerset	100
Tennessee	Lois M. DeBerry Special Needs Facility, Nashville	104
Utah	(Facility not identified), Draper	(Number not available)
West Virginia	Huttonsville Correctional Center, Huttonsville	100

Medical Care for Terminally Ill Inmates

Consolidation of specialized care. About half the responding DOCs (23 agencies) have consolidated the provision of care for terminally ill inmates in one or more facilities. Table 3, page 6, lists these DOCs and the facilities where specialized care is provided. Some of these agencies also use contracted hospital beds for acute or long-term care as needed. For example, the Massachusetts DOC can use beds in a prison ward in a public hospital.

Responses to terminally ill inmates' medical needs. The most prevalent approaches to caring for the terminally ill are compassionate release (available in 36 DOCs), special visitation policies (30 DOCs), and special housing, including placement of terminally ill inmates near medical care or in areas with special design or furnishings (29 DOCs).

Other major special provisions for the terminally ill include special counseling (26 DOCs), hospice care (24 DOCs), and using inmates to provide non-medical assistance (24 DOCs).

Special policies on use of pain medications for terminally ill inmates have been developed in 18 DOCs. Another agency noted that this is done in practice, although there is no policy addressing it. The New Mexico DOC provides pain medication on a case-by-case basis and notes that it is closely monitored by the primary care physician.

Table 2. Responses Available for Elderly Inmates with Medical Care Needs

	Compassionate Release	Assisted Living	Physical Therapy	Special Visitation Policies	Special Recreation Opportunities	Special Work Assignments	Special Release Planning
Alabama	✔						
Alaska					✔		
Arizona	✔	✔	✔				✔
Arkansas	✔		✔				
California							
Colorado	✔		✔	✔			✔
Connecticut							
Delaware				✔			
D.C.							
Florida	✔	✔	✔	✔	✔	✔	✔
Georgia	✔	✔	✔				
Hawaii							
Idaho	✔	✔	✔	✔			
Illinois		✔	✔	✔	✔		✔
Indiana	✔	✔	✔				
Iowa							
Kansas			✔		✔		
Kentucky		✔	✔				
Louisiana	✔	✔				✔	
Maine							
Maryland	✔						✔
Massachusetts					✔		
Michigan		✔	✔				✔
Minnesota			✔		✔	✔	
Mississippi	(No survey response)						
Missouri	✔						
Montana	(No survey response)						
Nebraska	✔						
Nevada							
New Hampshire						✔	
New Jersey	✔						
New Mexico		✔	✔				✔
New York	✔						
North Carolina	(No survey response)						
North Dakota			✔		✔		
Ohio		✔					
Oklahoma							
Oregon	✔	✔			✔	✔	✔
Pennsylvania		✔	✔		✔	✔	✔
Rhode Island							✔
South Carolina		✔	✔			✔	✔
South Dakota	✔	✔					
Texas	✔	✔	✔		✔	✔	✔
Utah	✔	✔	✔		✔	✔	✔
Vermont	✔			✔			✔
Virginia	(No survey response)						
Washington	✔	✔	✔		✔		
West Virginia		✔			✔	✔	
Wisconsin	✔			✔	✔	✔	
Wyoming							
U.S. Bureau of Prisons		✔	✔				
New York City	✔						
Virgin Islands	✔						

Eleven DOCs that normally charge inmates fees for medical services provide fee-exempt services for terminally ill inmates. In Massachusetts and other DOCs, terminally ill inmates' special treatment needs are addressed in individualized treatment plans addressing medication, housing, and counseling.

Availability of hospice care. Nearly half of the DOCs (24 agencies) offer hospice care for terminally ill inmates, some directly and others through special arrangements with publicly- or privately-funded programs.

