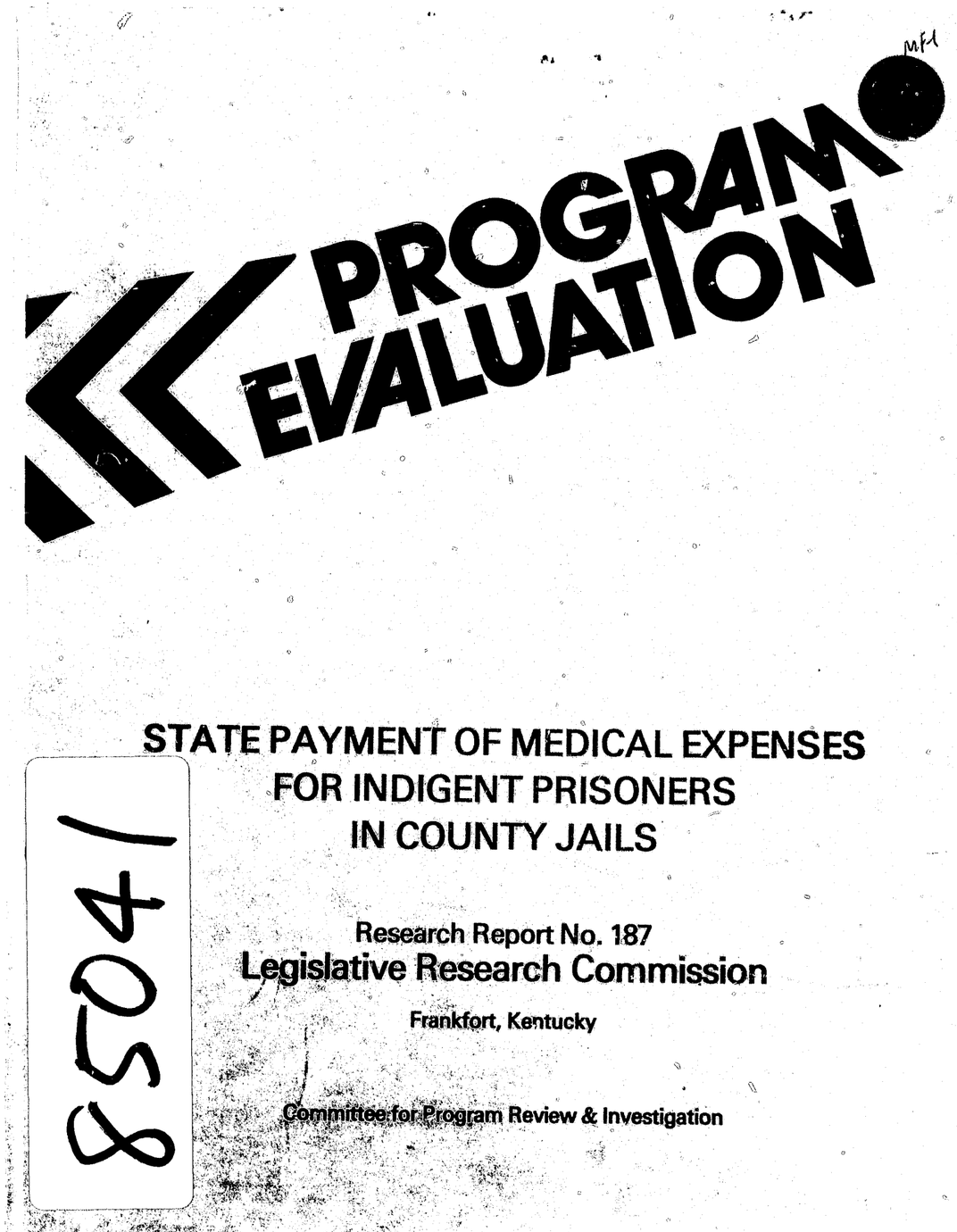

STATE PAYMENT OF MEDICAL EXPENSES FOR INDIGENT PRISONERS IN COUNTY JAILS

Research Report No. 187
Legislative Research Commission

Frankfort, Kentucky

Committee for Program Review & Investigation

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PROGRAM EVALUATION: STATE PAYMENT OF MEDICAL EXPENSES FOR INDIGENT PRISONERS IN COUNTY JAILS

KENTUCKY GENERAL ASSEMBLY
COMMITTEE FOR PROGRAM REVIEW AND INVESTIGATION

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Research Report No. 187

Legislative Research Commission
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FOREWORD

The Committee for Program Review and Investigation, at its August 27, 1980, meeting, voted to study the operation of the Commonwealth's program for payment of indigent jail prisoners' medical expenses. This study was requested by the 1980-82 Interim Joint Committee on Counties and Special Districts.

Our appreciation is extended to the staff of the County Fees System of the Department of Finance, and to those jailers and county judges/executive who provided information for this study. Special appreciation is expressed to Esther Robison and Jeanie C. Privett for their patience and perseverance in preparing this manuscript.

This study was conducted by Joseph F. Fiala and Sheila A. Mason, with the assistance of Sarah Hayes. Legal consultation was provided by Ethel Alston and Norman Lawson of the Legislative Research Commission.

VIC HELLARD, JR.
Director

The Capitol
Frankfort, Kentucky
December, 1981

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SUMMARY

House Bill 50 (HB 50), passed in the 1979 Special Session of the Kentucky General Assembly, and codified as KRS 441.010, provided that medical expenses necessary to preserve the life or health of indigent or needy jail prisoners be paid by the unit of government whose law the prisoner was charged with violating. Kentucky's local jails are administered by a popularly elected constitutional officer, the jailer. Construction, maintenance, and operation of jails are the responsibility of local government. Historically, local governments have had responsibility to provide necessary medical care for indigents residing in their jurisdiction, and for jail prisoners housed within their jail. With the adoption of HB 50, responsibility for obtaining medical care for a prisoner remains with the jailer, but the cost of this medical care for certain prisoners is now shared with other governmental jurisdictions, mainly the state. Some additional financial relief has been provided by HB 50 in the form of an additional $5 court cost in the district courts.

In July of 1980 the Interim Joint Committee on Counties and Special Districts requested that the Committee for Program Review and Investigation review the operation of the medical expenses for indigent prisoners program. This request resulted from complaints presented by jailers, county judges/executive, and the state's Department of Finance. Jailers and county judges/executive alleged the program was too cumbersome and in some cases did not meet the county needs. The Department of Finance claimed that the program was being misused because the wording of the legislation prevented the Department from exercising proper administrative control.

In September 1980, staff of the Committee for Program Review and Investigation began a review of the program to:

- identify the problems involved;
- determine the source of these problems; and
- recommend legislative and administrative action to resolve them.

Jailers and county judges/executive from a sample of thirty percent of Kentucky's counties were surveyed regarding jail and medical expenditures, as well as problems with medical care and payment under the HB 50 program. Seventeen of these sample counties had medical expenses paid by the state in FY 1980, while the remaining seventeen counties did not. Six counties were chosen from the sample for a review of medical claims submitted, rejected and paid in FY 1980 and FY 1981.

Results of this review indicate problems in both the legislation enacting the program and the administrative procedures implementing it.

- The current legislation is ambiguous in its definition of medical care covered by KRS 441.010, thus allowing treatment of routine or non-serious medical problems.
- Some parts of the program framework defined by legislation do not fit existing medical care programs of some counties. Also, the legislation does not seem to

have been designed to encourage the adoption of more effective or efficient medical care approaches.

- The third-party medical claims payment approach adopted by the Department of Finance removes local government involvement and control, reduces administrative oversight at all levels, and contributes to long time delays in payment.
- Administrative requirements for notarization of claims forms is unnecessary and cumbersome.
- The affidavit related to need for treatment does not provide sufficient information to determine the purpose of charges.
- The Department of Finance is not using the maximum payment limit for certain services required by KRS 441.010.

Several recommendations regarding legislative and administrative change or areas of study were adopted by the Committee for Program Review and Investigation. Some of the major legislative points are:

- a clarification of the types of medical care covered by KRS 441.010 is needed;
- legislation may be required to establish standards for medical care in Kentucky's jails;
- a revision of KRS 441.010 to allow for different medical care approaches, such as contract services, is needed; and
- the payment limit approach imposed by KRS 441.010 should be reviewed.

Major administrative recommendations adopted were:

- elimination of the notarization requirements and a rewording of the statement of oath;
- local health departments assuming a leadership role in helping jails develop health care plans;
- a revision of the physician's affidavit; and
- a cost-benefit analysis of optional maximum payment approaches.

In addition to these recommendations resulting from findings of this report, the Committee proposed and adopted one further recommendation regarding medical care for all jail inmates. This recommendation provides that:

- the unit of government whose law the prisoner has violated is responsible for payment of all medical expenses of the prisoner over and above the cost of initial diagnosis;
- in the case of jails having a state-approved medical delivery system, the unit of government is responsible for paying the operating government a portion of the cost of this system;
- the operating government may recover from nonindigent prisoners the cost of medical services rendered; and
- excess medical fees, reimbursements or recoupments are to be used to upgrade medical facilities and provide medical training for jail staff.

CHAPTER I

INTRODUCTION

On August 27, 1980, the Committee for Program Review and Investigation approved a request by the Interim Joint Committee on Counties and Special Districts for a study of the state's payment of medical expenses for indigent (needy and poor) prisoners in county jails, as authorized under House Bill 50 (HB 50) of the 1979 Special Session. The Interim Joint Committee on Counties and Special Districts cited several problems they felt existed in the program:

- Only sixty-two of one hundred and twenty counties are participating.
- Of the $104,120 expended by the state for an eleven-month period, thirty-six percent was for one county.
- Jailers, judges, physicians, and pharmacists appear dissatisfied with the paperwork involved.
- Treatment being certified as necessary appears to be of a questionable nature.

Purpose and Objectives

As approved by the Committee for Program Review and Investigation (CPRI), the primary purposes of this study were:

- to identify problems with the medical payment program authorized under HB 50;
- to recommend administrative and legislative changes to overcome these problems;
- to outline the legal rights of prisoners for medical treatment while in custody; and
- to determine if the program protects these rights.

Methodology

This study was conducted in a three-month period from October through December 1980. It involved two full-time staff persons of the CPRI as well as consultative services from several other staff persons of the Legislative Research Commission.

A sample of thirty percent of the counties was chosen, comprised of seventeen counties which had claims paid by the program in FY 1980 and seventeen counties which had not. The user and non-user counties were from the five geographic regions of the state—north, south, east, west, and central. The user group consisted of the seventeen highest use counties. High-use counties were chosen because it was assumed that their greater usage of the program meant greater exposure to its problems. Non-use counties

were chosen either because of their proximity to a high-use county or their comparability to the high-use counties in the number of prisoners served (as indicated by the total amount of diet fees received).

Identification of Program Problems

Data was obtained primarily through personal interviews and telephone surveys. Seven jailers, five county judges/executive and five district or circuit court judges in seven counties were interviewed in person. A telephone survey was conducted with jailers and county judges/executive in an additional twenty-seven counties.

Administrative problems with the program were documented through interviews with thirty-four jailers and a review of the medical claims submitted by six counties—Barren, Harlan, Henderson, Kenton, Madison, and Wayne. Harlan and Kenton counties were chosen because they were the highest medical claim counties in FY 1980. Barren and Madison were chosen randomly from those counties in the average claim range. Henderson and Wayne were chosen from the low-average claim counties.

Full claims for Kenton County were not reviewed because original documentation is unavailable at this time. The Department of Finance was able to provide summary information related to providers paid and the types of medical claims paid for a three-month period in FY 1980. Due to an ongoing FBI investigation, Kenton County was not included in the survey sample; however, testimony by the Kenton County jailer to the Subcommittee on Jails provided information on program use. This information has been used as the basis for describing the medical care approach used in this county. Additional documentation was provided by the interviews with the heads of the Department of Finance's Division of Internal Auditing and County Fees Section.

Determination of Prisoner Medical Rights

Legal standards for medical care were obtained from a review of several national associations' published and draft standards and a review of federal court decisions regarding medical care. In addition, interviews were conducted with a national consultant on jail standards, a member of the American Medical Association's panel on jail standards, an attorney from Kentucky's Office for Public Advocacy, and members of the Governor's Task Force on Jails.

Organization of Report

Chapter II begins with an overview of Kentucky's jail system and its administrative and financial structure. The second part of this chapter discusses the legal basis of the counties' responsibility for the necessary medical care of indigents, including county jail inmates. It concludes with a discussion of House Bill 50 and the differentiation between necessary and emergency care.

Chapter III describes the program implemented by the state payment of indigent prisoners' emergency medical bills. It differentiates the legislatively determined from the

administratively determined aspects of the program and concludes with a description of the program's use in FY 1980. This part includes a description of total expenditures and a more detailed description of the types of providers and types of diagnoses paid in three counties.

Chapter IV provides an analysis of the problems found in the program. Problems are divided into legislative and administrative, according to the source of the problem and the means needed for resolution. Recommendations for legislative and administrative changes or actions are made.

Chapter V discusses the minimum constitutional rights of jail inmates for medical care. A review of federal court cases affecting the rights and responsibilities of jail inmates and administrators is included, as well as a review of the medical standards established by the federal courts, the U.S. Department of Justice, the American Correctional Association, and the American Medical Association.

Chapter VI discusses the implications of these federal court decisions and national standards and assesses Kentucky's ability to comply with these standards. It concludes with some policy options available to Kentucky in meeting these standards.

CHAPTER II

THE KENTUCKY JAIL SYSTEM AND MEDICAL CARE

Kentucky's criminal detention system is composed of local jails and state correctional facilities. Local jails are operated and maintained by local government and administered by an elected, constitutional officer, the jailer. State correctional facilities are operated and maintained by the state's Bureau of Corrections, within the Justice Cabinet. Local jails house adults and juveniles, males and females. The primary uses of local jails are:

- detention of individuals awaiting trial in lieu of bond;
- detention of inmates in transit from one facility to another;
- detention of inmates with short-term sentences (one year or less);
- detention of federal inmates awaiting trial; and,
- detention of state correctional inmates on work-release or with less than one year of incarceration for a non-violent crime.

This chapter discusses organizational, legal and financial aspects of local jail systems and describes local government's responsibilities for providing medical care. After a discussion of recent legislative and court actions, some conclusions are drawn.

Organization of the Local Jail System

Kentucky's local jails operate independently from the state correctional system and from each other. No state agency has direct administrative or regulatory control of the jails. However, several state agencies have the authority to issue standards for, or provide technical assistance to, the jails. These include the Bureau of Corrections, the Department for Human Resources, and the State Fire Marshal. Responsibility for administration of the jail lies with the jailer. The county fiscal court has authority to adopt rules for its government and treatment of prisoners. The county judge/executive has responsibility to inspect the jails for compliance.

Currently there are 119 county jails and five city jails operating in Kentucky. During calendar year 1978 these jails served an average daily population of 2,761 inmates. A June 1979 survey by the Bureau of Corrections' jail consultants indicated that a majority of county jails failed to abide by many of the state's statutes and codes related to health, sanitation, security and safety.

Although in the 1970's several new county jails were constructed and several others renovated, a 1978 Bureau of Corrections report indicated some forty-three other facilities in need of total renovation or replacement. The major factor is the age of Kentucky's jails. There are thirty-six jails operating in Kentucky that were constructed before 1900, the earliest being built in 1779.

Responsibility for the "custody, rule and charge" of the jail and its inmates lies with the jailer (KRS 71.020). It is his responsibility to treat inmates humanely and to provide them with proper food and lodging (KRS 71.040). The jail is to be kept warm, clean and free of nauseating odors. Inmates are to be provided sufficient bedclothing, paid for by county levy (KRS 71.030). Finally, according to Kentucky Attorney General's opinions, the jailer has the authority to establish operating procedures affecting the security of the jail, regarding such matters as telephone calls, visitation, personal possessions, and security devices.[1]

County fiscal courts are charged with the responsibility for maintaining and operating the county jail (KRS 67.130). The fiscal court has limited control over internal management under its authority to prescribe rules for the "government" of the jail and treatment of prisoners (KRS 441.010). However, the Attorney General (OAG 79-73) cautions that the jail is not to be operated jointly by the county jailer and the fiscal court. Rules adopted by the fiscal court must remain within the boundaries of the fiscal court's authority and allow the jailer to exercise his authority and responsibility. The county judge/executive, as the chief executive, administrative, and financial officer of the fiscal court, has the general responsibility to oversee compliance with the rules adopted by the fiscal court. He has specific responsibility under KRS 441.010 to inspect the jail at least once per month to ensure this compliance.

Responsibility for Standards

Three state agencies have responsibility for establishing jail standards. Two of these, the Department for Human Resources and the Bureau of Corrections, have explicit responsibility. The State Fire Marshal's Office has implied responsibility.

The Department for Human Resources (DHR), under the 1974 Confinement Facilities Health Act (KRS 211.920-211.994) has several powers related to local confinement facilities. These include the power to:

- adopt rules, regulations, and standards relating to public health aspects of their operation;
- develop comprehensive plans for the elimination of conditions in these facilities which adversely affect the public health or the health of the inmates;
- inspect the facilities for conditions which endanger the health of the inmates or the public;
- seek legal action to transfer prisoners from a facility not in compliance to one in compliance; and
- levy fines of not less than $10 and not more than $100 for each day of violation of the rules, regulations or standards adopted.

The regulations adopted under this Act are contained in 902 KAR 9:010 and are designed to safeguard the environmental health of jail inmates. No standards to regulate medical or dental care in confinement facilities are established, although a comprehensive set of standards was developed by DHR in FY 1976.

Approval of jail construction and renovation plans is the responsibility of the Bureau of Corrections. Standards related to construction and design are incorporated in the state Confinement Facilities Health Act regulations cited eariler. A Jail Consultants Division was formed in 1974 within the Bureau of Corrections to evaluate the local jails for compliance with standards and to provide technical assistance in matters of jail security, safety and health.

The State Fire Marshal is charged with the responsibility for inspecting and investigating all property to determine compliance with fire and safety standards. "Standards for Safety," contained in 815 KAR 10:015, provide minimum standards for the design and construction of buildings. In addition, the National Fire Prevention Code, the National Builders Code, and the Life Safety Code are used as standards for regulating fire safety.

Financial Support

Responsibility for financing the operations, maintenance, and construction of local jails lies with the county governing body. Certain fees for dieting and other services are authorized under KRS 64.150 to be paid by the unit of government whose law the prisoner is charged with violating. Charges for federal prisoners and state correctional system prisoners are negotiated with those agencies by the jailer and fiscal court.

