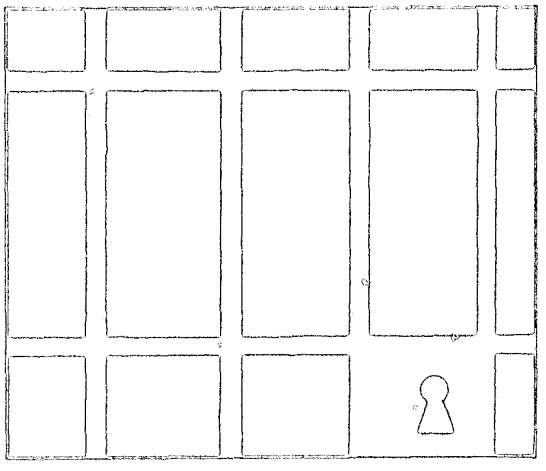
PROCEEDINGS

2nd National Conference on Medical Care and Health Services in Correctional Institutions



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HEALTH CARE PROVIDERS:

HOW DO YOU CHANGE HEALTH CARE SYSTEMS*

Changes need to occur if your present health services are inadequate, if progress is to be made, or if community standards for health care need to be adhered to and implemented. How change is accomplished is determined by:

1) The individual or groups who recognize the need for change, and
2) Their concern and determination in affecting it.

Change is extremely difficult in an environment where any deviation from standard operating procedure is regarded as suspect, where additional involvement with a client by health care staff is often misinterpreted or misconstrued, and where there are ambivalent feelings about the amount of service a client with an extensive criminal history and background is entitled to receive. The health care professionals, engaged in providing services to a group of unpopular clients (both in and out of our institutions) face these problems on a daily basis. Justifying, qualifying, supporting, explaining and protecting the services we provide in the day-to-day performance of our duties is time consuming, sometimes frustrating, and extremely upsetting. It is into this setting that we attempt to facilitate change. The physical plant does not readily lend itself to major changes, opposition from the institutional staff is openly voiced, department level officials are not trained to deliver health services and the legislature needs to be "sold" an expensive undertaking. In Minnesota we were faced with all the obstacles. In December of 1974, we opened our Security Unit in a community hospital. This month we will begin occupation of a Holding Unit adjacent to the Emergency Room in the same hospital. Both units are shared with the county. We have come a long way and effected some dramatic changes in the delivery of health care services to our Minnesota incarcerated clients.

There was no formula that guaranteed instant success or immediate solutions. The changes that occurred in Minnesota were a cumulation of efforts by several individuals and groups. There were many disappointments but there were also successes. The changes which occurred were not isolated to the infirmary or the hospital. We needed a commitment from the total institution and the Minnesota Department of Corrections. Deficiencies and inadequacies needed to be identified and workable solutions suggested. We did a great deal of sorting and asked many questions both of ourselves and the people with whom we came in contact. Would the changes we were suggesting work? Were the changes specific to all institutions or just to the main prison at Stillwater? Who would pay the bill? Would our new program be accepted by the custody element? Would there be transportation available to get the inmate to an outside facility? Would we have medical input on a department level? Were the new services we were describing designated to be "paper services" only? Who would make the final decision about the kind or amount of care the inmate was to receive--the physician, the nurse, or the custodial officer? In the new program would we utilize inmates as direct care providers? Would they administer medication? How would we handle our medical records? What system would we use for documenting information and for maintaining confidentiality? Would our unit be functional or would it just occupy physical space? What, if any, would be custody's role in making medical decisions? Who would call the doctor? Should we continue to operate as a

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hospital or change our classification to that of an infirmary? These are only a few of the questions we asked. We needed concrete answers before we could present our proposal for change to the legislature.

In 1965 when I arrived at the Minnesota State Prison to begin work as a surgical nurse I was surprised at what I found. Two civilian nurses were employed in the 45-bed hospital. They worked from 8 - 4 Monday through Friday. Their primary responsibility was medications. They prepared the medication for delivery to the population and administered a limited amount of medication in the prison hospital. Although a large number of medications were prepared by this team, the actual administration was either by inmate nurses in the hospital or correctional officers in the population. Major surgical procedures were performed by residents from the University of Minnesota surgical staff, and patient care was provided by inmates assigned to the hospital an "nurses." My job was to supervise the operating room where an inmate served at First Assistant to the surgeon. I soon discovered that this inmate was also "in charge" of the one-room surgical suite. Inmates requiring surgical procedures (either emergency or elective) were returned to the surgical ward following surgery, and the post-operative care was provided again by inmate nurses. I supervised the care but was not allowed to provide any direct service to the inmate/patient. This intervention was interpreted as fraternization and was subject to disciplinary action. The medical director, although on duty for eight hours a day, was physically ill and subject to violent outbursts of uncontrolled temper. Learning how to work in a foreign environment and trying to provide quality care without getting caught made this place of employment a major challenge.