- **Hospice care within the** DOC-Twenty (21) DOCs provide hospice care directly. Most of these agencies are among those with the largest incarcerated populations in the country. They include the DOCs in Alabama (minimal hospice care available), California, Colorado, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, New York, Ohio, Pennsylvania, South Carolina, Texas, Utah, New York City, and the U.S. Bureau of Prisons. In addition, the New Mexico DOC is developing a hospice unit. Inmate assistants in the Florida DOC facility are trained by staff of a community hospice.

- **Other publicly funded hospice care-Five** states provide other publicly funded hospice care. DOCs in Connecticut, North Dakota, and Washington noted that inmates can be placed in publicly funded hospice care outside the prison system. The South Dakota DOC contracts for hospital beds.

- **Privately funded hospice care-In** four DOCs, privately funded hospice care is available outside the DOC system. States include Nebraska, North Dakota, Vermont, and Hawaii.

- **Self-funded hospice care-Five** DOCs indicated that hospice care may be available if funded by the inmate, the inmate's family, or an insurance policy held by the inmate. Agencies include the Idaho, New Hampshire, North Dakota, Vermont, and Washington DOCs.

Medical Care for Inmates with Chronic Illnesses

Consolidation of specialized care. Rather than attempting to consolidate medical care for inmates with chronic illnesses, nearly all agencies (43 DOCs) provide such medical care at several facilities. Consolidation has been implemented in three DOCs:

- The Kentucky DOC uses 58 beds at a nursing facility to house inmates with chronic illnesses.

- The New Mexico DOC operates a 50-bed chronic care unit while also providing care at other facilities.

- In the Delaware DOC, only care for chronic mental illness is provided at a consolidated location.

Responses to chronically ill inmates' medical needs. The most common approach to caring for chronically ill inmates is through specialized clinics. Agencies identified chronic care clinics for conditions ranging from diabetes, HIV disease, asthma, and cardiopulmonary problems to weight reduction, pain control, general medicine, oncology, dermatology, and prenatal care.

Other common approaches to caring for the chronically ill include providing special housing arrangements (25 DOCs), using inmates to provide non-medical assistance (22 DOCs), and exempting chronically ill inmates from the payment of medical co-pays or fees, especially for participation in special chronic care clinics (14 DOCs).

Less common ways in which DOCs are providing care for the chronically ill include the use of telemedicine in the Louisiana DOC for a chronic care specialty clinic and in the Illinois DOC for a nephrology clinic for dialysis patients. The New York City Department of Correction has a separate infirmary that provides specialized care for inmates with chronic illnesses.

Table 3. Main Facilities Housing Inmates with Terminal Illnesses

	Facility Name and Location	Number of Beds Available for Terminally Ill Inmates
Alabama	St. Clair Correctional Facility, Springville (cancer patients)	(Number not available)
	Limestone Correctional Center, Capshaw (AIDS patients)	(Number not available)
Arizona	Arizona State Prison Complex, Florence	(Number not available)
	Arizona State Prison Complex, Tucson	(Number not available)
Arkansas	Pine Bluff Diagnostic Unit, Pine Bluff	66
California	California Medical Facility, Vacaville	17
	Central California Women's Facility	(Number not available)
Colorado	Colorado Territorial Correctional Facility, Cañon City (licensed hospice unit)	(Number not available)
Delaware	Delaware Correctional Center	(Number not available)
Idaho	Idaho State Correctional Institution (infirmary), Boise	13
Kentucky	(Facility not identified)	(Number not available)
Massachusetts	DOC infirmary (facility not identified)	33
Minnesota	Minnesota Correctional Facility, Oak Park Heights	10
Nevada	Regional Medical Facility, Carson City	50
New Hampshire	New Hampshire State Prison Complex, Concord	(Number not available)
New Mexico	Penitentiary of New Mexico (infirmary)	(Number not available)
New York	Coxsackie Correctional Facility, Coxsackie	60
	Walsh	112
	Bedford Hills Correctional Facility, Malone (in design/construction)	30
	Fishkill Correctional Facility, Beacon (in design/ construction)	78
	Wende Correctional Facility (in design/ construction)	78
Ohio	Corrections Medical Center	(Number not available)
Oregon	Oregon State Penitentirrectional Institution, Waymart	5
	State Correctional Institution, Laurel Highlands	(Number not available)
	State Correctional Institution, Muncy	(Number not available)
South Carolina	(Hospice services—facility not identified)	(Number not available)
Tennessee	Lois M. DeBerry Special Needs Facility, Nashville	(Number not available)
Utah	(Facility not identified)	(Number not available)
Vermont	Northern State Correctional Facility, Newport	6
Wyoming	Terminal care provided only in men's facility-only place with 24-hour nursing care	(Number not available)
U.S. Bureau of Prisons	(6 medical referral centers)	1,500 beds (approx.)
New York City	Goldwater	6
	HHC acute care facilities	(Number not available)