A county's general responsibility for indigents implies responsibility for the necessary medical expenses of indigent prisoners, including transportation related to obtaining medical care, providing hospital guards,[2] and the provision of basic equipment. To carry out these governmental functions, the county has the authority to levy taxes, issue bonds, and appropriate funds (KRS 67.083).

Certain fees directly related to the inmate are payable to the jailer by the governmental unit whose law the inmate is charged with violating (KRS 64.150). These fees typically include: placing a prisoner in irons, imprisoning and releasing an inmate, feeding him, and attending court.

Responsibility for Medical Care

Kentucky has historically placed responsibility for medical care of indigents or paupers with the local governments, primarily the county.[3] The city in which an indigent resides also shares responsibility, but what proportion has never been resolved.[4] With the implementation of the Social Security Act of 1935, the state assumed some responsibility for indigent medical costs [KRS 205.520(2)].[5] This was in the form of state-federal medical assistance programs such as Medicaid and the medical assistance portion of Aid for Families with Dependent Children (AFDC). In the 1979 Special Session of the General Assembly, ostensibly due to the financial burden of indigent prisoner medical care on the counties, House Bill 50 was passed. This bill, codified as KRS 441.010, places financial responsibility for certain medical expenses of indigent prisoners on the unit of government whose law the prisoner is charged with violating.

Prior to HB 50

The powers of local governments under the democratic form of government are subject to "Dillon's Rule."[6] The applicability of Dillon's Rule to Kentucky's local governments has been upheld by the Kentucky Court of Appeals.[7] According to this doctrine, local governments exist and act under powers delegated to them by the state. These powers include:

- those expressly granted;
- those necessary, implied, or incident to the expressed powers; and,
- those essential and indispensable to the objectives and purposes of the local government.

In order to grant the counties greater flexibility in the management of their affairs, the Kentucky General Assembly adopted the home rule concept in 1978. The original legislation of 1972 was struck down by the courts as being too broad.[8] The 1978 legislation was more specific in defining the areas of county government authority; however, its main purpose was still to provide county government with as much flexibility and control over local issues as possible.

Prior to the 1978 county home rule legislation, responsibility for the medical care of indigents was delegated to the county under KRS 67.080(8). However, with the adoption of home rule, specific reference to indigent medical care was removed from KRS 67.080 and therefore is not contained in the statutes.

The home rule legislation embodied in KRS 67.083(3) delegates authority to local government to provide correctional facilities and services as well as public health facilities and services. Home rule legislation replaced the specific references previously contained in KRS 67.080(8) so as to:

> provide local government with the necessary latitude and flexibility to provide and finance various governmental services within those functional areas specified in subsection (3) of this section [KRS 67.083(3)].[9]

The intent of this broad language is to provide determination of specific responsibilities, such as indigent medical care, upon such historical precedents as court decisions, "prior" legislation and opinions of the Attorney General.[10]

It is important to note here that some of the "prior" opinions of the Attorney General that pertain to the issue of medical care responsibility are based upon statutes that no longer exist. According to informal opinion obtained by Committee staff from the Attorney General's Office, even though passage of home rule legislation meant that specific language was removed from the statutes, the intent of this language was not removed. This interpretation is based upon the assumption that the broadly worded home rule legislation was intended to allow broader latitude for local government to finance its various needs, not to restrict it.

Historically, two Kentucky Court of Appeals decisions have served as the basis for the counties' medical care responsibility. These cases are the City of Richmond v.

Madison County Fiscal Court (1942), and the City of Paducah v. McCracken County et al (1947). In both these decisions it was determined that the county had primary responsibility to care for the poor and sick of the county. The city, however, may share this responsibility. According to the Kentucky Attorney General, if the indigent resides within the limits of a city, the city and county share joint responsibility.[11]

Therefore, prior to the passage of HB 50 in 1979, county and city responsibility for indigent prisoner medical care was viewed as a more specific case of the general responsibility for indigent medical care. Questions about the types of indigent prisoner medical care for which counties and cities are liable, are, for the most part, being clarified by opinions of the Kentucky Attorney General.

According to the Attorney General's opinions, the county is responsible for furnishing "necessary" medical care to indigent prisoners.[12] This responsibility extends to any indigent prisoner awaiting trail within the county's jail.[13] Necessary medical care includes the cost of drug bills,[14] the cost of transportation,[15] and the cost of guards when a prisoner is hospitalized.[16] Of course, this responsibility is subject to the county's ability to pay and to payment being a properly budgeted item of the county.

After HB 50

HB 50 became effective on July 1, 1979. It placed financial responsibility for non-postponable, life- or health-threatening medical claims of prisoners declared indigent under KRS 31.120 on the unit of government whose law the indigent prisoner had violated. It specified that only a licensed physician could determine if medical care was postponable without hazard until after the period of confinement. A subsequent Attorney General's Opinion, 79-455, determined that the jailer is that instrument of government which must transport the prisoner to proper medical authorities for such determination and other necessary services.

Although HB 50 specified responsibility for emergency medical expenses of indigent prisoners, it failed to resolve the dispute over responsiblity for non-emergency care and care of non-indigent prisoners. Two court cases in Kentucky have recently addressed these issues. One, a 1980 Kentucky Circuit Court case in Campbell County, and the other, a 1980 U.S. District Court Case in the Eastern District of Kentucky. There are still other related cases currently pending in the federal courts.

The U.S. District Court case, Brenda Sebastian, et al. v. Lambert Hehl, et al. (No. 78-76), claimed that conditions at the Campbell County Jail violated the rights of prisoners under the Eighth and Fourteenth Amendments of the U.S. Constitution. In separate consent decrees for the county commissioners and for the county jailer several specific responsibilities related to medical care were declared by the court. In summary these were:

- operation of the jail in compliance with recognized and acceptable standards, e.g., ACA or AMA;
- provision of a medical examination room and table;

- two regularly scheduled sick call visits by a licensed physician, with inmates notified of time and permitted unrestrained access upon request;
- physician on-cali 24 hours per day;
- medical screening and records procedures;
- jail personnel with medical training on all shifts;
- provision of emergency dental care; and,
- provision of guidance counseling services.

The U.S. District Court decree required the county fiscal court to provide the funding or supplemental funding necessary for the jailer to fulfill his duties under the court-ordered agreement. The court order for the jailer outlines the specific medical care services and facilities to be provided, the administrative procedures to be implemented, the staff training needed, and the per shift staffing pattern to be followed.

As a result of this decision and the court-ordered changes, Campbell County Fiscal Court attempted to sue the Commonwealth of Kentucky in the Campbell County Circuit Court (No. 79-CI-205). This suit claimed that the Court of Justice of the Commonwealth was responsible for the operation of the jail and should pay all compensation and necessary expenses for its operation.[17]

The declaratory judgment of the Campbell Circuit Court in Campbell County Fiscal Court, et al. v. Commonwealth of Kentucky dismissed the plaintiff's suit for failure to state a claim upon which relief could be granted. In this declaratory judgment the court reaffirmed the county's responsibility

- to maintain and operate the jail;
- to prescribe rules for its government and cleanliness; and,
- to enact ordinances, issue regulations, levy taxes, issue bonds, appropriate funds, and employ personnel for the provision of corrections facilities and services.[18]

Furthermore, the court stated that these responsiblities were not of a discretionary nature, despite the use of the word "may" in the home rule legislation contained in KRS 67.083.[19]

This declaratory judgment also refuted the county's claim that responsibility for all county jail operations belongs to the judicial or executive branches of state government. According to this judgment neither branch has any statutory responsibility for maintaining and operating county jails, or for keeping and dieting of prisoners.[20]

Conclusion

Kentucky counties have always had certain responsibilities for the operation and maintenance of county jails as well as the provision of necessary medical care for indigents. The basis for this responsiblity lies in the Kentucky statutes, court decisions and Attorney General's opinions. Home rule legislation adopted in 1972 and amended in 1978 did not remove these responsiblities.

County responsibility to provide necessary medical care for indigent county

prisoners is a specific instance of the county's general responsibility to provide care for indigents. According to several Attorney Generals' opinions, the fiscal court of the county in which the indigent prisoner resides is responsible for his necessary medical expenses. When HB 50 became effective in 1979 some financial relief was granted the counties by placing responsiblity for payment of certain non-postponable medical expenses for indigent prisoners on the unit of government whose law had been violated. The determination of whether treatment is necessary to preserve the prisoner's life or health may be made only by a licensed physician.

The scope of "necessary" medical care has been broadened by federal standards and recent court decisions, including a 1980 decision against the Campbell County jailer and fiscal court. Medical responsibilities for all prisoners are now taken to include the provision of medical examination facilities, weekly sick call visits by a physician, medical training for staff, emergency dental care and guidance counseling.

CHAPTER III

INDIGENT PRISONER MEDICAL PAYMENT PROGRAM: DESCRIPTION AND USE

The legislation embodying House Bill 50 authorizes the state and local governments to pay for certain medical expenses of indigent county prisoners. This bill specifies the type of treatment covered, the maximum allowable payment, the criteria for indigency, and the responsibility for determination of the need for treatment. The form and persons responsible for determining indigency are also specified in the legislation.

This chapter describes the state's medical payment program and expenditures at the state level. The program description details the process for filing a claim and identifies the aspects of this process which are under legislation or administrative control. In the program expenditure section, information is provided on the amount and types of medical claims paid. The relationship between medical expenses paid and total jail expenses is also discussed.

Program Description

At the state level the Department of Finance has responsibility for administering the state's payment program. This agency determines the payment approach and the procedures to be followed in filing a claim. It also handles the processing and payment of claims.

Since HB 50 did not specify the payment approach to be used for this program, the Department of Finance chose a third party method. When a jailer obtains treatment for a prisoner and files the medical claim, the Department of Finance, upon approving the claim, makes payment directly to the provider.

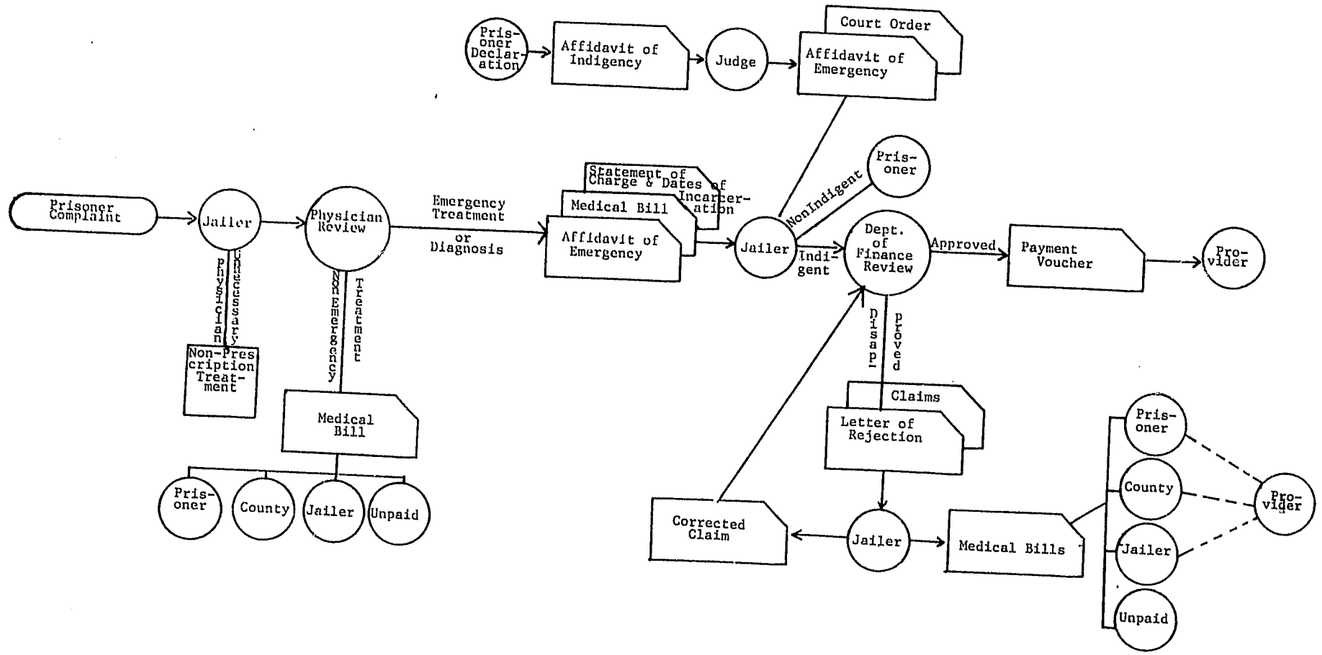
Claims Procedure

Obtaining payment for authorized medical bills of an indigent prisoner charged with the violation of state law requires the process shown in Figure 1. The jailer obtains the treatment, is responsible for the completion of all forms, and files the claim with the state. As a result, in cases where medical bills are rejected by the state and the county, the provider holds the jailer liable for the unpaid bills.

FIGURE 1

PROCEDURE FOR PAYMENT UNDER KRS 441.010

Flow Chart of Claims



Claims for payment of a medical bill are submitted to the County Fees Section of the Department of Finance. These claims must include:

- a notarized Affidavit of Indigency, signed by the prisoner treated;
- a Court Order from, or signature of, the Circuit or District Judge verifying the Affidavit of Indigency;
- a notarized Affidavit of Expenses, signed by the attending physician; and
- original copies of all medical and prescription bills claimed.

Claims are reviewed by the Department of Finance to ensure that all forms are properly completed and that the medical services are incurred by a prisoner incarcerated for a state statute violation at the time of treatment. Verification of the charge and dates of incarceration are provided by the monthly diet fee claims submitted to County Fees.

Rejected medical claims are returned to the jailer with a cover letter explaining the reason for rejection. Approved claims are paid directly to the provider of the medical service.

Statutory Requirements

KRS 441.010 (HB 50) requires state and local governments to pay specific medical expenses of indigent county prisoners. It also establishes certain administrative requirements. The affidavit of indigency to be used and the time and responsibility for determination are specified. In addition, the method of determining non-indigency and demanding repayment from the prisoner are referenced. Finally, the types of treatment covered by this legislation, persons responsible for determination, and maximum payment schedule are included in the statute.

Determination of Indigency. According to KRS 31.120 determination of indigency must be made no later than the prisoner's first appearance in court or in a suit for payment or reimbursement, whichever comes first. The affidavit of indigency is to be compiled by "the pre-trial release officer, where practical" [KRS 31.120(2)]; final determination of indigency is the responsibility of the court. KRS 441.010 explicitly states, however, that determination can be made after treatment if a licensed physician determines that medical care cannot be postponed.

A form for the determination of indigency is contained in Appendix A. This form, required by KRS 31.120(6), asks for information on the prisoner's income, real property, dependents and obligations. It requires the signature of the prisoner and the officer administering the oath.

Prior to July 1, 1980, the criteria for indigency specified in KRS 31.120 were proposed as information that should be considered in the determination. This is the same information currently contained on the form cited above. The statute specified that release on bail or any other form of release authorized under KRS 431 did not prevent a person from being declared indigent.

After July 1, 1980, those criteria for indigency (in KRS 31.120) were designated as prima facie evidence of non-indigency. Under this statute the following are considered prima facie evidence of non-indigency:

- the prisoner owns real property in or out of state;
- the prisoner is not receiving or is not eligible to receive public assitance payments at the time the affidavit is executed;
- the prisoner has paid money bail (other than a property bond of another); or
- the prisoner owns more than one motor vehicle.

The amendments to KRS 31.120 did not modify the form of the affidavit of indigency, the persons responsible for compilation and determination, or the time of determination.

In the event a prisoner is determined to be non-indigent after receiving services as an indigent, he may be required to make reimbursement [KRS 441.010(3)(c)]. The extent of the prisoner's inability to pay and the amount and method of reimbursement are to be determined by the court [KRS 31.120(1)].

Medical Coverage. According to KRS 441.010 only a licensed physician may determine that medical care can be postponed until after the period of confinement without hazard to the needy person. Payments are to be made only for treatment certified under oath by a physician as:

- medical care which could not be postponed until after the period of confinement without hazard to the prisoner;
- medical procedures limited to those necessary to preserve the life or health of a prisoner; and
- medical procedures which are non-elective.

Payment is authorized for the initial examination to determine the need for treatment. Psychological testing and evaluation or care are specified as non-eligible treatment under this program.

Payment Limits. KRS 441.010 references payment limits for medical claim payments. These limits are set at the maximum payment allowed similar providers under the Kentucky Medical Assistance Program (KMAP). According to statutes on Medical Assistance Payments (KRS 205.560), the types of services and payment limits shall be set through administrative regulation by the Secretary for Human Resources upon the recommendation of the Advisory Council for Medical Assistance. These payment limits are to be related to the cost of providing the services.

Administrative regulations pertaining to payment under KMAP are contained in 904 KAR 1:009-1:061. The maximum limits for each type of medical service-physician, in-patient hospital, out-patient hospital, laboratory and x-ray, emergency transportation, and prescriptions—are determined on different bases. For some services there are several possible maximums requiring individual calculations for each provider and each type of medical procedure. For other services there is only one maximum limit established.

Reimbursement of physician's office services are based on "usual, customary,

reasonable and prevailing charges." For a specific claim the maximum payment is limited to the lowest of:

- the actual charge for service;
- the physician's median charge for a given service as determined from claims submitted by the physician in the previous calendar year; or
- the physician's reasonable charge recognized under Part B, Title XVIII, for similar service in the same locality [904 KAR 1:010(4)].

Actual charge for service is obtained from the bill submitted. The physician's median charge is obtained from an analysis of all bills submitted by the physician for the particular service in the previous calendar year. This median is calculated yearly in January by the Medical Assistance division of the Bureau for Social Insurance, Department for Human Resources.

The prevailing charge recognized under Part B, Title XVIII is also established yearly by this division. It is based upon the median charge for the procedure of all physicians within a similar region of the state. Kentucky has three regions. These are determined by population density, not geographic location. Each region has the potential for a different median charge for the same medical procedure. Under the KMAP, processing of a claim is computerized. It involves determining each of the three possible payment limits for the physician and the procedure and selection of the lowest.

Payment for physician's in-hospital services is calculated differently. The first $50 of charges is reimbursed at 100%. The remaining charge is reimbursed on a percentage of the physician's usual, customary and reasonable charge in excess of $50 per procedure after the prevailing fee screens are applied. This rate is set at 70%.

In-hospital services are reimbursed on the basis of reasonable cost determined by one of several methods outlined in the federal regulations governing this program. Out-patient hospital services are to be reimbursed on the basis of reasonable cost, as related to charges utilizing the reimbursement standards of Title XVIII, as applied to patient services under Title XIX.