In 1968 a new medical director arrived at MSP. It was with this man that we began to change. He was energetic, enthusiastic, and determined. He was an administrator. Under his direction the hospital changed. Nurses were employed around the clock. A full time pharmacist was secured. Consultant services in physical therapy, dietetics and administration were obtained. The need for consultant speciality services (i.e., surgery, medicine, neurology, dermatology, urology, etc.) was identified, and the consultants were brought to the prison to provide weekly consultant services. We were encouraged to attend educational workshops and seminars. A sick call process was developed, and patients with medical problems were seen systematically rather than at random. Complaints were followed with appropriate medical/surgical intervention. Inmate problems were heard rather than ignored. We thrived under the new system, despite the fact that our supplies, equipment and physical space was limited. We were an interesting operation. We operated a non-accredited hospital on a temporary license. We were, however, reasonably secure--for all practical purposes where could we go with a population of 1,000 inmates with varying health needs?

We ran our hospital, in the new pattern, for about two years. At this time David Fogel became Commissioner of Corrections in Minnesota. Many changes occurred in our institutions. We found ourselves answering inquiries from citizens' groups, legal organizations and the ombudsman for corrections. These inquiries were directed to the quality of care we were delivering to our inmate population. A team was formed that included a physician, nurse, pharmacist and systems analyst. We visited all of the DOC institutions in Minnesota and evaluated the medical services. A report on our findings was written and presented to the commissioner. A hospital administrator consultant was hired,

and other outside consultants were brought in to further evaluate the quality of care. It was difficult to extract information on either the cost or the amount of services we were and had been providing. Records were incomplete, oftentimes non-existent. Officers' salaries for escorting medical special duties could not be retrieved. Hospital records had been kept by inmates and the information was so drastically altered that it could not be considered factual. A class action lawsuit was filed by a group of inmates. It alleged inferior care. The consultant administrator worked long and hard, sifting, sorting and gathering information. Our temporary license to operate was denied by the Health Board. The progress we had made did not seem like any progress at all. It was time to make a move. We were spending a great deal of money and delivering a low quality of health care.

With help from a deputy commissioner, our consultant administrator and the prison physician, a proposal to improve the quality of health care services and make them equal to community standards was taken to the legislature. The combined efforts of a group with a purpose were successful. The Minnesota Legislature approved a request for 1-1/2 million dollars to (1) build a hospital unit at a community hospital, (2) provide a consultant full time physician for MSP, (3) hire a consultant psychiatric social worker, to be assigned to the MSP hospital at Stillwater, (4) hire a hospital administrator on a departmental level, and (5) provide the unit with 13 correctional officers to staff the unit.

We began researching the community to find a facility that would consent to the prison unit as part of their institution. Many hospitals were contacted. Finally, based on location, services available and its academic affiliations with the University of Minnesota, SPRH was selected.

In 1973 SPRH and the DOC entered into a contractual agreement. Renovation of one-half of a general surgical circle at SPRH was less expensive than constructing a new facility. A security-medical care committee was organized. Administrative security and policy making members from both City-County and the DOC met with representative physicians, nurses and administration and hospital board members from SPRH. The City-County correctional officials were included in the planning, since the county penal clients needing medical care have traditionally been treated at SPRH. The different elements of the committee cooperated fully, since it was important to the hospital and to the correctional units that the project succeed. Guidelines were established by the committee, and in the four years of operation of the unit very few changes have been needed. Important to the successful operation of the unit is the nurse coordinator, an employee of the DOC employed full time at SPRH. She is the communication link between the hospital and the correctional institutions.

We also implemented changes in our institutions. We began to systematically plan the care we offered our clients rather than to randomly treat them. Today the patient is initially seen by the institution physician. Using supportive laboratory and radiological findings, a diagnosis is made. If the problem needs further evaluation, the client is sent to the outside institution where the diagnosis is confirmed. Continued follow-up in the outpatient clinics or admission to the Security Unit is suggested. The patient is followed both at the sending institution and the outside facility until he is either discharged by the specialist or paroled by the institution. The provision of care is now a total program beneficial to the patient and the care provider. Positive communication between the custodial staff and the medical community assures a good working relationship

these two groups. Each is now aware of the other's responsibilities, and the program continues to thrive.

The program is expensive. Soaring hospital costs, physicians' fees, officers' salaries and transportation, nurses' salaries and administrative costs add up quickly.

Our emphasis is on the quality of the service. Our inmates in Minnesota receive a standard of care equal to that of the community. What we are paying medical services we are saving in lawsuits. Our populations seem satisfied with the services we are offering them. We have changed our method of delivering health care services and are far more confortable in our work environments.

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