PART II: Controlling Costs of Medical Services

The second section of the survey examined some means that DOCs are using to contain or reduce their overall costs for medical services.

Current Trends in Cost Control

Among the many approaches DOCs use to contain medical costs, three are undergoing dramatic increases in use among corrections agencies: telemedicine, inmate co-payment for medical care, and computer-based administration of medical services.

Telemedicine. DOCs are increasingly using telemedicine to treat or diagnose patients from a distance, as shown on Table 4, page 8. At least 31 DOCs either are using telemedicine now or are planning or developing systems.

- Eighteen (18) DOCs are already using telemedicine at one or more facilities. Among these agencies, six are expanding their systems to link additional sites.
- Thirteen (13) agencies are currently developing telemedicine capabilities for the first time.

The Hawaii DOC is considering the use of telemedicine at two sites.

Survey data were incomplete on the number of sites involved; at least six DOCs have implemented telemedicine at only one site. In contrast, the New York DOC plans to have 30 sites operational in 1998.

Inmate co-payment. Thirty-nine (39) DOCs, identified on Table 5, page 9, are charging or implementing fees for inmate medical care:

- Twenty-four (24) DOCs now charge inmates a fee or co-pay for medical services.
- An additional 15 agencies are planning to implement such charges.

Fourteen agencies have computer-based systems for tracking inmates' medical fees.

Use of computers to manage medical services. At least 40 DOCs are using computers to manage aspects of inmate medical care and its administration and to control related costs.

- In 23 DOCs, one or more computer applications for medical services cost containment are already in use.
- Another 17 DOCs are now developing computer applications for medical services cost control.

The DOCs reporting the most extensive use of computers in managing their health care costs are Arkansas, Connecticut, Florida, Illinois, Kentucky, Louisiana, New York, Ohio, Oklahoma, Texas, Utah, and West Virginia, along with the U.S. Bureau of Prisons. Contract providers administer all or most of the agency's automated medical systems in four DOCs.

Major uses of computers include pharmaceuticals inventory/purchasing (35 DOCs) and materials and equipment inventory/purchasing (19 DOCs). Other uses include tracking inmate fees for services (14 DOCs), administration of in-patient and out-patient (in-facility) medical services (each with 13 DOCs), and monitoring of medical care by contracting hospitals (12 DOCs). Nine DOCs currently have computerized inmate medical records and another four agencies are partially using this approach or are planning to implement it.

Agency respondents also noted the following uses of computer technology:

- The Michigan DOC tracks disabilities, chronic diseases, TB follow-up, and mental health referrals.
- The New Mexico DOC uses spreadsheets to track HIV medication costs and project future needs.