Pharmacy services are reimbursed according to the medical assistance program drug list. This list reflects the basic cost of the drug as established under a federally determined formula. Reimbursement is for the established cost plus a professional dispensing fee ($2.35 in 1979, $2.75 in FY 1981). If the prescription service is provided by a physician in a county without a pharmacy, reimbursement is for the cost of the drug only.

Laboratory and x-ray services are reimbursed on an established fee schedule. This schedule is based on "reasonable and customary fees" that are within the prevailing charges in the medical locality for comparable services under comparable circumstances.

Emergency transportation services include several types of providers, each subject to a different payment limit. For ambulance services participating in the medical assistance program, payment is based on a base rate of $20 for the first ten miles plus fifty cents per mile for mileage above the first ten. Commercial transportation vendors are to be reimbursed at the normal passenger rate charged the general public. Private automobile vendors are

to be reimbursed twelve cents per mile plus two dollars per passenger, if waiting time is required. For round trips of less than five miles in which there is waiting time the provider may be paid a maximum of three dollars for the first passenger and two dollars each for the remaining passengers. For round trips of five to twenty-five miles involving a waiting period the maximum allowable is five dollars for the first passenger and two dollars each for the remaining passengers, with all tolls fully reimbursed. Non-commercial group carriers are to be reimbursed on a negotiated rate not to exceed twelve cents per mile per recipient. Specialty individual carriers are to be reimbursed at the lesser of: the actual charge, the usual and customary charge of the carrier, or the established program maximum. This program maximum is based on the type of patient transported. Transport of non-ambulatory wheelchair patients is to be reimbursed a maximum of ten dollars for the first patient and five dollars for each additional. No mileage is paid if the distance is under ten miles; if over ten miles, mileage is reimbursed at thirty-five cents per mile for all miles over ten, plus all tolls incurred. Ambulatory disoriented patients generate a maximum reimbursement of four dollars each. If the distance traveled is greater than ten miles the mileage over ten is reimbursed at thirty-five cents per miles.

Administrative Requirements

At the state level, the Department of Finance is responsible for the implementation and administration of the program. The County Fee Systems section of the Department is the unit which processes and pays claims. This is the same unit which processes and pays the diet and other fee claims for maintenance of prisoners held in county jails for state statute violations.

Administrative requirements for this program are not formally incorporated into the Kentucky Administrative Regulations. Jailers have been informed of these requirements via memoranda sent by the County Fee Systems. Administrative action is responsible for the program's payment approach, the need for notarization, the submission of original copies, the judge's signature, and the emergency declaration form.

Payment Approach. Several options have been suggested as payment approaches to this program. For counties with an established medical program under contract the suggestion has been to pay a portion of this contract. For counties without contract services direct payment to the provider (third party approach) and reimbursement of the county or jailer (reimbursement approach) have been suggested.

Currently the state program uses the third party approach, in which the jailer files the medical claim and payment is made directly to the provider. This approach places the jailer in the central role and removes the county from all involvement. Payment of a portion of contract medical services has not been an option taken by the Department of Finance.

Reimbursement of the jailer or county remains a viable option. However, the supervisor of the County Fee Systems expresses the concern that if the state pays the reimbursement but the reimbursed party fails to pay the provider, the state may be held liable

for paying the provider. Currently, Jefferson County has requested approval of a reimbursement approach. Legal counsel for the Department of Finance is reviewing the advisability of this approach.

Submission of Original Documents. The Department of Finance has traditionally required original copies of all documents representing a financial claim against the state. In lieu of an original document the Department does accept notarized copies. The rationale is to avoid the submission of false claims by using copies of an original document, to verify the authenticity of the document and to avoid alteration of the original document.

Notarization. Notarization of the original document is required by the Department for both the Affidavit of Indigency and the Affidavit of Emergency. This requirement was adopted to ensure the validity of the statements. An additional requirement to ensure validity is the judge's signature on the Affidavit of Indigency. Notarization of these documents is not required by statute. Furthermore, it is not a requirement of the payment claim documents submitted for diet and other jailer's fees.

Certificate of Medical Need. The form used by the physician to attest to the need for treatment and to verify the non-postponable and non-elective nature of the treatment was designed by the Department. This form (Appendix B) requires the name and address of the physician, the name of the prisoner, the date and type of treatment. It includes a statement that the treatment could not be postponed, was necessary to protect the life or health of the prisoner, and involved non-elective treatment. It also contains a statement certifying that charges are the physician's "usual and customary" ones, as well as being "reasonable and in line with prevailing medical fees."

The document has a place for the physician's signature and the notary's verification. Although the form indicates that it represents a sworn statement, it does not point out the penalties associated with false statements.

Program Expenditures

House Bill 50 became effective July 1, 1979. In its first fiscal year of operation (FY 1980) the state paid $140,070 for medical claims. Only fifty-one of one hundred and nineteen counties had medical claims paid by the state. Of these fifty-one counties, one county received forty percent ($56,080) of the monies expended by the state.

This section begins with a description of the revenues provided to the jails and looks at the state and local share of the total expenditures for county jails as well as the expenditures for medical care. It concludes with a description of the medical claims paid, including a description of the percentage of submitted claims paid and a description of the types of medical services paid for in a sample of counties.

County Jail Revenues

Responsibility for the maintenance and operation of the county jails lies with the counties. Jails are funded from the general revenues of the county; counties have the

authority to levy taxes and issue bonds for supporting the cost of jails. Jails, depending upon whose law the prisoner violated, have the authority to collect fees for dieting and other services from local government, the state, or the federal government. Additional revenue was provided by the 1980 General Assembly through Senate Bill 278. This bill increased court costs and fines for criminal cases in district courts by $5, and authorized that payment of this additional $5 be made to the county treasury.

Authorized Fees. Fees paid to the county for prisoners charged with a state law violation include:

- $6.75 per day diet fee;
- $.75 release fee per prisoner released;
- $.50 per prisoner placed in irons; and
- $6.00 per day court attendance.

Only the diet fee is directly related to prisoner upkeep. Diet fees are paid at a rate of $6.75 per day per prisoner. One day's fee may be collected on any prisoner housed prior to midnight. There is no minimum incarceration time. Thus, a prisoner incarcerated at 11:50 p.m. and released at 12:10 a.m. would generate two days of diet fees.

$5 Court Cost Revenue. Senate Bill 278 of the 1980 General Assembly increased costs and fines by $5 for criminal cases in district courts. Codified as KRS 24A.175, this revenue source became effective July, 1980. Revenue collected under this law was authorized to be used by the fiscal court "for the purpose of defraying the costs of operation of the county jail." The State Local Finance Officer of the Department for Local Government projected total revenues of $3,074,000 as a result of this legislation. Estimates based on actual revenues received, as reported by our sample of counties, indicate that revenues may be only one-half of the original projection—$1,659,960 (See Table 1).

Survey responses provided by thirty of thirty-four counties indicate that twenty-six counties (seventy-six percent) have credited the total projected revenue to the jail operations budget without specifying its purpose, by replacing county general funds, rather than increasing the jail budget to reflect the additional revenue. Seven percent of the counties have specified the purpose of this money, e.g., repairs, maintenance or salaries, but have not increased the jail budget. In five counties (sixteen percent) the jail budget has been increased to reflect the anticipated revenues and the use has been specified for salaries or repairs.

TABLE 1

$5 COURT REVENUE,
PROJECTED VERSUS ACTUAL
FY 1981

County	Annual Projected Revenue	Reported Received Revenue	Number of Months Reported	Annual Revenue Estimated from Received
Adair	$ 8,000	$ 1,905	6	$ 3,810
Barren	30,000	5,885	5	14,124
Boone	40,000	13,980	6	27,960
Boyd	34,000	13,185	5	31,644
Boyle	20,000	2,374	4	7,122
Bullitt	25,000	3,050	4	9,150
Calloway	15,000	3,255	5	7,812
Carter	15,000	3,835	5	9,204
Christian	53,000	12,068	6	24,136
Franklin	40,000	3,385	3	13,540
Graves	18,000	3,425	6	6,850
Grayson	16,500	2,390	5	5,736
Greenup	26,000	5,970	6	11,940
Harlan	50,000	7,945	5	19,068
Harrison	8,500	555	2	3,330
Henderson	39,000	14,825	5	35,580
Hopkins	30,000	11,249	5	26,998
Laurel	30,000	8,000	5	19,200
Letcher	18,500	1,780	5	4,272
Lincoln	12,000	2,005	4	6,015
Mason	10,000	2,750	5	6,600
Mercer	15,000	2,335	5	5,604
Monroe	2,500	1,255	5	3,012
Montgomery	24,000	3,200	5	7,680
Nelson	20,000	3,730	5	8,952
Rockcastle	9,000	1,680	5	4,032
Rowan	17,000	6,140	6	12,280
Trigg	6,000	2,940	5	7,056
Wayne	16,000	2,740	5	6,576
Wolfe	7,000	2,114	5	5,074
SAMPLE TOTAL	$ 655,000	$ 149,950		$ 354,357
COUNTIES	$3,074,000			$ 1,659,960[a]

SOURCE: Projected Data - State-Local Finance Officer, Department for Local Governments
Received Data - Reported by Counties, CPR1 Survey
Estimated - Calculated from Reported Data Adjusted for Number of Months Reported

[a]Based on estimated revenue as a percentage of projected revenue (.54) times the projected revenue for all counties.

Expenditures for County Jails

County governments are generally dissatisfied with the jail system in Kentucky, according to our survey. Since the Judicial Amendment of 1975 many county governments feel that because they no longer have judicial powers they should no longer have responsibility for the jails. According to many county governments, this responsibility belongs either to the court system that receives the revenues or to the state, since a large proportion of prisoners are accused of violating state laws.

The importance of this dispute lies in the financial liability for construction, operation and maintenance. Given the age of Kentucky's jails, most counties face the prospect of having to significantly renovate their jails or to construct new ones. A 1978 report by the Bureau of Corrections estimated the cost of renovating or rebuilding county jails at $48,770,000. Aside from these future costs, counties are also concerned over the cost of operating jails and the amount the state contributes toward these costs.

This section looks at the total operating costs for twenty-seven of the thirty-four jails (eighty percent) in our sample that provided data on their expenditures. Data for FY 1980 indicates that state jail fees paid, on the average, seventy-two percent of the total expenses for the jail. Furthermore, state payments for medical claims paid sixty-four percent of the medical expenses.

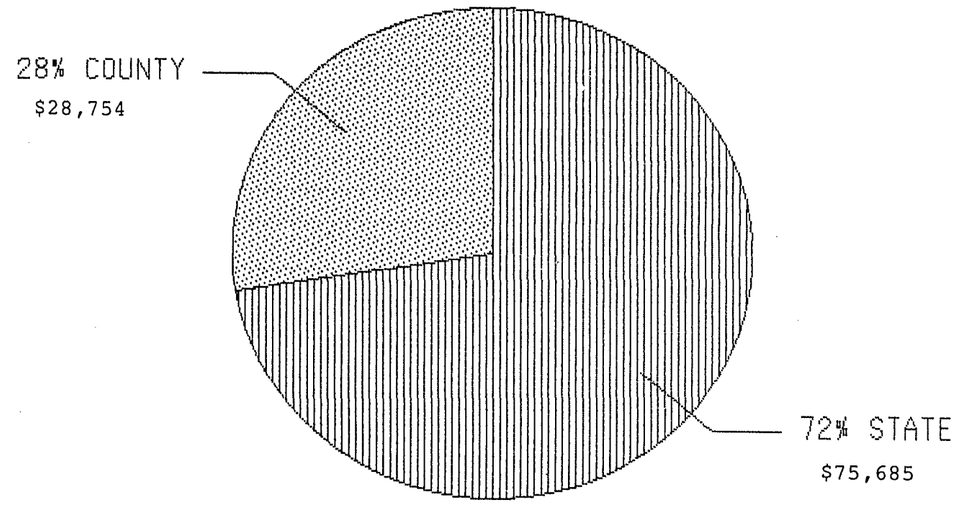
Total Expenditures. The state and county proportions of average jail expenditures for the sample of counties surveyed are presented in Figure 2. (See Appendix C for data on actual expenditures.) Totals were arrived at by adding the total jailers fees paid by the state to the county's reported jail operational and maintenance expenditures, minus the excess jail fees received by the county. Fees paid by the state do not include the medical claims paid, although medical, dental, and psychological expenses paid by the county are included in the county expenditures column. The amount of fees paid is used in calculating total expenditures, since their use by the jailer is restricted to necessary expenses for maintaining the prisoner, with any excess accruing to the county at the end of each year. Subtracting the excess fees received by the county from their expenditures provides the amount of county revenues used for supporting the jail.

As expected, total jail expenditures increase as the number of inmates served increases (Figure 3a). However, average daily expense per prisoner (average annual total expenditures for each category of jail, divided by the average daily population times 365) decreases with the size of the jail (Figure 3b). Average expense is $14.46 per day per prisoner in jails of fifteen or fewer average daily population, $10.76 for the sixteen to thirty prisoner jails, and $9.13 per prisoner for jails with thirty-one to one hundred prisoners. Economy of scale resulting from high fixed costs seems the likely reason for this pattern. Once operation, maintenance and personnel are provided, larger numbers of prisoners can be served at a lower average cost.

The average state contribution toward jail expenses increases with the size of the jail, as shown in Figure 3a. For instance, the total expenses paid by the state is approximately sixty-six percent in jails that house fifteen or fewer and about seventy-five percent

FIGURE 2

AVERAGE JAIL EXPENDITURES
FOR A SAMPLE OF THIRTY-THREE COUNTIES
FY 1980



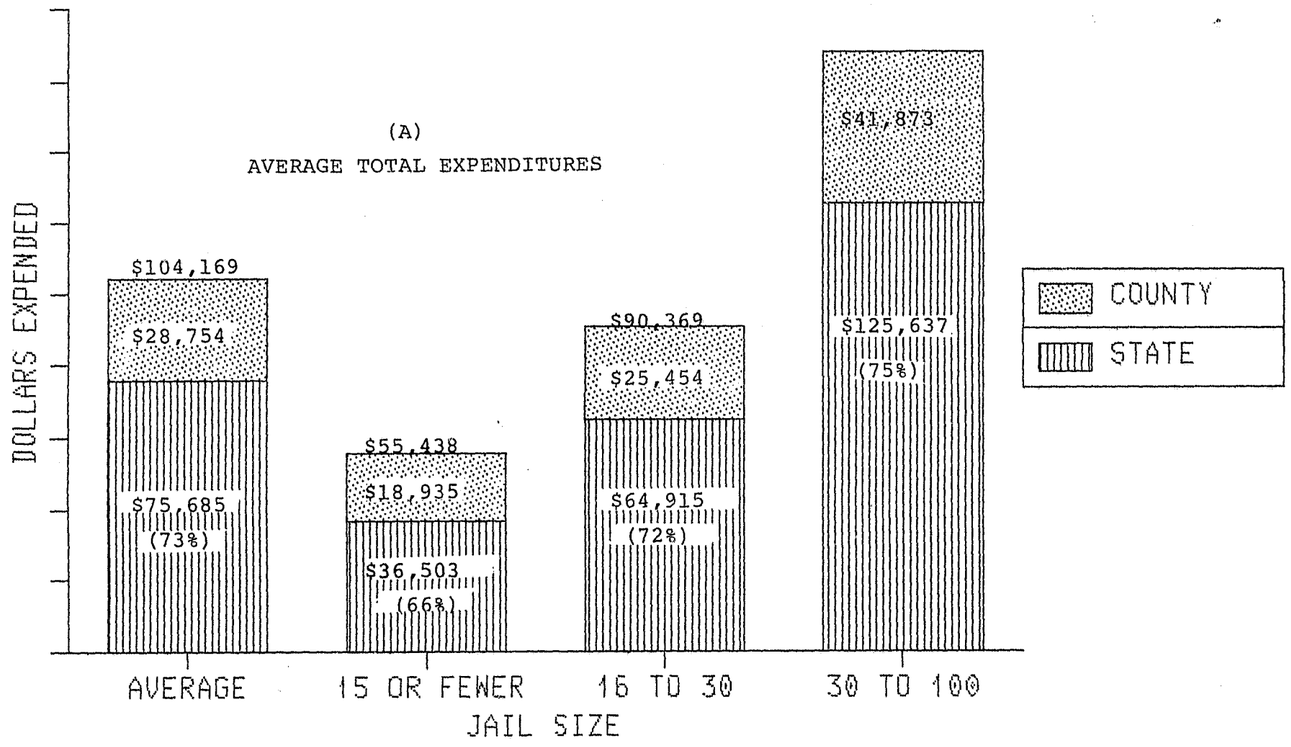
AVERAGE EXPENDITURES TOTAL = $104,169

SOURCE: Compiled from Committee for Program Review and Investigation Survey of thirty-three counties.

NOTE: This data does not include Fayette County.

FIGURE 3

AVERAGE STATE AND LOCAL JAIL EXPENDITURES
BY JAIL SIZE
FOR A SAMPLE OF COUNTIES
FY 1980

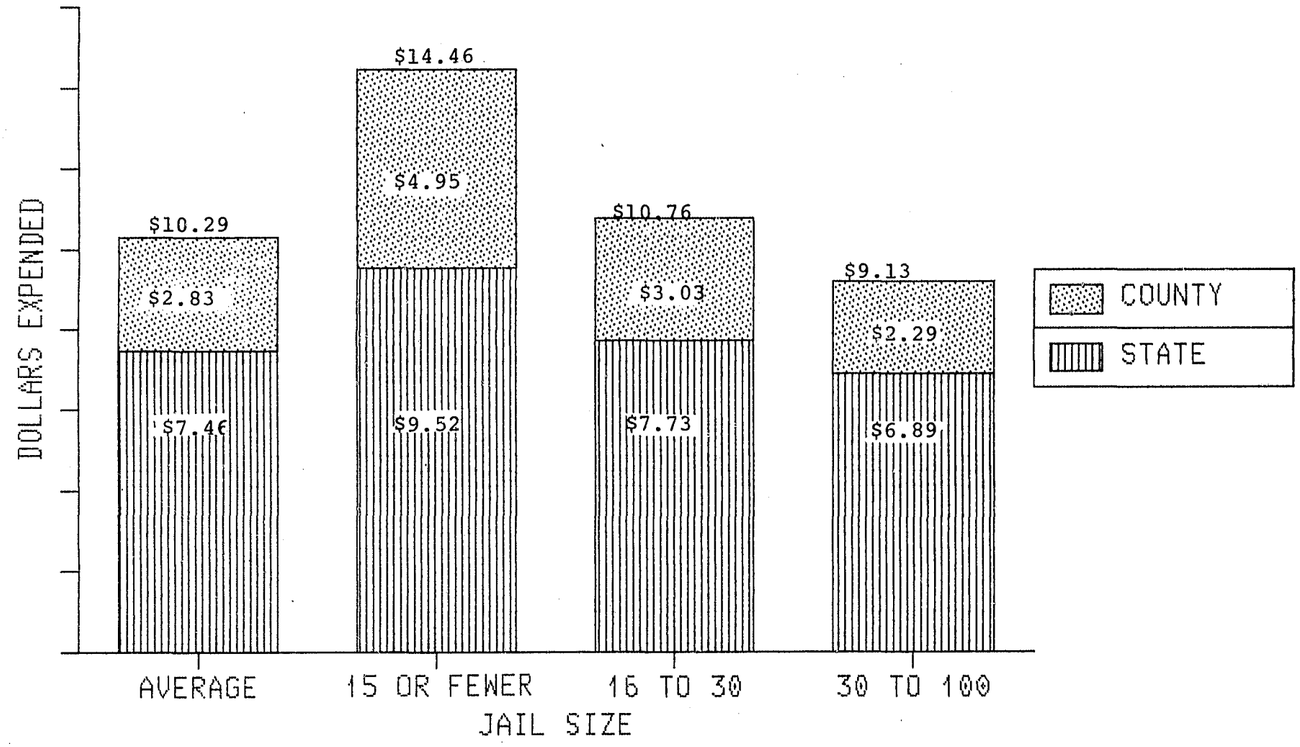


SOURCE: Committee for Program Review and Investigation Survey.
NOTE: This data does not include Fayette County.

FIGURE 3, Continued.

(B)

AVERAGE DAILY EXPENDITURE
PER PRISONER



in jails that house thirty-one to one hundred prisoners. As shown in Figure 3b, the average daily state contribution per prisoner also decreases as the size of the jail increases. The average is $9.52 for the fifteen or fewer prisoner jails, $17.73 for the sixteen to thirty prisoner category and $6.89 for the thirty-one to one hundred prisoner category.

Fayette County, the largest county in the sample, does not conform to this pattern, however. The proportion of state support, fifty-six percent, is lower than for the smallest category of jails. The average per prisoner expense of $11.30 daily is about equal to that of a median size jail of sixteen to thirty prisoners. The state's contribution of $6.30 is closer to the average of $6.89 for the largest category of jails.

Data in Figure 4 indicates the average state and local contributions for medical care in our sample of counties. The proportion of state contributions is less than that for the total expenses, but is still greater than local contributions. The data on medical expenditures for our sample indicates that the percentage of total medical expenses paid by the state does not vary predictably with the size of the jail (Figure 5a). It is eighty percent for the fifteen or fewer category, and seventy-six percent for the sixteen to thirty category, with an overall average of fifty-eight percent. The average daily per prisoner medical expense paid by the state decreases with the size of the jail, from $.25 for the fifteen or fewer, $.19 for the sixteen to thirty, and $.13 for the thirty-one to one hundred category (Figure 5b).

Medical Claims Paid

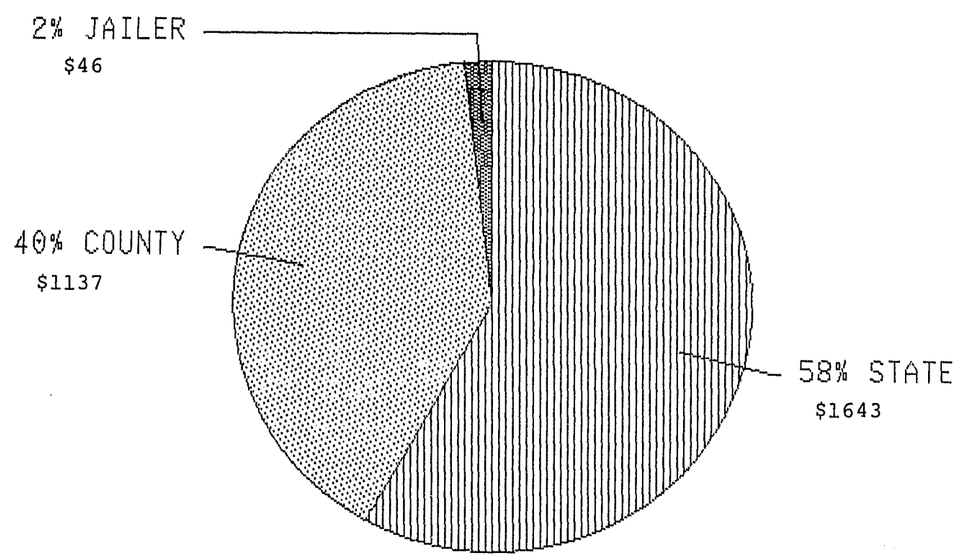
This section presents data on the FY 1980 medical claims paid in six counties, two from each of the high, medium, and low claims counties (determined from the average annual medical claim per prisoner per day). For five of these counties the actual claims submitted were reviewed for the full FY 1980. For Kenton County, only three months, February to March 1980, were reviewed. In addition, for this county, only summaries of total expenses paid to each provider and a list of diagnoses and inmates served were available. Per diagnosis charges were not available.

There is also a description of the number of claims rejected in FY 1980 and the number of claims submitted and rejected thus far in FY 1981. Reasons are given for choosing the sample of thirty-four counties.

Data on types of claims paid are presented in summary form for type of provider paid in each county. Data on the total claims paid by county and by diagnosis are also included. More discrete information on the provider services paid for each county is provided in Appendix D. From this data, it can be seen that the pattern of use can vary widely among counties. The types of diagnoses for which medical claims are paid also vary widely. In some counties it would seem that few diagnoses are serious medical problems. Many claims have been paid for such diagnoses as skin irritations, colds, influenza, aches and pains.

FIGURE 4

AVERAGE MEDICAL EXPENDITURES
FOR A SAMPLE OF THIRTY-THREE COUNTIES
FY 1980

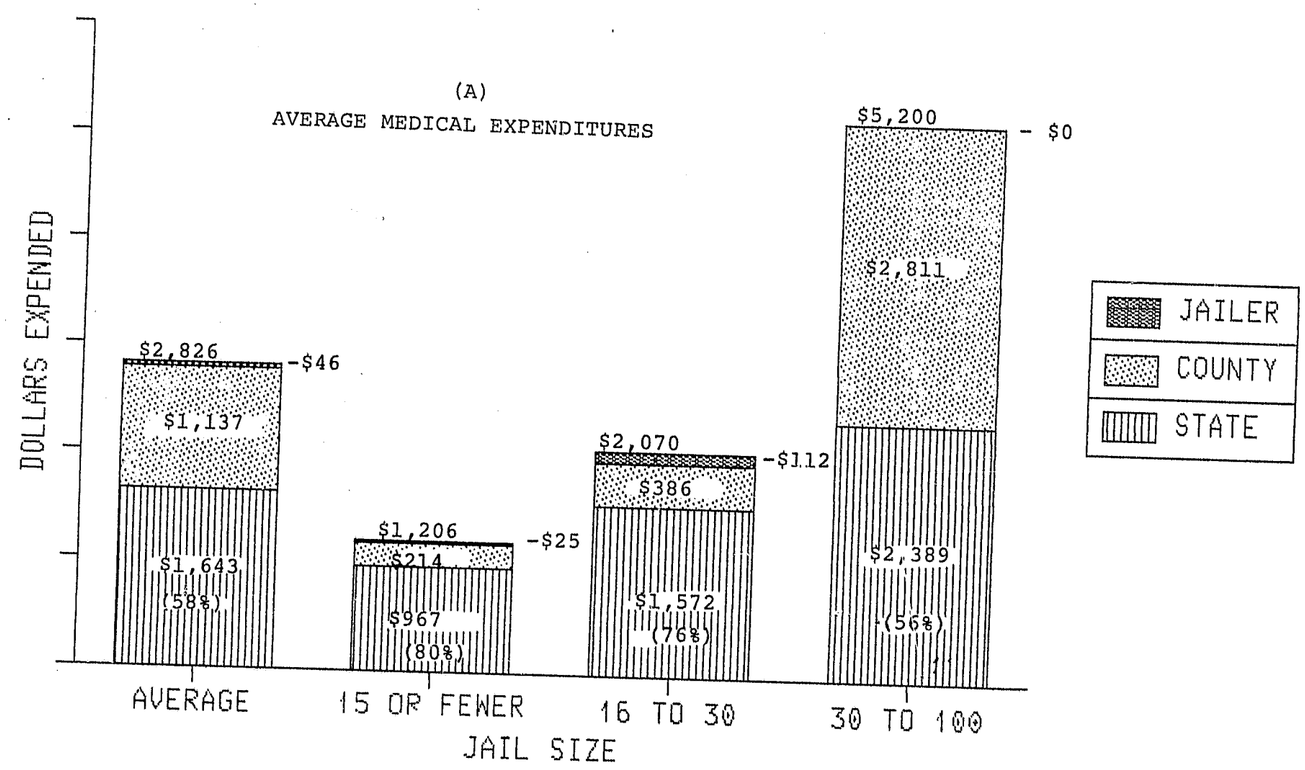


SOURCE: Compiled from Committee for Program Review and Investigation Survey of thirty-three counties.

NOTE: This data does not include Fayette County.

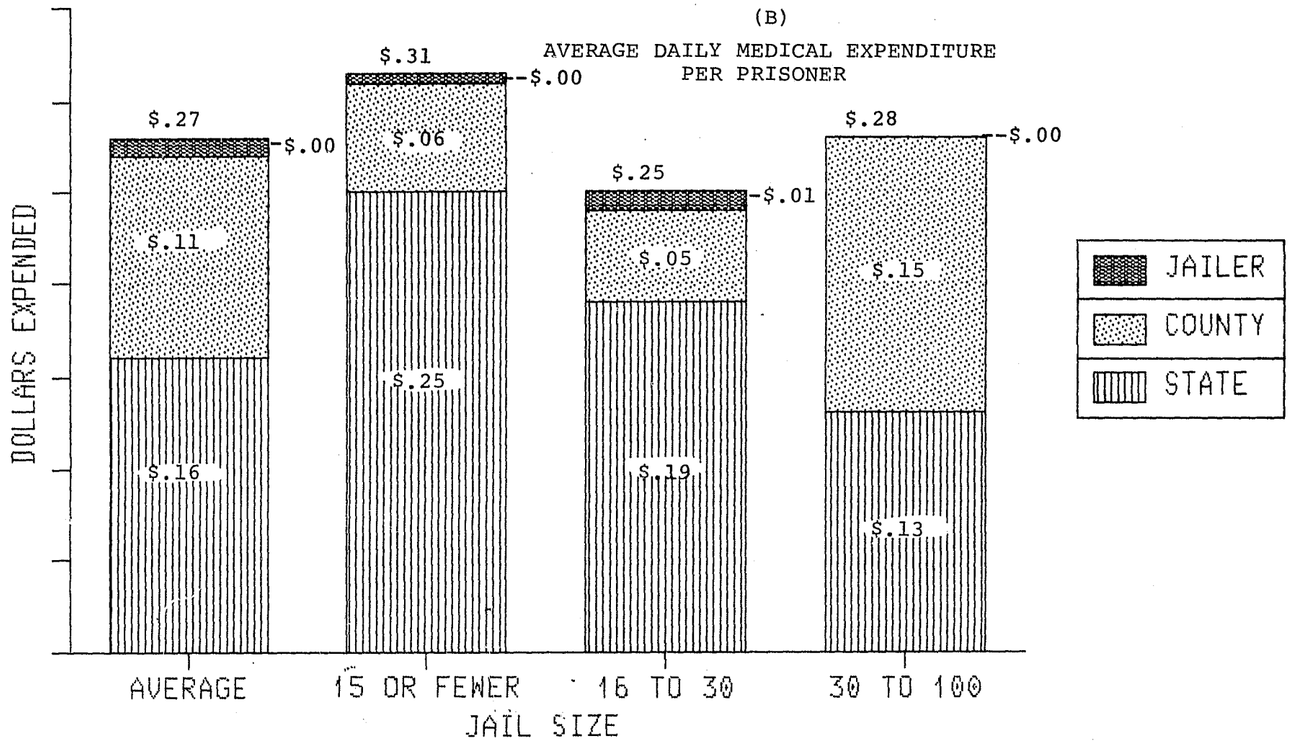
FIGURE 5

AVERAGE STATE AND LOCAL JAIL MEDICAL EXPENDITURES
FOR A SAMPLE OF COUNTIES
FY 1980



SOURCE: Committee for Program Review and Investigation survey.
NOTE: This data does not include Fayette County.

FIGURE 5, Continued



Claims and Rejections. Data for FY 1980 (see Table 2) is incomplete because only rejected claims that have not been resubmitted are available. Claims rejected but resubmitted and paid are not readily identifiable. Consequently only the number of claims currently rejected and their dollar amount are available. Many other claims were rejected in FY 1980. This data only reflects FY 1980 claims which were not resubmitted, or were resubmitted and rejected again.

Table 2 lists claims submitted, paid and rejected for six months, July through December, of 1980. Twenty of the sample of thirty-four counties had not submitted a claim during this period. Of the fourteen counties that have submitted claims, six of them have a rejection rate of five to thirteen percent. According to Department of Finance records, a total of 88 rejected claims are still active. The reasons for these rejections are categorized in Table 3.

Portion of Inmates Claimed. From a count of prisoners lodged in the six-county sample during FY 1980, it is possible to calculate the percentage of medical claims based on the annual prisoner population. This data is presented in Table 4. The range of population served is from less than one percent to eleven percent. These figures are influenced and may be inflated by the possibility that more than one claim may have been filed per prisoner.

Types of Services Paid. The distribution of claims paid in the six counties and the amount for each basic type of service are indicated in Table 5. The proportion of total claims paid for each service varies widely across the six counties. Appendix D presents more discrete information on the distribution of services within each county for the various diagnoses reported. In Barren, Henderson, and Madison Counties, emergency room services have been used in many cases for medical problems that do not seem to be serious. Without knowledge of the time at which service was needed or the conditions surrounding the need for treatment, a judgment as to the necessity of the service cannot be made, except by the physician in charge.

Types of Diagnoses Paid. The types of diagnoses for which medical claims were paid are presented in Table 6. On the surface it appears that many of the claims paid do not represent conditions which would threaten the life of the patient. However the term "a threat to the health of the inmate" is only definable by a licensed physician. Furthermore, in most cases, the charges are for a single treatment as part of the initial examination to determine need; and, the diagnostic visit is a claimable expense.

TABLE 2

NUMBER AND DOLLAR AMOUNT OF EMERGENCY MEDICAL CLAIMS
SUBMITTED AND REJECTED

	FY 1981								FY 1980	
COUNTY	Number of Claims	Amount Claimed	Claims Paid	Amount Paid	Claims Rejected	(%)	Amount Rejected	(%)	Claims Rejected	Amount Rejected
Adair	0	$ 0	0	$ 0	0		$ 0		0	$ 0
Barren	40	2,762.03	38	2,748.43	2	(5)	13.60	(1)	0	0
Boone	2	117.02	2	117.02	0		0		2	98.06
Boyd	0	0	0	0	0		0		2	187.00
Boyle	0	0	0	0	0		0		0	0
Bullitt	0	0	0	0	0		0		0	0
Calloway	0	0	0	0	0		0		1	85.35
Campbell	374	12,853.20	368	12,710.37	6	(1)	142.83	(1)	1	18.00
Carter	0	0	0	0	0		0		0	0
Christian	0	0	0	0	0		0		28	1,180.75
Fayette	0	0	0	0	0		0		0	0
Franklin	0	0	0	0	0		0		1	74.00
Graves	0	0	0	0	0		0		1	18.85
Grayson	31	1,609.31	27	1,384.91	4	(12)	224.40	(13)	1	42.50
Greenup	0	0	0	0	0		0		8	482.47
Harlan	19	4,596.50	17	2,174.45	2	(10)	2,422.05	(50)	2	988.00
Harrison	0	0	0	0	0		0		0	0
Henderson	15	2,968.95	13	2,470.65	2	(13)	498.30	(16)		0
Hopkins	0	0	0	0	0		0		0	0
Laurel	0	0	0	0	0		0		5	228.52
Letcher	7	752.25	7	752.25	0		0		1	19.00
Lincoln	0	0	0	0	0		0		1	297.78
Madison	28	2,806.75	26	2,775.60	2	(7)	31.15	(1)	2	74.50
Mason	6	207.88	6	207.88	0		0		0	0
Mercer	0	0	0	0	0		0		0	0
Monroe	0	0	0	0	0		0		0	0
Montgomery	7	416.29	7	416.29	0		0		2	72.99
Nelson	14	6,908.50	14	6,908.50	0		0		0	0
Pike	0	0	0	0	0		0		0	0
Rockcastle	4	585.09	4	585.09	0		0		11	980.58
Rowan	0	0	0	0	0		0		0	0
Trigg	9	1,425.24	9	1,456.24	0		0		0	0
Wayne	0	0	0	0	0		0		1	45.00
Wolfe	1	8.00	1	8.00	0		0		0	0
TOTAL	557	$38,017.01	537	$34,715.68	18	(3)	$3,332.33	(9)	70	$4,893.35

TABLE 3

NUMBER AND REASONS FOR ACTIVE REJECTIONS
FY 1980—FY 1981

REASONS FOR REJECTION OF A CLAIM:*	
Physician's affidavit not received	48
Lacking date physician provided services	28
Affidavit of Poverty not received	59
Court order stating indigency not received	49
Affidavit of Poverty not notarized	62
Affidavit of Poverty not signed by prisoner	59
Invoices from provider of services not included	1
ADDITIONAL REASONS FOR REJECTION:	
No drug refills allowed	1
Not on diet claim	1
State does not pay for court-ordered psychological exams	43
State does not pay for shampoo	1
Cannot accept copies of invoices	4
Prisoners not jailed at date of treatment	3
No indigency statement by judge	1
Not a prisoner	1

SOURCE: County Fee Systems rejected claims file.

* The totals given for rejected claims and reasons for rejection are not equal, due to the fact that a claim may be rejected for numerous reasons. This table is based on the 88 rejected claims in Table 2.

TABLE 4

COMPARISON OF INMATES SERVED TO MEDICAL CLAIMS
FILED FOR A SAMPLE OF SIX COUNTIES
FY 1980

COUNTY	Number of Inmates FY 1980	Number Medical Claims Paid FY 1980	Claims as a Percent of Inmates FY 1980
Barren	2,952	48	2
Harlan	3,639	46	1
Henderson	3,342	19	Less than 1
Kenton	2,058[a]	224[a]	11[a]
Madison	6,006	63	Less than 1
Wayne	1,549	2	Less than 1

SOURCE: Compiled from County Fee Systems records.