Table 4. Use of Telemedicine in DOCs

	Current Status of Telemedicine		
	System Now in Use	System Being Developed or Expanded	Number of Sites
Alaska		✔	1 site planned.
Arizona	✔		1 site operational.
Arkansas		✔	(Number not available.)
California	✔	✔	2 sites operational; 7 sites planned.
Colorado	✔		1 site operational.
Connecticut	✔		1 site operational.
Florida	✔		(Number not available.)
Georgia	✔		(Number not available.)
Illinois	✔		1 site operational; no expansion planned.
Indiana		✔	(Number not available.)
Iowa	✔		2 sites operational.
Louisiana	✔	✔	2 sites operational; expansion planned.
Maryland		✔	(Number not available.)
Michigan	✔	✔	4 sites operational; expansion planned.
Minnesota	✔		7 sites operational.
Nebraska	✔		1 site operational.
Nevada		✔	(Number not available.)
New Hampshire		✔	3 sites planned.
New York	✔	✔	16 sites operational; 14 added sites planned.
Ohio	✔	✔	7 sites operational; 4 added sites planned.
Oklahoma		✔	5 to 6 sites planned.
Oregon		✔	3 sites planned.
Pennsylvania	✔	✔	1 site operational; expansion planned.
Tennessee		✔	(Number not available.)
Texas	✔		(Number not available.)
Utah		✔	2 sites planned.
Vermont		✔	4 sites planned.
Washington		✔	(Number not available.)
Wisconsin	✔		1 site operational.
U.S. Bureau of Prisons	✔		(Number not available.)
New York City		✔	(Number not available; pilot beginning Nov. 1997.)

- In Oklahoma, DOC medical staff use computers to track funds paid to the medical services contractor.
- The Oregon DOC tracks billings from private providers, such as hospitals, clinics, and physicians.
- The Texas DOC uses computers extensively for utilization measurement.

Table 5. Inmate Fees for Medical Care

	Current Status of Inmate Fees/Co-Pays		Does a Computer System Track Payment of Inmate Fees/Co-Pays?
	System Now in Use	System Being Planned or Implemented	
Alabama	✔		
Alaska		✔	
Arizona	✔		
Arkansas		✔	
California	✔		
Colorado	✔		Yes
Connecticut		✔	
Delaware	✔		
Florida	✔		Yes
Georgia	✔		
Hawaii		✔	
Idaho		✔	
Illinois	✔		Yes
Indiana		✔	
Iowa	✔		
Kansas	✔		Yes
Kentucky	✔		Yes
Louisiana	✔		Yes
Maryland	✔		
Michigan	✔		
Minnesota	✔		Yes
Missouri		✔	
Nebraska		✔	Yes
Nevada	✔		Yes
New Hampshire	✔		
New Jersey	✔		
Ohio		✔	
Oklahoma	✔		Yes
Pennsylvania		✔	
Rhode Island	✔		
South Carolina		✔	
South Dakota		✔	
Tennessee	✔		Yes
Texas		✔	
Utah	✔		Yes
Washington	✔		Yes
Wisconsin	✔		Yes
Wyoming		✔	
New York City		✔	

Other Prevalent Cost Control Strategies

Three approaches to containing medical care costs have been implemented by at least 40 DOCs and continue to be adopted by others. These include managed care, contract services/privatization, and consolidation or regionalization of specialized medical care.

Managed care. Forty (40) agencies use managed care, also known as defined levels of care, to control their medical costs. An additional four DOCs are now implementing managed care approaches, for a total of 44 DOCs currently committed to this strategy. Several states, including Maine and Ohio, are using a managed care approach at some institutions and are in the process of implementing it at others.

Agencies differ in their approach to determining levels of care to be provided, with approximately equal reliance on DOC-developed definitions and on criteria developed by private providers. Fewer agencies rely on levels of care defined by Medicare or on some combination of approaches.

- **DOC-developed criteria-Fifteen** (15) DOCs rely on criteria developed within the agency. States using this approach are California, Colorado, Connecticut, Hawaii, Indiana, Iowa, Kentucky, Louisiana, Maine, Minnesota, Nebraska, New Hampshire, Utah, Washington, and Wyoming.