[a] Represents claims for February, March and April, 1980 only, other months records in possession of FBI.

TABLE 5

TOTAL MEDICAL CLAIMS PAID
BY TYPE OF SERVICE
FOR A SAMPLE OF SIX COUNTIES
FY 1980

COUNTY	MEDICAL SERVICE						
	Hospital	Emergency Room	Ambulance	Prescriptions	Physician	X-Ray/ Lab	TOTAL
Barren	$ 948	$ 575	$ 45	$ 764	$ 609	$ 387	$ 3,328
Harlan	6,154	789	1,312	2,425	713	664	12,057
Henderson	831	270	70	116	280	293	1,866
Kenton	28,639	a		18,364	39,895	1,639	88,537
Madison	1,314	610	865	608	1,431	691	5,900
Wayne	$ 919	$ 70	$ 75	$ 24	$ 370	$ 95	$ 1,833

SOURCE: Compiled from Claims Records, Department of Finance, County Fee Systems.

[a] Included in hospital total.

TABLE 6

NUMBER AND AMOUNT OF MEDICAL CLAIMS, BY DIAGNOSIS, FOR A SAMPLE OF SIX COUNTIES FY 1980

DIAGNOSIS	TOTAL Number	TOTAL Amount
DISEASE		
Anorexia	2	$
Diabetes	2	
Epilepsy	10	47
Gall Bladder	2	123
Pulmonary	1	23
Venereal Disease	3	152
DRUGS/ALCOHOL		
Alcohol Withdrawal	1	38
Alcoholic Shock	2	210
Delirium Tremens	2	105
Drug Overdose	2	240
Drug Withdrawal	3	97
Toxic Inhalation	1	135
Unspecified Withdrawal	1	45
FOLLOW-UP		
Burns	1	232
Office Visit (Non-specific)	1	12
Sutures Removed	7	25
INFECTION		
Abcess/Arm	1	85
/Cheek	2	
/Cyst	1	20
/Thigh	2	
Foot	1	57
Head	1	62
Hepatitis	3	119
Unspecified	1	19
Urinary Tract	8	211
Vaginal	5	12
Wound Oozing	1	
INFLAMMATION		
Arthritis	9	17
Bursitis	1	
Conjunctivitis	5	93
Dermatitis	1	39
Epididymitis (Testes)	1	173
External Otitis (Ear)	5	21
Foliculitis	1	50
Gastritis	7	467
Gastroenteritis	1	
Hydradenatitis (Sweat Glands)	1	
Tenosynovitis	1	34
Tonsilitis	2	8

DIAGNOSIS	TOTAL Number	TOTAL Amount
INJURY		
Abrasion/Back	5	204
Abrasion/Multiple	2	35
Back Strain	1	
Burns	1	3,951
Contusion/Chest	2	394
/Facial	2	85
/Hand	3	41
Dog Bite	3	
Fractured Foot	1	107
/Nose	1	27
/Toe	1	22
Gunshot Wound	1	182
Head Trauma	1	
Insect Bites	1	30
Knot on Head	9	349
Laceration/Eyebrow	1	
/Lip	1	50
/Scalp	3	241
/Wrist	2	32
Penile Trauma	1	91
Slashed Wrist	2	134
Smoke Inhalation	1	530
Sprain (Unspecified)	1	68
Strain/Sacroiliac	2	71
Throat Wound	1	182
MISCELLANEOUS		
Colic	4	
Congestive Failure	1	$ 1,078
Constipation	2	
Foreign Body Taken In	3	173
Gastro-intestinal Bleeding	1	155
Hemorrhaging	1	30
Hemorrhoids	4	
High Blood Pressure	3	29
Hyperacidity	2	
Hypertension	4	19
Hysteria	2	84
Insomnia	7	
Kidney Failure	1	20
Loose Stool	1	
Pilonidal Cyst	1	30
Psychosis/Anxiety	1	470
Subconjunctive Hemorrhage	1	
Swollen Foot	2	
Ulcer	7	324

NOTE: Actual claims for Kenton County are not available pending an FBI investigation.

(Table 6, continued)

DIAGNOSIS	TOTAL Number	TOTAL Amount
PAIN		
Abdominal	32	490
Ankle	2	
Anal Pain	2	
Arm	1	
Back	15	
Chest	14	570
Chest/Back	9	57
Earache	3	1,140
Feet	5	
Guinal (Groin)	1	
Hand	7	
Headache	56	
Hip	3	
Jaw	1	
Joint	2	
Knee/Leg	3	
Leg/Back	5	
Migraine	11	
Muscle Spasms	2	40
Myalgia (Muscle Pain)	6	
Neck	3	
Neck/Back	1	
Shoulder	1	
Sore Throat	22	50
Stab Wound	1	1,779
Stomach	12	88
RESPIRATORY		
"Acute Viral Syndrome"	4	
Asthma	5	293
Bronchitis	7	
Bronchiospasm	1	1,625
Cold	23	
Congestion	2	
Coughing	10	
Flu	2	9
Pleurisy	1	121
Rhinitus (Nasal)	1	
Runny Nose	2	
Sinusitis	8	
Upper Resp. Infection	13	63
SKIN IRRITATION		
Athlete's Foot	2	88
Blisters/Lips	1	
Breaking Out	4	10
Cyst/Ear	1	10
Eczema	1	
Boils	4	19
Itching/Anal (Pruritis)	9	
/General	14	
Rash/Arm	5	201
/General	9	39
/Leg	2	
/Scalp	3	
Scabies	1	56
Scrotum Rash	1	
Verruca Accuminato (Penile Warts)	1	

DIAGNOSIS	TOTAL Number	TOTAL Amount
NON-SPECIFIC		
Auto Accident After Arrest	1	$ 30
Bloated	2	
Blood in Stool/Urine	2	
Coughing Blood	1	35
Double/Blurred Vision	1	
Electric Shock	1	92
Fainting	3	10
Internal Bleeding	1	75
Lump in Face	1	
Malaise	2	
Nausea	4	
Nervousness	1	19
Nosebleed	1	35
Numbness/Tongue	1	
Palpitations	2	
Seizures	12	942
Shortness/Breath	2	
Swollen Penis	2	
Testicle Tenderness	1	22
Tremors	3	
Unconsciousness	1	73
Vomiting	2	
Vomiting Blood	1	
Weak/Pale/Dizzy	16	
OTHER		
Acute Dysteria	1	100
Arthrolgia	1	
Cervical Adenetis	1	
Cervical Lymphadenitis	1	
Congenital Toxoplasmosis	1	35
Costochonsitis	1	40
Epigastor Pains	1	
Epitoxis	2	
Fibrortis	1	
Furmicle	2	
Gastric Neuroses	1	90
Lindner	1	15
Malnise	1	
Myolpin	1	
Nerve Neuropathy	1	45
Obitipated	1	
Picondal Abcess	1	85
Trivlapide	1	
Unintelligible/NA	5	238
TOTAL	644	$20,938

SOURCE: County Fee Systems, Claims Paid Files.

CHAPTER IV

PROGRAM ANALYSIS AND RECOMMENDATIONS

Several problems which affect implementation of this program have been identified. These arise from two sources: the legislation establishing the program and the administrative procedures implementing the program. Legislative problems affect the program's:

- adaptability to different jail medical care approaches;
- differentiation of authorized medical expenses from non-emergency expenses; and, as a result,
- control of the program's use.

Administrative problems exist in:

- the payment approach adopted;
- the claims procedures established; and
- the manner in which the program is being used.

These legislative and administrative problems are discussed in the context of their effects on the program's operation. Recommendations for specific changes are presented when appropriate. In some cases, recommendations or options are suggested for legislative review by the Interim Joint Committee on Counties and Special Districts that requested this study.

Legislative Problems and Recommendations

KRS 441.010 attempts to accomplish three things.

- First, to relieve counties of the financial responsibility of a certain type of medical expense of indigent prisoners.
- Secondly, to institute controls to ensure use of the program for its intended purpose.
- Third, to protect the prisoner from denial of care.

The challenge in this legislation is to be specific enough to restrict misuse while being broad enough to allow flexibility and adaptability in its intended use. As important as controls are, it is difficult to place them on the program's use without some risk to prisoners' health.

Based on the program's first eighteen months of operation, it can be said that the legislation is having mixed success in meeting its purposes. The amount of medical care paid to date indicates that the program is relieving some of the financial burden for counties using the program. However, some counties are not using the program because it does not fit their medical care approach. Although the program may be protecting some indigent

prisoners from denial of medical treatment, it is doing so at some costs in administrative control and efficiency.

Approaches to Medical Care

The program has paid the major proportion of total medical expenses for the county jails in 48% of the twenty-three counties in the sample (Table 2) having medical expenses in FY 1980. Some counties, however, have either had to change their approach to medical care or have elected not to use the program.

Eighty-five percent of the county jails in our survey have no formalized or routine medical care services. Instead, medical care is provided on an as-needed basis through an available physician or local hospital. Fifty-nine percent of our sample of jails use the local health department to provide shots, blood tests, and venereal disease treatment. Seventy-eight percent use the comprehensive care centers to provide psychological treatment as well as alcohol and drug treatment.

Three counties in the sample have routine medical services. Campbell County and Kenton County both have a physician who visits the jail on a periodic basis. Fayette County has a contract with the Fayette County Health Department to provide a physician, nurses, and pharmaceuticals.

Kenton and Campbell counties both use the HB 50 medical payment program. In these counties, a physician holds sick call twice per week in the jail. All prisoners with medical complaints are examined and treated if necessary. The state is billed by the physician for this examination and the cost of treatment, when the patient is an indigent prisoner. As indicated in the previous chapter, in a three-month period, Kenton County submitted indigent medical claims for eleven percent of its jail population, amounting to a total of $7,035. For FY 1980, Kenton County had indigent medical payments of $56,880 paid by the state.

Fayette County's detention center has a contract with the local health department to provide two full-time nurses in the jail and a pharmacy for the estimated one hundred and forty prisoners per week that receive medical services. Twenty-four hour emergency services are provided through a physician's exchange. A separate contract with the local comprehensive care center provides some in-jail psychological services. When the program was first implemented, Fayette County requested payment of a percentage of the contract cost based on the number of indigents served.[21] The Department of Finance indicated that payment would be made only for claims having the necessary paperwork required by statute for each treatment claimed.[22] Therefore, Fayette County elected not to participate in the program. Henderson County, on the other hand, has chosen to change its approach to medical care in order to take advantage of the program. This county had a medical services contract with the local health department at a cost of $4,000 per year. This arrangement included the service of one physician and two nurses. Since HB 50 did not allow for payment of contract services other than on a per treatment basis, the county cancelled its contract services. The as-needed medical care approach resulted in $2,366 of medical expenses in FY 1980. This apparent reduction in cost should be viewed cautiously, however, since it does not include the expenses paid by prisoners, the time and transportation costs of the jailer, the increased security risks incurred, the value of discontinued services, or the increase in financial liability of the jailer and county in case of a legal suit.

Alternative Payment Method

KRS 441.010 requires that a medical claim have a physician's certification and a court determination of indigency. The physician's certification is required for each incident claimed. These requirements make it clear that the statute did not envision payment of a percentage of a medical services contract. However, the contribution of contract services to reducing emergency costs should be considered. Contract services used in Fayette County and previously in Henderson County provide for the detection, treatment and prevention of medical problems of inmates. Ideally, this approach should reduce the need for emergency care and afford greater protection of the prisoner's physical health. Furthermore, this type of program would be in compliance with federal court decisions requiring the provision of detection, treatment and prevention services.

RECOMMENDATION

1. The General Assembly should expand KRS 441.010 to include paying a percentage of contract medical services in county jails.

Administrative and Professional Program Controls Set by Statute

To protect prisoners and prevent abuse of the program, KRS 441.010 specifies certain characteristics of medical care to be covered, defines the eligible population and identifies certifying authorities. In addition, it specifies that only a licensed physician can determine medical need and recognizes the possibility of costly diagnoses for problems which, ultimately, may be determined as not threatening to the life or health of the prisoner, and therefore postponable. Notwithstanding these guidelines, there are grey areas and there are non-intended uses. For example, some counties are using the program to pay for routine sick call visits.

KRS 441.010 authorizes payment for non-postponable life or health threatening medical care or the initial examination to determine the need for care. Although such minor problems as colds, influenza, and skin irritations are generally not considered life threatening, they could be in particular instances. Only a licensed physician may determine this distinction. Since only a licensed physician may determine the need for treatment, according to HB 50, costs of these minor problems are charged to the state under the guise of an initial examination.

Payment of the initial diagnosis is unqualified in terms of minimum cost, type of examination, or resultant diagnosis. It has two positive aspects. For the county it ensures that payment will be made for costly diagnoses to determine the presence of a medical problem, even it the final diagnosis requires no treatment. Secondly, it increases the likelihood

that jailers will respond to the medical complaints of indigent prisoners by eliminating concern as to who will pay the cost of diagnosis.

Requiring a physician's certification attesting to the necessity for treatment is intended as an administrative control against misuse. Stating that only a physician may determine the need for medical care to preserve life or health protects the prisoner from being denied care by persons not qualified to judge, and at the same time relieves jail staff of certain responsibilities. Notwithstanding this, the medical care needs of jail inmates present jailers with a difficult situation. As a confinement facility administrator, the jailer has control over an inmate's access to medical care. Court decisions regarding the inmate's rights under the United States Constitution hold that a prisoner has a right to the same level of care available to the general public. An administrator's failure to provide a prisoner with adequate and reasonable care can be interpreted as a violation of the prisoner's civil rights. Such an interpretation makes the jail administrator and the county administrators liable in both their personal and professional capacities.

Determining the need for medical care presents jail administrators with a difficult decision. In some cases medical complaints are used by inmates to avoid activities, to reduce monotony or boredom, to obtain a freer environment or to attempt an escape. Furthermore, a diagnosis or the securing of medical care for an inmate outside the jail complex presents problems of cost and security. It represents not only direct costs related to the medical care, but also indirect costs in the form of unreimbursed transportation, staff salaries and time involved in transporting and guarding.

As shown in Table 7, most jails in the sample are ill-equpped to handle indigent medical care. Only sixteen percent have any formalized medical services provided in the jail that would allow periodic medical reviews of inmate medical complaints. According to survey responses by twenty-five county jailers, only forty percent of these jails have jail staff with such emergency medical training as first-aid, CPI or Department of Justice's Bureau of Training workshops. However, this forty percent represents only twenty-four percent of the jail employees in this sample.

TABLE 7

NUMBER OF STAFF WITH MEDICAL TRAINING
IN A SAMPLE OF KENTUCKY JAILS
FY 1981

SIZE OF JAIL	JAILS RESPONDING	JAILS WITH TRAINED STAFF	(%)	NUMBER OF EMPLOYEES	NUMBER WITH TRAINING	(%)
Fewer than 15	8	3	(38)	29	3	(10)
More than 15, fewer than 30	11	5	(45)	75	14	(19)
More than 30, fewer than 100	6	2	(33)	48	20	(42)
TOTAL	25	10	(40)	152	37	(24)

SOURCE: Compiled from Jailers' responses to Committee for Program Review and Investigation survey and interviews.

Kentucky jailers are obligated to provide jail inmates with minimum constitutionally guaranteed medical care, as interpreted by federal courts. Failure to do so makes the jailer personally and professionally liable. The jailer, however, has the burden of this responsibility within a system that provides him with little support. At the state level there is no direct support for the provision of medical care which could be termed routine or preventative; and there are no standards or statutes requiring local governments to provide these services. At the county and city levels there appears to be little interest on the part of officials in providing some form of routine medical care. As already mentioned, only fifteen percent of the counties surveyed have formalized medical services in the jail. Only twenty-seven percent have or have had contract services in the past and only four percent are currently considering contract services. Despite all county judges/executive being represented on the county boards of health, only twenty-three percent have actually discussed with their board the possibility of providing regular medical services to the jail.

The overall situation, therefore, has no doubt encouraged Kentucky jailers to seek solutions regarding the grey areas of KRS 441.010. The program controls that authorize payment of initial diagnosis and specify determination of need only by a physician allow a legitimate claim to be filed using the face value of a prisoner's complaint as sufficient basis to request a physician's examination. The Department of Finance is obligated to pay all charges legitimately related to the examination. If a physician construes even a minor complaint as affecting the health of the inmate and certifies such, the Department of Finance does not have the authority to question the claim. In such a case, one program control restricts another.

Before further controls for use of this program may be implemented, two areas need to be clarified by the General Assembly. These involve the responsibility of the jail administrators and the incarcerating unit of government for medical care. Similarly, the type of medical care for which each is responsible must be clarified. Two recommendations seem appropriate.

RECOMMENDATIONS

2. The General Assembly should determine if the intention of KRS 441.010 is to supplant the county's financial responsibility for providing necessary routine medical services, including detection, prevention and treatment, as required under court interpretations of the minimum constitutional rights of jail inmates. It is the view of the Committee for Program Review and Investigation that the state should consider assuming the full cost of medical expenses for state prisoners.

If it is decided, however, that the purpose of KRS 44.010 is not to supplant county responsibility, then:

3. KRS 441.010 could be amended to clearly indicate the medical care covered by this program. If the intention is to cover only emergency medical problems a

definition similar to the one for emergency medical services in KRS 211.950 should be adopted.

Restricting use of this program to specific needs while allowing for costly diagnosis and protecting inmate rights is not simple. Any attempt to restrict use of the program could adversely affect indigent medical care. Three approaches could offer a compromise between control of misuse and protection of inmates needs. The Committee for Program Review endorses the last of the three options which follow:

> Amend KRS 441.010 to provide for those costs of initial diagnosis which exceed a certain minimum amount. This amount could be based upon an estimate of the average physician's routine examination charge and the minimum use charge for emergency room services.

This approach should reduce the use of physician and emergency rooms for the provision of sick call services by increasing the financial liability of local government. However, it might reduce the willingness of jail administrators to seek medical care for an inmate lacking overt signs of a serious medical problem, or result in higher charges by doctors.

> Amend KRS 441.010 to authorize payment of only those additional diagnostics determined necessary upon initial examination by a physician. Payment would not include the normal charge for the initial examination performed in the office, in the jail or in the emergency room.

This approach would reduce payment of medical claims involving only an initial examination with no further diagnoses or treatment of a life saving nature indicated. Furthermore, it would tend to place financial responsibility for non-emergency care back in the hands of the local government.

4. Amend KRS 441.010 to allow payment of the initial cost of diagnosis only in counties having an acceptable, formalized medical procedure providing for the detection, treatment and prevention of medical problems.

This last option was adopted by the Committee. It should serve as an incentive for counties to provide formalized and routine medical services, especially if it is combined with Recommendation #1 regarding payment of a proportion of contract medical services.

Administrative Problems and Recommendations

Problems presented in this section are those that can be addressed by administrative action without any changes in the statutes, such as those recommended in the first part of this chapter. Such changes include:

- the payment approach adopted;
- the claims procedures required; and
- the review and approval of claims.

It is concluded in this section that the existing payment approach reduces local control and involvement in both the administration and control of this program. The administrative procedures adopted to ensure control of program usage are unnecessarily cumbersome. Changes can be effected to maintain administrative control while reducing the time and effort necessary to file a claim. Also, the imposition of payment limits required under KRS 441.010 is not included in the Department of Finance's claims process. However, strict adherence to this requirement could be unduly costly and time consuming.

Alternative Payment Method

In implementing the payment program authorized under HB 50, the Department of Finance chose to make payment for medical claims directly to the provider. This approach results in time delays in the payment of claims, reduces local government involvement, and hampers state oversight activities. An alternative approach of reimbursing the county for medical expenses paid would reduce these problems and be more consistent with the current home rule policy adopted by the General Assembly.

The approach now used by the Department of Finance to pay medical claims for indigent prisoners is best characterized as a third-party payment method. The jailer obtains treatment and files claims, which, upon approval by the Department of Finance, results in payment being sent directly to the provider of medical services. Generally the county fiscal court is not involved in this process, although in one county the fiscal court clerk does file the paperwork and in another the county attorney has this responsibility. Excluding county government from the process has the effect of pre-empting the fiscal court's authority to implement local administrative controls and to oversee use of the program.

Third-party payment also restricts state administrative oversight by placing the Department of Finance in the position of determining the validity of claims submitted. Other county official fee payment programs are designed to be audited yearly by the Auditor of Public Accounts or an approved independent auditor. This approach requires a systematic audit program conducted on-site, which provides greater access to information sources for determining the validity of questionable claims.

A third-party payment approach also lengthens the time a provider must wait for payment. Data on the time between treatment and payment for a sample of twenty-five claims in the five-county claims review indicates a time delay between treatment and payment of as long as 260 days. Data from five of the six counties reviewed indicated an average time delay of 92 days. The delay between the time of treatment and the time the claim was stamped "received" by the Department of Finance averaged 78 days, with a range of 18 to 245 days. The delay between the date the claim was stamped "received" and the date the claim was stamped "paid" by the Department ranged from 11 to 20 days, averaging 14 days. Delay problems are compounded by the rejection of claims for improper paperwork and subsequent resubmission.

Subjecting providers to excessive payment delays causes considerable dissatisfaction. Eleven of thirty-one jailers responding to our survey indicate reluctance on the part of

some local medical providers to service jail inmates. According to jailers, this reluctance has several sources, including payment delays, excessive paperwork required and the effect on the security of non-inmate patients of treating inmates within the physician's office.

The policy of the General Assembly, expressed in home rule legislation, is to allow counties greater local control. Returning control and responsibility to the county could be achieved by adopting a reimbursement approach. The county would pay the provider, and then submit a claim for reimbursement to the Department of Finance. Upon approval of the claim the Department would make a payment to the county fiscal court, or jailer, if the court authorized the payment. Aside from consistency in legislative policy endorsing greater local determination, this approach could improve accountability and administrative oversight, as well as reduce time delays and paperwork.

Being involved in the payment process would encourage the county to adopt rules governing medical care procedures and to oversee compliance. The reimbursement approach would also enable introducing a yearly audit of medical claims paid. Since reimbursement would be an item of revenue for the county, it would become part of the independent audit program for auditing county officials.

Since the county would be required to show proof of payment with all reimbursement requests, paperwork delays at the state level would be reduced. Medical service providers should be less hesitant to participate in the program if a local party were responsible for payment. Additionally, shifting responsibility to the local level might encourage the county government to seek the involvement of local agencies and individuals in the provision of medical care to the jail.

Claims for reimbursement submitted to the Department of Finance could require only a proof of payment and a statement certifying the claims as proper under KRS 441.010. The county would need to maintain the court-approved affidavit of indigency and the physician's certification on file. The yearly independent audit should review these claims for compliance with statutory and regulatory requirements. The Department of Finance would have responsibility to review the reimbursement request, to ensure that the inmate was incarcerated for a violation of state law at the time of treatment, and to determine the maximum payment.

Although a recommendation was made to the Committee for Program Review and Investigation to modify the current payment approach to a reimbursement plan, this recommendation was rejected by the Committee. Rejection was based on the general orientation of the Committee to view the state, not the county, as responsible for providing medical care.

Claims Procedures

Under KRS 441.010, the Department of Finance was given authority to determine the form for certification of medical need and the requirements for notarization of the indigency and certification form. Forty-five percent of the responding counties in the sample reported one or more problems with the program. Almost all of these had general problems

with the required paperwork. One of the paperwork problems is notarization. Jailers do not have the resources available to determine the inmates' financial condition required by the Affidavit of Indigency. The certification of medical need form requires modification to provide the physician with more information regarding its use, penalties for misuse, and program control.

Affidavit of Indigency. Although our survey provides incomplete information on who actually completes this form, the responses of thirteen jailers indicate that fifty-four percent of them complete the form. In two cases, the pre-trial release officer completes the form, while in two other cases the presiding judge handles it. In one county, the public defender performs the task, while in one other county, the fiscal court clerk is responsible.

The Department of Finance memorandum to jailers on the subject of filing claims does not specify who is to complete the form, only that a judge must certify indigency. However, this memorandum was sent only to the jailer and does not refer to the responsibility of the pre-trail officer. It just indicates the need for completing the form and obtaining the judge's order. This creates the impression that completing the form is the jailer's responsiblity. Jailers are ill-equipped to determine the indigency of an inmate, since they lack a court's authority to obtain access to medical assistance records or other financial information sources. Access to medical assistance information is important, since one of the criteria for indigency is the receipt of, or eligibility for, medical assistance.

Thirty jailers responded to the survey question on the methods used to determine the prisoners' ability to pay for medical treatment. In most cases one or more methods are used. Seventeen jailers base the decision on the prisoner's statement; eleven others rely on their knowledge of the inmate for determination or corroboration. Twenty-four jailers use some objective evidence, such as the inmate's possession of a medical card, evidence of insurance, or money. Two jailers indicate the Affidavit of Indigency is the sole criteria used and in one county all jail prisoners are assumed indigent.

Given the responsibility of the pre-trial release officer and the presiding judge for determining indigency and the jailer's lack of resources for obtaining financial information, procedural clarification is necessary. The inaccurate impression that this determination is the jailer's responsiblity should be corrected. Jailers should be informed of the statutory requirement. Pre-trial release officers and judges should be informed of the medical claims procedures and the necessity of assessing a prisoner's ability to pay medical expenses soon after incarceration.

Notarization Requirements. Department of Finance procedures for submitting a medical claim require that the Affidavit of Indigency and the Certificate of Medical Need be notarized. Notarization requires that the document be signed in the presence of a certified notary public. For the Affidavit of Indigency this could necessitate assembling the jailer, the inmate, the judge, and the notary at one time for the signing. Likewise, the Certificate of Medical Need requires at least assembling of the physician and the notary. In some cases this requirement is no particular burden because the jailer is a notary or the physician has a notary on staff. However, survey responses by twenty-two jailers indicate

that for at least six, obtaining notarization, particularly of the certificate of need, is a problem. The consequences are repeated trips to obtain certification or simply ignoring the notary's requirement for personally witnessing the signature.

The Department of Finance requires notarization to ensure the validity of the forms and to fulfill the legislative requirement for certification under oath. Certification of indigency by the presiding judge and notarization would be duplicative if the proper procedure for establishing indigency were followed. Notarization is not required for the diet and other jail fee claims submitted to the Department. Furthermore, the Kentucky statutes do not require notarization for an oath to be legal. KRS 523.010 defines an oath as "an affirmation or other legally authorized manner of attesting to the truth of a statement." A written statement may serve as an oath

- if it is made on or pursuant to a form bearing notice, authorized by law, that false statements are punishable, or
- if the document recites that the statement was made under oath and the declarant is aware of the intention, intends to swear, the form is presented in the manner of a sworn statement, and is signed by an officer authorized to administer an oath.

Following proper procedures for the determination of indigency should eliminate the need for additional verification of the court declaration. Modification of the Certificate of Medical Need to clearly state the medical coverage authorized by the program, the form's purpose as a certificate of oath, and the penalties for false statements would serve to replace the need for notarization.

Certificate of Medical Need. Two modifications of this form have already been mentioned: the need to provide more precise information on the purpose of the program and inclusion of statements identifying the form as an oath implying certain penalties for false statements. Additional modifications in the form could provide the Department of Finance and independent auditors with more complete information regarding the diagnosis and treatment.

One modification essential to this form is the inclusion of the prisoner's anticipated or established length of incarceration. To validly determine if the medical problem cannot be postponed and to certify this under oath requires informing the physician of the length of incarceration. The length of incarceration identified by the jailer should be recorded as a part of the oath if it is a basis for deciding need.

Another important modification of the form is the inclusion of a section for itemizing charges. This section should differentiate between the charges for diagnosis and treatment. Itemization should distinguish necessary treatment charges from postponable or elective treatment charges. Furthermore, specifying both the symptoms upon which diagnosis was sought and the proper medical diagnosis should be required. In addition, the physician should be requested to determine whether the problem is due to a pre-existing condition or a new condition and whether further treatment related to this episode will be necessary, according to the meaning of KRS 441.010, during the anticipated period of incarceration.

These changes to the Certificate of Medical Need are accomplishable by administrative action. They should reduce some of the problems caused by the need for notarization and should increase the form's usefulness for determing the validity of the claims and charges. Although the form would require the provider to detail the charges and information about the condition, a check list format could be designed to reduce the time and effort required.

RECOMMENDATIONS

Several recommendations are appropriate to reduce some of the paperwork problems involved, to clarify responsibility for completing portions of the paperwork and to increase administrative control.

5. The Department of Finance and the Administrative Office of the Courts should cooperate and increase their efforts to inform the jailers, judges, and pre-trial release officers of the medical program authorized under KRS 441.010. This publicizing should include information on the required Affidavit of Indigency, responsibility for completion of the form and the need to establish financial liability soon after incarceration.
6. The Department of Finance should eliminate its requirement for notarization of the Affidavit of Indigency. In place of this, the local office of the court should provide the jailer or county government with an original affidavit signed by the presiding judge.
7. The Department of Finance should remove its requirement for notarization of the Certificate of Medical Need. This certificate should be modified to include a clear statement of its purposes as an oath and the penalties for false statement. Included in the oath should be a statement of the prisoner's anticipated length of incarceration, if this is used for determining need.
8. The Department of Finance should modify the Certificate of Medical Need to provide a clearer statement of the program's purpose and the authorized treatment. More precise information as to the complaint, diagnosis, necessity of treatment and the combination of charges should be required by the form.

Program Use

As discussed in the section on legislative problems above, there are ambiguities in the definition of eligible medical care as well as a grey area between valid and invalid claims created by payment of diagnoses and determination by a physician. These limit the Department of Finance's ability to reject claims that appear to be questionable. However, the Department has one other control responsibility with which it is not complying. This concerns the payment limitation under the Kentucky Medical Assistance Program.

Payment Limitation. Currently the Department of Finance is not limiting payments for medical claims to the maximum allowable under the Kentucky Medical

Assistance Program. All claims are paid at the face value of the charge for services. This has apparently been the practice of the Department since implementation of this program, but a documented reason for not using this limit could not be found by the current supervisor of the County Fee Systems. In place of this limit, the Certificate of Medical Need includes a statement in the physician's oath that the charges are the physician's

> usual and customary charges for such services and are reasonable and in line with the prevailing medical fees for like services in this county.

Feasibility of Legislated Limit. On the surface, the legislated requirement seems simple; in reality, it may not be. As described in Chapter II, three possible maximums may exist for many medical services. Actual payment is limited to the lesser of the three. Calculation of these limits requires knowledge of the physician's charges for different services, the median charges of other physicians in the same population density region, and the payment schedule adopted by the federal regulations governing medical assistance.

The most effective way for the Department of Finance to apply this limit would be through the computerized process currently used by the Medical Assistance Program division in the Department for Human Resources. However, the director of this unit indicates that this would not be a simple procedure. First, the availability of staff and the current processing load experienced by the Medical Assistance Program division needs to be considered. Secondly, modifications to the processing software program may be necessary to override other claim verification procedures designed into the software.

The ability of the Department of Finance to implement this payment limit in a cost-effective manner seems questionable. Therefore, it is not recommended that the Department begin complying at this time. Rather, it would seem in the best interests of the Department and this program that this question be explored in more detail. The Department of Finance, in cooperation with the Department for Human Resources, should prepare information on the costs and benefits of this approach and alternative approaches.

RECOMMENDATIONS

9. The Department of Finance, in cooperation with the Department for Human Resources, should review the costs and benefits of imposing the payment limit mandated in KRS 441.010. In addition, these departments should supply the Interim Joint Committee on Counties and Special Districts with cost-benefit information on alternative payment limit approaches that might be used.
10. The Interim Joint Committee on Counties and Special Districts should review the costs and benefits of the mandated limit and alternative approaches to determine the most efficient method for limiting payment.
11. If the Interim Joint Committee on Counties and Special Districts decides that the mandated payment limit is the most desirable approach, the Department of Finance should immediately implement this limit as required under KRS 441.010.

CHAPTER V

MEDICAL RIGHTS OF JAIL INMATES

Persons detained in jails, prisons, or other institutions maintain basic needs which must be provided for during their incarceration. These basic needs are not considered privileges but rights guaranteed by the United States Constitution. Significant among the legal rights retained by prisoners is the right to adequate medical care.

The program established in KRS 441.010 (HB 50) addresses the rights of jail inmates in regard to the payment of emergency medical care expenses. The program does not, however, address the quality and quantity of medical services, or the overall medical rights of inmates. Under its present structure the medical payments program does not protect the legal rights of jail inmates for medical care and is not flexible enough to encourage development of better health delivery programs.

This chapter reviews federal court activity regarding the medical rights of jail inmates and outlines constitutional standards for adequate medical care as delineated by the federal courts and by various national organizations.

Constitutional Basis for Prisoner Rights

The constitutional rights of jail inmates, which governmental and correctional officials are often charged with violating, are those specifically guaranteed by the Eighth and the Fourteenth Amendments to the United States Constitution. These guarantees are further secured by Section 1983 of the Civil Rights Act of 1871, 42 U.S.C. § 1983, which prohibits state or local officials from denying a person those rights which are granted by the United States Constitution.

The Eighth Amendment

The Eighth Amendment to the United States Constitution reads:

> Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishment inflicted.

The federal courts' interpretation of the Eighth Amendment is flexible. At one time "cruel and unusual punishment," as addressed by the amendment, was predicated on actual physical mistreatment. However, the courts recognized that the Constitution must adapt to the changing standards of a growing and maturing society. "Cruel and unusual punishment," as addressed in the context of today's society, includes any intentional or wanton infliction of pain or suffering which is inconsistent with current standards of decency.[23] Pain and suffering can be experienced mentally as well as physically.

The Fourteenth Amendment

The Fourteenth Amendment to the United States Constitution states in part:

> No state shall make or enforce any law which shall abridge the privileges and immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without the due process of law; nor deny any person within its jurisdiction the equal protection of the laws.

Penal institutions traditionally serve to detain persons who are accused of crimes and awaiting trial, and to punish and rehabilitate persons convicted of crimes and sentenced by the courts. The judicial system operates under a presumption of innocence until sufficient evidence establishes guilt. Persons who are detained in jails pending trial are not to be subjected to punishment which is not applicable to other non-convicted citizens.[24] Incarceration of a person by necessity results in a certain restraint on civil rights. It is essential that the restraints imposed on the constitutional rights of pre-trial detainees be non-punitive and not exceed that which is necessary to protect the safety of the prison community and ensure the detainee's presence at trial.

The due process and equal protection clauses in the Fourteenth Amendment provide a guarantee of a pre-trial detainee's constitutional rights. This is similar to the guarantee provided under the Eighth Amendment. Any conditions and actions which violate a prisoner's Eighth Amendment guarantee against cruel and unusual punishment also violate a detainee's due process rights as guaranteed under the Fourteenth Amendment.

Section 1983

During the period of reconstruction following the Civil War, Congress passed the Civil Rights Act of 1871. This law, codified as 42 U.S.C. § 1983, protects citizens from being deprived of their constitutional rights by government officials acting "under color of a statute, ordinance, regulation, custom or usage of a state or territory." Section 1983 protects most of those rights granted under the first eight amendments to the United States Constitution. These basic rights include freedom of speech, freedom of religion and association, and freedom from illegal search and seizure.

Section 1983 is of particular importance to persons incarcerated in state and local penal institutions. It protects a prisoner's guarantee against cruel and unusual punishment and excessive bail, as outlined in the Eighth Amendment, and the right to due process and equal protection under the laws, as granted in the Fourteenth Amendment. By virtue of Section 1983, these constitutional guarantees prevail over any rules and regulations established by state and local governments for the administration and internal management of penal institutions.

Civil Rights Suits

With increasing frequency, inmates in prisons and jails across the nation are filing suits against state and local officials and correctional personnel, charging deprivation of constitutional rights. Most of these suits allege violations of Eighth and Fourteenth Amendment rights and they are generally initiated under Section 1983 of the Civil Rights Act of 1871, 42 U.S.C. §1983. These suits focus on various aspects of the prison environment, including physical conditions and administrative practices. Local jails within the Commonwealth of Kentucky have been subjected to lawsuits of this nature.

Medical professionals are not the target of most civil rights suits involving alleged violations of the medical rights of inmates. These suits are generally directed toward jail administrators and correctional personnel, and state and local governmental officials.

Types of Suits

Civil rights cases challenging conditions in penal institutions have covered several different areas. Suits filed against jails under the Eighth Amendment have challenged both the conditions and administrative practices of jails.

The conditions of confinement challenged in suits based on the Eighth Amendment include lack of sufficient staff, overcrowding, unsafe and unsanitary physical facilities, lack of adequate medical and dental care, and inadequate food and food service. Administrative practices which have been challenged under the Eighth Amendment include the use of open barrack sleeping arrangements, the use of a trustee system, failure to provide adequate exercise and recreational opportunities, failure to provide an adequate law library, and certain disciplinary procedures.

In an ordinary lawsuit against state officials, such as civil action in tort, a plaintiff must prove several elements:

- the official had a duty;
- the official breached this duty;
- the official was negligent in his behavior; and
- the official's negligence caused the plaintiff harm.