- **Private provider's criteria-Fourteen (14)** agencies using a system of managed care rely on criteria defined by a private provider. DOCs using this approach are Alabama, Alaska, Arkansas, Delaware, Georgia, Idaho, Illinois, Kansas, Michigan, Missouri, New Jersey, Pennsylvania, South Dakota, and Tennessee.

- **Medicaid criteria-Four** (4) DOCs use Medicaid criteria in their managed care systems. They include the DOCs in Arkansas, Maryland, and North Dakota and the U.S. Bureau of Prisons.

Several agencies use a combination of criteria as the basis of their managed care systems:

- The Massachusetts DOC is using a combination of a public assistance model, statewide public health criteria, and criteria developed by the DOC and a contracted vendor.

- Colorado uses a combination of criteria established by the DOC, Medicaid, and a private provider.

- Florida uses a combination of Medicaid and private provider guidelines; the DOC is now in the process of developing its own criteria.

- The Vermont DOC has developed criteria jointly with its private provider. DOCs in Ohio and South Carolina are working with private providers to do the same.

Contract services for medical care. DOCs involved in medical services contracting currently total at least 43 agencies. Thirty-nine (39) responding DOCs are now contracting for medical services, and an additional four DOCs are planning to do so.

Consolidation of specialized medical care. Thirty-nine (39) responding DOCs have consolidated portions of their medical services at one or more sites, and five more agencies are planning to do so, for a total of at least 44 DOCs. Findings in Part 1 indicated that at least 27 DOCs have consolidated medical care for elderly and/or terminally ill inmates.

Other approaches to cost management. DOCs use several additional approaches to controlling costs for medical services. Among the remaining major strategies explored in the survey, all are very commonly used and none are now being adopted by additional agencies. They include:

- Bulk pharmacy purchases (42 DOCs);

- Preauthorization of elective surgery (37 DOCs);

- Second medical opinions (37 DOCs);

- Negotiated per diem rates for hospital-based care (31 DOCs); and

- Use of medical furloughs (16 DOCs).

In addition to strategies identified within the survey instrument, agencies also noted the following unique approaches to reducing medical costs:

- In the Arizona DOC, medical expenses related to assaults and self-abuse are paid from the athletic and recreation fund. The DOC also has eliminated weight lifting, which has reduced orthopedic costs.

- Specialty consultations must be pre-approved in the Michigan DOC.

- The Ohio DOC uses diagnostic related groupings (DRGs) in establishing costs for hospital care and also contracts for the services of individual physicians.

- The Oklahoma DOC refers cases to the state hospital system for secondary and tertiary care.

- Oregon DOC inmates pay for certain items that then become their personal property; examples are eyeglasses, dentures, splints, and shoes.

- The Texas DOC uses a system of capitation, paying its private provider a fixed per inmate/per diem amount, which provides an incentive for the provider to emphasize preventive care and to avoid non-essential services.

Formal Evaluations of Cost-Reduction Strategies

Among the 50 DOCs that responded to the NIC survey, 15 have conducted some formal evaluation of their cost-reduction strategies. Several other agencies noted that evaluations are underway or planned for recently implemented cost control measures.

- A Michigan DOC evaluation of telemedicine found an approximate break-even point of 83 to 124 consultations per month, or 29 to 44 consultations if equipment costs were ignored. The Oregon DOC found that its telemedicine system saved the agency money when it was used for 43 or more consultations per month.

- An evaluation of the inmate co-payment program in Oklahoma found that use of sick call decreased by 34 percent, over-the-counter medications by 67 percent, and prescription medications by 49 percent. Implementation of inmate co-payments resulted in drops in sick call of from 39 to 45 percent in the Michigan system, depending on the site.

- Review of prospective specialty consultations in the Michigan DOC has reduced consultations from a high of 817 in 1994 to 731 in 1996.

Some of these studies were included with agencies' survey responses and may be requested from the NIC Information Center.■

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