In Section 1983 civil suits, however, the plaintiff has to prove only two points:

- the plaintiff's constitutional rights were violated; and
- the act was done by an official under the color of state law.

The advantages of filing suits under Section 1983 are significant:

- the petitioner is not required to exhaust state remedies prior to seeking redress in the federal courts;
- class action suits may be filed; and
- remedial allowances granted are more flexible.

Criteria Used

The courts guard against establishing a precedent of second guessing a physician or restricting the right of a physician to exercise his professional judgment. There is no con-

stitutional foundation for a prisoner's claiming an injury sustained as a result of simple negligence. Therefore, inmates filing valid Eighth Amendment suits must allege more than simple negligence or medical malpractice.

Federal suits alleging constitutional violations of medical rights granted under the Eighth Amendment prohibition against cruel and unusual punishment fall into four basic categories:

- inadequate medical treatment;
- denial of access to medical care;
- denial of prescribed medical treatment; and
- inadequate medical treatment systems and facilities.

Inadequate Medical Treatment. The federal courts hold that a constitutionally based claim alleging inadequate medical treatment must establish more than medical malpractice by a physician, negligence, or valid differences in medical opinion.[25] To be considered under the Eighth Amendment, a claim of inadequate medical treatment must substantiate that essential medical care was either deliberately withheld or was so grossly inadequate that it constituted a barbarous act. When medical care is provided, a prisoner does not have a valid constitutional claim if the complaint involves professional negligence or a difference of opinion with the physician. The federal courts have recognized negligence a an "apparently unavoidable frequent occurrence of life, . . . not . . . cruel and unusual punishment."[26]

Denial of Access. Inmate allegations of denial of access to medical care are most often directed toward jail administrators. The federal courts hold these complaints to be valid under the Eighth Amendment only when it can be established that the jail authority was personally involved in a decision to deny treatment. Furthermore, the complaint must demonstrate that this gross negligence resulted in needless suffering that could have been avoided through readily available relief. Delays in providing medical care have been interpreted by the courts as denial of treatment.[27]

Denial of Prescribed Medical Care. Prisoners alleging denial of prescribed medical care must prove either that deliberate interference by correctional personnel precluded their receiving prescribed care, or that inadequate and inflexible administrative procedures hindered receipt of prescribed medical care. Eighth Amendment complaints of this nature can be filed against both correctional personnel and local officials.

Inadequate Medical Facilities. Suits alleging inadequate medical treatment systems and facilities are generally directed toward jail administrators and local government officials. Typical complaints of this nature under the Eighth Amendment have included inadequate diagnostic procedures, lack of medical personnel, administrative procedures which restrict access to medical care, and inadequate treatment facilities.

Federal Court Posture

In judging suits based on the Eighth Amendment, the federal courts look beyond the surface complaints of prisoners concerning inadequate medical treatment, denial of access to medical care, denial of prescribed medical treatment, and inadequate medical treatment systems and facilities. The quality and training of the health staff provided by the facility and the adequacy and availability of medical facilities and equipment are analyzed in-depth. The courts are interested in the overall policies established by confinement facilities for the provision of essential medical care to inmates. Systematic, structural, and procedural inadequacies can hinder an institution's ability to provide constitutionally mandated health care. In addition, inadequate administrative sick call and emergency procedures can be pertinent factors in the delay of health care to inmates. Deficiencies in these areas may establish a pattern which deprives an inmate of basic health care and thereby amounts to cruel and unusual punishment.

The tests used by the federal courts to determine cruel and unusual punishment are flexible and subjective. These include:

- a "shocks the conscience" test;
- a comparison of the inflicted punishment to the offense committed; and
- a comparison of the inflicted punishment to its intended purpose.[28]

The "shocks the conscience" test, the most widely used criterion, refers to a determination that an act is so inhumane and barbarous as to "shock the conscience" of the court. Comparison of punishment to the offense committed calls for a judgment by the courts as to the proportionate difference between an inflicted punishment and the offense for which it was imposed. The third test, the comparison of punishment to its intended purpose, is a combination of the first two and calls for a judgment of the degree of punishment in light of the purpose for which it was intended.

Federal Court Decisions

Proper health care of prisoners has become the subject of numerous lawsuits initiated by persons incarcerated in penal institutions. Incarceration prevents a person from freely securing medical care. The federal courts have therefore reacted with increasing sensitivity in this area. Judicial opinion maintains that a prisoner's right to adequate provision of his health and well-being is constitutionally protected. Detention facility administrators are expected to provide inmates with a level of medical care comparable to that available to the general public. Pursuant to federal court rulings, administrative authorities are responsible for:

- establishing procedures for either bringing medical personnel and supplies into the confinement facility or for transporting prisoners outside of the facility whenever necessary;
- the quality and safety of medical personnel and equipment used for providing necessary care;
- alternative procedures as an insurance for prompt, full-time medical care when needed; and
- establishing effective procedures through which inmates can receive answers to health-related inquiries.

Essential Medical Care. The Supreme Court recognized the Eighth Amendment as the basis for constitutional claims concerning medical care in Estelle v. Gamble, 429 U.S. 97 (1976). In this case, the federal court acknowledged a governmental obligation to provide medical care to those being punished by incarceration. The court reasoned that failure to provide essential medical care not only causes pain and suffering which is inconsistent with contempary standards of decency, but also serves no penological aim.

In the Estelle case, an inmate charged that he had not received adequate medical treatment from prison doctors after receiving a back injury on a work assignment. During a three month period, the inmate was seen and treated by medical personnel for lower back sprain on seventeen different occasions. Although the Supreme Court ruled that the plaintiff in Estelle v. Gamble had not sufficiently substantiated a claim of inadequate medical treatment under the Eighth Amendment, the decision cited a standard of "deliberate indifference" to the medical needs of prisoners as a measure of constitutional violations. The court specifically stated that:

> In order to state a cognizable claim, a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. It is only such indifference that can offend 'evolving standards of decency' in violation of the Eighth Amendment.[29]

Adequate Medical Facilities. The standard adopted by the Estelle case holds that a complaint of deliberate indifference is actionable only if it establishes acts or omissions which indicate deliberate indifference to the serious medical needs of inmates. The prisoner's claim in Estelle v. Gamble involved inadequate medical treatment. The deliberate indifference standard is also applied in prisoners' claims involving inadequate medical facilities. In Palmigiana v. Garrahy, 443 F. Supp. 956 (1977), the standard was applied as follows:

> An individual seeking relief must prove 'deliberate indifference to a prisoner's serious illness or injury,'. . . . In the case of a class action challenging the entire system of medical care delivery, 'deliberate indifference' can be shown . . . by evidence that 'the medical facilities are so wholly inadequate for the prison population's needs that suffering would be inevitable.'

Thus, the failure of a confinement facility to maintain an adequate medical system is a viable Eighth Amendment charge under the deliberate indifference standard.

The constitutional challenges against inadequate medical facilities have involved three basic areas:

- inadequate medical facilities inside the jail;
- inadequate medical staffing; and
- inadequate medical policies and procedures.

Upon finding instances of constitutionally inadequate medical facilities, the courts generally order specific relief. In Gates v. Collier, 349 F. Supp. 881 (1972), the

federal courts determined that an inadequate medical system was in violation of the Eighth Amendment and ordered the formation of a written timetable to correct the deficiencies. Similarly, facilities have also been required to acquire a specific number of additional medical staff, to provide an infirmary for overnight medical care, to have medical care available at certain times within a day or week, to conduct intake physicials and to provide facilities for routine care and innoculations.

Minimum Standards. The medical standards which can be formulated from decisions handed down by the federal courts are numerous. A decision in the case of Barnes v. Government of Virgin Islands, 415 F. Supp. 1218 (1976), typifies the standards for medical, dental and psychiatric care which have been delineated as minimum requirements for medical care. These consist of:

- medical, dental and psychiatric care comparable to that offered to the general public;
- a medical doctor with regular hours known to the inmates and always available on call;
- provisions for 24-hour emergency medical treatment;
- intake physicals;
- prescription drugs under strict supervision by trained medical personnel;
- complete and accurate medical records;
- provision for special tests, or equipment needed to conduct them, through either medical furloughs, purchased services, or transfer to appropriate facilities;
- part-time dentist on call for curative and preventative treatment;
- psychiatrist to be provided one day per week within sixty days;
- psychiatric aide permanently on staff;
- intake medical status exam and transfer to an appropriate facility if needed; and,
- establishment of an alcohol and drug rehabilitation program.

Economic Consideration. Compliance with minimum standards for health care delineated by the courts can have a heavy fiscal impact. However, the federal courts have taken the position that cost should not be a factor in determining adequate medical care for inmates. A federal court has specifically ruled that a limited budget will not justify insufficient medical care.[30]

Federal Court Decisions Involving Kentucky Jails

There may currently be from six to ten Eighth Amendment suits pending in federal courts against county officials and jailers in Kentucky. One case which was settled in 1979 involved Campbell County in northern Kentucky.

Inmates at the Campbell County jail filed a suit against the jailer, the county judge/executive and the fiscal court. The inmates alleged that the totality of conditions at the jail rendered the entire facility constitutionally deficient under the Eighth and Fourteenth Amendments. The plaintiffs cited, among other things, overcrowding, absence of an

adequate classification system, unhealthy environmental conditions, inadequate food services, lack of exercise facilities and rehabilitative programs, and lack of both facilities and an organization to provide adequate medical care.

In the specific area of medical delivery, the inmates claimed that the entire system for providing medical services was so inadequate as to contravene the Eighth Amendment. The suit specifically cited the lack of medical screening and the lack of a formal system for providing medical care.

The Campbell County jail had very little medical equipment and no medical examining room. The medical staff consisted of one doctor with no regular or consistent hours. For the most part, health care determinations were made by untrained jail personnel. The jail had no system for segregating and caring for psychologically and emotionally disturbed prisoners. The jail also had no dental facilities and a very limited arrangement for outside dental services.

A consent decree issued by the federal district court imposed certain mandates on both the jailer and the county judge/executive and fiscal court. Table 8 outlines the responsibilities for each as set by the court. Generally, the decision called for:

- medical histories and exams;
- a medical examination room;
- routine sick calls;
- periodic visits by a physician;
- medical training for jail personnel; and
- counseling services for inmates.

The court required that the jail be operated in compliance with recognized and acceptable jail standards and appointed an overseer to ensure compliance with the court order by both the jailer and the county officials.

In addition to the expense of implementing court-ordered changes in the jail program and facilities, counties may also find themselves liable for the plaintiff's court and attorney fees resulting from the litigation. The amount of court costs that Campbell County will have to incur for the plaintiffs is the subject of additional litigation.

TABLE 8

MANDATES BY EASTERN U.S. DISTRICT COURT
IN CAMPBELL COUNTY JAIL CASE

JAILER	FISCAL COURT
1. To operate jail in compliance with ACA or other recognized and acceptable standards.	1. To operate jail in compliance with ACA standards.
2. Private medical examination room with a usable medical examining table.	2. Guidance counselor to establish, monitor, and implement an inmate intake and classification system and make recommendations relative to placement of inmates within facility.
3. Licensed medical doctor for 2 regularly scheduled visits per week.	3. Provide sufficient and supplemental funding necessary for jailer to establish private medical examination room and examining table.
4. Doctor on call 24 hours a day.	4. Licensed medical doctor for 2 regularly scheduled visits per week.
5. Inmates notified of sick call days.	5. Doctor on-call 24 hours a day, to provide emergency medical consultation on a full-time basis, to provide follow-up treatment if necessary, and to prescribe drugs if necessary, through written contract or memorandum of agreement.
6. Inmate access to doctor upon request during regularly scheduled visits.	6. Prescription drugs provided free of charge to indigent prisoners.
7. Retention of medical records at jail.	7. Provide sufficient and supplemental funding necessary for jailer to provide a first-aid kit and training for jail staff.
8. Designated member of jail staff to administer medication under doctor's instruction.	8. Contract or memorandum of agreement with dentist to provide emergency inmate care.
9. One person per shift trained for medical screening.	
10. Collect health appraisal data on all inmates expected to remain overnight or longer.	
11. Physical examination after 14 days of incarceration.	
12. One member of jail staff per shift trained in CPR and first-aid.	
13. Emergency care provided through access to local hospital.	
14. First-aid kit at jail.	
15. Licensed dentist to provide emergency dental care.	

National Movements Toward Jail Reform

A 1976 U.S. Controller's report to Congress strongly criticized the conditions of local detention centers. The report cited the continued inadequacies of jails in spite of federal funding for improvements. The report also called for the development of jail standards.

In May 1980, the U.S. Congress passed the Civil Rights for Institutionalized Persons Act of 1980. Under this act, the United States Attorney General has the right to initiate suits on behalf of institutionalized persons who allege deprivation of constitutional rights by state officials. This provision places the United States Government in a more effective position for protecting constitutional rights. The Justice Department subsequently issued a comprehensive set of standards to apply to correctional facilities.

Jail standards specifically addressing the constitutional rights of the incarcerated have also been issued by various national interest groups and organizations. The table in Appendix E lists Justice Department standards pertaining to health and medical care. As might be noted, these are more extensive than the minimum standards typified in Barnes v. Government of Virgin Islands (above), and existing standards issued by national interest groups. Appendix E also indicates those Justice Department standards which are included in some form in standards adopted by the American Correctional Association, the American Medical Association, and the American Bar Association. The final column reflects those standards which are supported by case law.

Federal Legislation

The Civil Rights for Institutionalized Persons Act of 1980, 42 U.S.C. 1977, authorizes the Attorney General to sue a state whenever there is reasonable cause to believe that a person confined in a state correctional or health facility is being deprived of constitutional rights by the state or its agent. To do so the Attorney General must substantiate that there is a pattern or practice by the state of depriving institutionalized persons of constitutional rights. The act further authorizes the Justice Department to intervene in existing lawsuits against a state. The existing suit must have been initiated at least ninety days prior to intervention.

Prior to enactment of this legislation, persons alleging deprivation of their constitutional guarantees could only file private suits. The Justice Department's involvement in these cases was limited to intervention in existing cases as a friend of the court. With the authority to initiate suits, the Justice Department may now choose those situations in which it believes it can be most effective. The new law provides the federal government with a tool to ensure that states do not violate the rights of institutionalized persons. This change especially benefits those institutionalized individuals who are not aware of their rights or who lack the resources and skills necessary to secure legal representation.

Development of Jail Standards

Continued litigation in the federal courts involving the constitutional rights of prisoners has contributed to increased national interest in correctional facilities and the problems they face. The call for jail reform in the United States has steadily risen. This national concern for the quality and effectiveness of jails has been exhibited not only by the federal government, but also by independent interest groups comprised of persons of various professions and persuasions.

The Justice Department and some of the national organizations have independently adopted standards which address the overall inadequacies of correctional institutions. Although these standards have been established from varying professional viewpoints, there are many specific points of agreement.

Department of Justice Jail Standards. Subsequent to enactment of the Civil Rights for Institutionalized Persons Act of 1980, the Justice Department adopted and published jail standards consistent with the constitutional rights of inmates. These standards are used to evaluate federal, state and local correctional systems throughout the United States. They reflect a growing concern over the quality of the nation's jails. Several of these standards are supported by case law.

The Justice Department emphasized that these standards do not create a legal cause for action. They will be used by the Justice Department to:

- evaluate its own policies and programs for prisons and jails;
- administer financial or technical assistance in the corrections field in response to applications for grants, research proposals and other requests from state and local governments; and
- provide guidance to litigating divisions of the Justice Department engaged in suits involving federal, state or local correctional systems.[31]

Jail Standards by National Organizations. The different sets of standards which have been adopted by national organizations address the same issues from varying perspectives. Standards focusing on corrections in general with no emphasis on a specific area have been issued by such organizations as the Association of State Correctional Administrators, the National Advisory Commission on Criminal Justice Standards and Goals, the National Council on Crime and Delinquency, and the United Nations. Such organizations as the United States Bureau of Prisoners, the National Sheriffs Association, and various individual state governments have adopted correctional standards from the perspective of jail administration. The standards issued by these groups deal with precise problems peculiar to jail administration in general.

The American Medical Association and the American Public Health Association have each issued standards which deal precisely with the issue of medical care in correctional institutions. These standards reflect the viewpoint of health and medical professionals relative to health care in confinement facilities.

The individual initiative of national interest groups and professional organizations in addressing constitutional standards is encouraging. A cooperative effort among

medical, legal, correctional, and governmental personnel, which is important in correcting the conditions of constitutionally unsound jails throughout the nation, has been evident. Collectively, the various sets of standards attempt to "define the essentials of human liberty and dignity as they should exist for all of society."[32] All of the standards issued are considered to be attainable and provide criteria for quantitative and qualitative evaluation of the overall adequacy of confinement facilities.

Comparison of Standards. Four sets of medical standards for confinement facilities are illustrated in Appendix E. Medical standards issued by the United States Department of Justice are listed first. Notations in the next three columns indicate the number of the corresponding standard of the American Correctional Association, the American Medical Association, or the American Bar Association.

Local confinement facilities house a diverse population. Detainees include men and women, adults and juveniles, sentenced and unsentenced persons, first-time and repeat offenders, drug and alcohol users, the mentally retarded and mentally ill, the disabled and infirm, and criminals and non-criminals. The American Correctional Association believes that local detention facilities have a mandate to provide equal care and services to each of these diverse groups.

The ACA separates jails into two categories:

1. The general purpose facility, which is used as a detention facility for persons facing criminal charges and as a correctional facility for persons convicted of misdemeanors or felonies; and
2. The holding facility, where persons are temporarily detained while awaiting arraignment and disposition, or transfer to other authorities.

The American Correctional Association assigns a value of importance to each of its adopted standards as it applies to each type of facility.

American Medical Association standards stress the need for cooperation between the medical staff, correctional personnel and the facility administrator. These standards focus more on chemical dependency and psychiatric problems than the other standards. They attempt to outline a program necessary to properly detect, treat, and refer psychiatric patients in correctional facilities. AMA standards particularly address the need for adequate screening, referral and treatment of inmates with these problems, and the need for training the correctional staff in these areas.

The standards issued by the American Bar Association were drawn up by a Joint Committee of the Criminal Justice Section. This joint committee was composed of representatives of seven ABA sections, commissions, and divisions. ABA standards cover the broad range of the criminal justice process, beginning with arrest and ending with post-conviction remedies. They are broad enough to be generally applied to small jails as well as large prisons.

The American Bar Association refers to its standards as "legal standards," rather than correctional standards: the standards for medical care are drawn against a legal and constitutional background. Although some standards may be more difficult to implement

in small jails, or more dangerous to maintain in large, over-crowded prisons, the American Bar Association does not address the particular problems of different types of facilities.

The four sets of standards charted in Appendix E address medical care in prisons from four different perspectives: governmental, correctional, medical, and legal. They agree, however, on the following basic points. Standards should:

- acknowledge an obligation that inmates be provided with medical services or with unrestricted access to medical services;
- agree that health care should be consistently monitored through a timely reporting system between the facility administrator and a central coordinating health authority;
- agree that health personnel should be duly qualified and properly licensed;
- require that adequate space for private examinations and adequate staffing and supplies be available;
- require inmate access to 24-hour emergency medical care;
- require that emergency medical kits be available;
- require written policies and procedures for receiving, screening, and placing inmates;
- require the collection of health appraisal data;
- require that inmates be informed orally and in writing of health care procedures and sick call;
- require written policies and procedures specifying daily processing of medical requests;
- require that facility personnel be trained in emergency health care, basic first-aid, and CPR;
- require that chronic and convalescent care be provided;
- require written policies and procedures for preventative medical maintenance and the provision of medical and dental prostheses;
- require screening and referral of the mentally ill;
- require special programs for the handicapped;
- require medical supervision for detoxification;
- require trained pharmacy administrators and standard operating procedures for the management of drugs;
- require that a detailed health record be kept separately from the confinement record;
- require a transfer of health files with an inmate to another institution; and
- require that an inmate have the right of informed consent.

Conclusion

The federal court has done more than merely establish a governmental obligation

to furnish medical care to those detained in confinement facilities. The specific mandate to governmental officials and correctional administrators is twofold:

- to provide essential medical care, and
- to maintain adequate medical plans and facilities.

The standards for medical care attributed to federal court decisions and outlined by the Justice Department and the various professional organizations are more specific definitions of these constitutional and judicial mandates.

CHAPTER VI

MEDICAL DELIVERY PROGRAMS IN KENTUCKY JAILS

Development of an effective health care delivery program for a county jail should involve an assessment of the current delivery system, including its costs and efficiency, as well as the medical needs of the inmates and available community resources. The health care standards outlined in Chapter V can be useful to county officials and jail administrators in:

- identifying specific deficiencies in an existing health care delivery program; and
- developing a constitutionally effective and cost-efficient health care delivery program.

This chapter outlines an approach toward establishing a medical delivery system which will bring county jails into compliance with the minimum standards as delineated by the federal courts. Recommendations for legislative and administrative action are offered to promote the active involvement of the Commonwealth in assisting counties in guarding the constitutional rights of jail inmates to adequate medical care.

Existing Medical Care

An assessment of current medical care in Kentucky's local jails in terms of the minimum standards outlined by the federal courts and by national organizations (compiled in Appendix E) reflects many deficiencies. In almost all counties surveyed in this study medical care was provided on an as-needed basis. The state has imposed no standards for medical care which would insure protection of the inmate's health.

Facilities and Personnel

Unfortunately, many of Kentucky's county jails do not have staff qualified to provide adequate health care. In many cases neither the jailer nor his employees have formal training in first-aid or basic health care. Only a limited number of these counties have doctors or nurses to provide treatment within the jail on a regular basis. In many of Kentucky's jails, the jailer or deputy on duty is responsible for deciding when a medical complaint is serious enough to refer to a health professional. After professional medical treatment has been rendered, the same jailer or deputy is responsible for providing continuing medical care.

Basic primary medical care and routine medical screening and health appraisal are not provided within the jail. Few of Kentucky's county jails have facilities available, e.g., a private medical examining room, for providing these routine services. Yet the Kentucky

Health Confinement Facilities Act, KRS 211.290-211.295, calls for a medical examining room which is physically and visually separated from inmate housing.

Medical Standards

The Commonwealth lacks a comprehensive set of standards for local jails. The Kentucky Confinement Facilities Health Act authorizes the Department for Human Resources to adopt rules, regulations, and standards relative to the public or health aspects of the operation of state and local confinement facilities. KRS 211.925(3) specifically gives the Department authority to:

> Develop comprehensive plans for the elimination of conditions in state and local confinement facilities which adversely affect the public health or the health of those persons confined or likely to be confined in any state or local confinement facility.

In February 1975, the Department for Human Resources drafted "Standards for Health Care in Kentucky Confinement Facilities" and "Standards for Dental Care in Kentucky Confinement Facilities." The standards for health care specifically outlined acceptable procedures for:

- medical inspection of incoming inmates;
- medical screening and placement of inmates;
- delousing procedures;
- handling of medical requests;
- sick call procedures;
- maintaining medical history and records;
- storing and administering drugs;
- quality of medical care provided;
- mental health standards; and
- nutritional standards.

When 902 KAR 9:010 was promulgated by the Department for Human Resources in October 1976, however, the proposed medical and dental health standards were not included. The only reference to medical care was in section six of the administrative regulation, which reads: "A medical examining room physically and visually separated from cells and dormitories shall be provided."

Health Care Delivery Programs

Basic medical delivery programs providing essential services in local confinement facilities as defined by the courts should be based on the health and medical needs of the inmates, the size of the jail population and the resources available in the community. The objective of a medical program should be the promotion of health and the prevention of disease within the jail population, and the provision of constitutionally adequate medical care to persons confined in the facility.

A medical delivery system should be modeled upon the standards for medical care adopted by the U.S. Department of Justice and various national organizations. It ought to address the following:

- What medical services are to be provided?
- Who are the service providers?
- Where are the services provided?
- How are the services maintained?

Only through a comprehensive study of existing medical conditions and establishment of goals and objectives can correctional personnel develop effective medical delivery programs.

Proposed Program for County Jails

According to the standards of national organizations, jails should have a consistent and operable plan for providing essential health care to inmates. Such a plan includes a written policy for routine medical treatment and acute medical care, and written procedures for emergency care within and outside the jail. A good medical program collects and maintains health appraisal data on each inmate housed in the facility.

Standards dictate that jail personnel and administrators be trained in basic first-aid care and cardiopulmonary resuscitation (CPR) procedures. This provision ensures that medical needs not requiring immediate professional attention are attended to by persons with some degree of medical background. It also ensures that the decision to refer medical complaints to medical professionals or to defer treatment to a more convenient time is supported by knowledge acquired through training.

Inmates of the jail should be screened for existing health problems upon intake and prior to integration within the jail population. The initial screening should consist of a history of illnesses and health problems, notations of medications taken or other special health requirements, a statement of the inmate's mental and emotional condition, a recording of existing injuries, infections, and other such conditions, and a listing of allergies.

Information gathered during intake screening becomes a part of the inmate's medical file. This file should contain a record of all medical complaints and medical care the inmate receives while incarcerated. Notes on medications and prescriptions received by the inmate also become a part of the medical file. The medical file should be kept separate from the inmate's confinement record and should be forwarded with the inmate if he is transferred to another confinement facility.

Medical complaints from inmates should be reviewed and processed daily. Those complaints which are not considered emergencies are scheduled for routine sick call. Sick call should be available at least one day a week. At sick call all medical complaints should be privately attended to by a licensed physician.

Written procedures recommended by the standards should outline a plan for 24-hour emergency medical care for inmates. In the absence of an agreement with medical professionals for on-call 24-hour service, inmates requiring emergency medical care should be

transported to a hospital or clinic for treatment. First-aid kits and adequate resuscitation equipment must be available at the jail, pending arrival of an emergency medical vehicle to transport the inmate.

Standard operating procedures should exist for maintaining and dispensing medications and prescription drugs. Prescription medicines should be controlled by a trained and accountable administrator and dispensed in accordance with a physician's orders. Non-prescription medicines should be maintained for inmate use and dispensed as recommended by the manufacturer. Any medication given an inmate should be documented in the inmate's medical file.

County Development of a Health Care Program

As previously stated, development of a basic program for providing essential medical care in county jails is somewhat dependent on the resources available in the community. Development of a comprehensive health plan would require a certain amount of financing from local funds. Some actions toward improved health services can be taken, however, which should not require significant expenditures.

Counties should study their existing health care delivery system for the local jail to determine ways in which to comply with national standards. Policies and procedures could be established by county officials which would utilize available community resources for provision of routine and emergency medical care for inmates.

Upon admission to the jail, an inmate should be administered a health questionaire by the jailer. Pertinent data on the inmate's medical history and existing health problems should be gathered for his record. If responses warrant further medical consultation, a nurse could conduct a more in-depth interview. A doctor would only be necessary if the nurse's evaluation should warrant it.

Routine medical care procedures ought to be established which involve a daily check of inmates by facility personnel to determine any medical needs. The responses should be documented. A trained nurse could visit regularly to respond to basic medical needs. In addition, a doctor should visit at least twice a week to handle a routine sick call.

Obtaining medical care for jail inmates on a 24-hour basis can be achieved in a number of ways. These include:

1. employment of a physician(s), dentist(s), and health care staff;
2. contracted medical care and health services;
3. a fee-for-service contract with one or more community physicians and/or dentists;
4. provision of health services by a state or local health department;
5. voluntary physician and/or dentist services;
6. use of group practice or clinic prepayment on a fee-for-service health plan.

Jail size and community resources determine what may be developed. However, any of the above options, except number 5, would have a fiscal impact.

State Involvement in Development of a Health Care Program

Preferably, the state would play an active role in the improvement of medical care delivery in the county jails. As previously mentioned, the Commonwealth lacks a comprehensive set of standards for local jails. One standard emphasized by several of the national organizations is a designated health authority to oversee jail health care services. The health authority may be a physician or a physician's group, the health department, or another agency. The standard recommends that this physician or organization be used in an advisory and approval capacity in aiding local jails in the development of an adequate medical program. In Kentucky the Department for Human Resources and the local health departments could serve this purpose. The Department has the responsibility and authority to establish standards for health care. Local health departments are currently involved in local jail inspection and enforcement activities regarding health and sanitation standards.

Local Health Department Powers and Duties

At the present time, Kentucky has eighty-four county and nine district health departments to service all 120 counties. Each health department is an autonomous agency of the local government unit. Each is governed by a board consisting of seven nembers: three physicians, one dentist, one nurse, the county judge/executive, and a fiscal court appointee. Fiscal pressures and the distribution of medical personnel and facilities are moving the local health department system toward a district approach, permitting improvements derived from economies of scale.

Local health departments have several statutory powers and duties:

- to adopt rules and regulations to protect the health of the local citizens [KRS 212.230(1)(c)].
- to administer and enforce all applicable public laws of the Commonwealth and the rules and regulations of the Department for Human Resources [KRS 212.240(1)].
- to formulate, promote, establish, and execute policies, plans and programs to safeguard the public health [KRS 212.240(2)].
- to maintain, implement, promote and conduct facilities and services for the purpose of protecting the public health [KRS 212.240(2)].

Current powers and duties of the local health departments are broad enough to permit their designation as the local health administrative agency to oversee the provision of medical services in the local jails. Since local health departments are administrative agencies of the local government, their designation would be appropriate within the philosophy of home rule. Furthermore, their statutory relationship with the Department for Human Resources permits the establishment of a uniform statewide approach.

Local Health Department Resources

Although traditionally health departments have served basically a preventive role,

they have gradually moved in the direction of diagnosis and treatment in areas lacking available or adequate nonpublic medical services. Among the diagnosis and treatment services provided are blood tests, vaccinations, x-rays, disease treatment, health counseling, medical and dental treatment and nursing services. Staffing patterns vary greatly among the counties (Table 9).

Ninety-nine percent have some form of nursing service, while seventy percent have some physician service available. Only twenty percent have dental services, and only one percent have pharmaceutical services. This variance in staffing indicates that it is not possible to legislatively prescribe the involvement of health departments in providing health care to the jails without funding a minimum staff composition. However, it is reasonable for county jails to contract for a certain level of services based upon the funds for medical care available to the county and jail. This cooperative effort between the jails and health departments would benefit both. It would provide the jail with some basic medical services, presumably at a cost lower than the private sector would offer and it would provide the local health department with additional revenues.

TABLE 9

MEDICAL PERSONNEL AVAILABLE
IN LOCAL HEALTH DEPARTMENTS
FY 1980

		Medical Service						
	Health Departments	Physicians	Nursing	Therapy	Lab/X-ray	Dental	Community Health	Pharmaceutical
Number	92*	64	91	28	10	21	79	1
Percent	100	70	99	30	11	23	86	1

* Data not available for Jefferson County.

SOURCE: Compiled from FY 1980 "Local Health Department Fact Sheet," Bureau of Health Services.

RECOMMENDATION

12. The Kentucky General Assembly should adopt broad policy standards for medical care in local jails. These should conform to the constitutional rights of prisoners as defined by the federal courts.

Approximately thirty-five states have established mandatory medical standards to bring their confinement facilities into compliance with the minimum constitutional rights of inmates. Establishing state standards can protect jail administrators from arbitrary federal court-ordered changes; the courts do seem disposed to evaluating confinement facilities by the state's standards when they exist. In the absence of state standards, a federal judge may establish his own set of standards, or impose such standards as those of the Justice Department or some national organization.

Implementation of some medical standards will have a significant impact on local jails. This is especially true of those standards requiring an increase in medical facilities, space, personnel, and staff medical training. Other standards, such as the establishment of formal medical care policies and procedures, medical screening, and a medical records system, could be implemented without significant financial cost.

RECOMMENDATIONS

13. Pursuant to the authority already granted the Department for Human Resources under KRS 211.925(3), the Department should adopt specific standards for medical care of inmates in local jails which can be implemented with minimum cost. These standards should require:

- a written policy acknowledging the intent to provide inmates with unrestricted access to adequate medical care;
- that medical professionals hold proper licensing or registration;
- that the qualifications and duties of non-medical personnel providing health care be outlined;
- written policies and procedures for providing inmates with emergency medical service;
- written procedures for required medical screening and placement of inmates;
- collection of health appraisal data and maintenance of medical records;
- standard operating procedures for proper management of medicines and drugs; and
- a written policy for informing inmates of their rights and the availability of medical care while incarcerated.

14. In accordance with KRS 212.240(1), local health departments should assume the role of an administrative health authority to work with local jails in developing a health care plan, implementing improvements, providing some medical services and overseeing compliance to state standards.

The development of standards having low fiscal impact is the first step toward bringing local jail medical care practices into compliance with the minimum constitutional rights of inmates. The federal courts may react positively toward jail administrators' exhibiting a good faith effort to comply with constitutional standards. This good faith effort can be demonstrated through the adoption of low cost standards and a written plan and timetable for implementation of more costly medical standards.

CHAPTER VII

CONCLUSION

The Committee for Program Review and Investigation's hearings were held in June and July, 1981. The recommendations contained in this final version of the report were approved in these hearings. The Committee added one recommendation concerning medical care of all jail inmates.

Several times during the hearings on indigent medical care, the need to address the broader issues of responsibility for jails and responsibility for medical care of all inmates were raised. In general, the Committee acknowledged the deteriorated condition of Kentucky's jails, the potential cost of upgrading jails, and the inability of local governments to meet these costs. Furthermore, the Committee felt that the state, as administrator of the judicial system, should also assume responsibility for the incarceration of inmates. Therefore, the Committee unanimously adopted the following recommendation.

RECOMMENDATION

15. The General Assembly should amend KRS 441.010 to encompass the provision of medical care, including dental and psychiatric care, for all prisoners incarcerated in local jails. This amendment should:

- allow local government to determine the method of providing medical services to the jail, including fee-for-service or set-fee contracts, encouraging the use of community services such as local health departments whenever possible;
- designate the unit of government whose law the prisoner is charged with violating as responsible for paying for the major medical expenses of its prisoners housed in the local government's jail;
- limit the unit of government's responsibility to those expenses in excess of the usual and customary physician and/or emergency room charge for initial diagnoses and minor medical treatment unless the jail has a state approved medical delivery program which includes the provision of medical pre-screening and routine sick call services;
- designate the unit of government as responsible for contributing, through a per diem fee or a reimbursement of a percentage of the local government's jail medical contract, to the provision of pre-screening, diagnosis and minor treatment services in jails with a state approved medical delivery system;
- allow the local government operating the jail to recoup the cost of medical services provided non-indigent prisoners during the period of incarceration;
- designate that excess medical fees, reimbursements or recoupments be used to provide state approved medical training for jail personnel and to upgrade medical facilities within the jail according to state standards; and

- require that all excess medical fees reimbursements or recoupments not expended within two years of collection be returned to the state to accrue in a non-lapsing trust and agency fund for emergency medical jail expenses.

FOOTNOTES

1. OAG 70-484, OAG 72-296, OAG 72-534, OAG 74-529, OAG 74-562, OAG 77-197, OAG 79-73, OAG 79-314.

2. OAG 70-304, OAG 80-434.

3. Court of Appeals decision, City of Richmond v. Madison County Fiscal Court (1942), City of Paducah v. McCracken County, et al. (1947).

4. OAG 66-7.

5. *Duties of Elected County Officials*, Legislative Research Commission Informational Bulletin No. 114, Revised, (Frankfort, 1979).

6. *Kentucky Government*, Legislative Research Commission Informational Bulletin No. 137 (Frankfort, 1980).

7. Court of Appeals decision, Guch v. Rash (1921).

8. Harvey, Prentice. *County Government in Kentucky*, Legislative Research Commission Informational Bulletin No. 115, (Frankfort, 1979) p. 6.

9. KRS 67.083(1).

10. From a telephone conversation with Charles W. Runyan, Assistant Deputy Attorney General, Commonwealth of Kentucky, January 7, 1981.

11. OAG 66-7.

12. OAG 69-464, OAG 70-304, OAG 77-690, OAG 78-7, OAG 78-268.

13. OAG 69-464.

14. OAG 68-344.

15. OAG 70-304, OAG 74-494.

16. OAG 70-304, OAG 80-434.

17. "Findings of Fact, Conclusions of Law, Orders and Judgments," Campbell County Circuit Court, Division One, No. 79-CI-205, September 19, 1980, p. 1.

18. Ibid., p. 8.

19. Ibid., pp. 10-12.

20. Ibid., p. 8.

21. Correspondence, Mr. Ray Sabbatine, Assistant Director of the Fayette County Detention Center, to Don Evans, Supervisor of County Fees Systems, June 7, 1979.

22. Reply to Ray Sabbatine from Don Evans, July 5, 1979.

23. William Barry Birdwhistle, "County Jail Reform in Kentucky—A Second Look," *Kentucky Law Journal*, 68, No. 2, (1979-80), p. 378.

24. Rhem v. Malcolm, 507 F. 2d 337 (C.A. 2, 1974).

25. Church v. Hegstrom, 416 F. 2d 451 (C.A. 2, 1969).

26. Ramsey v. Ciccone, 310 F. Supp. 600 (1970).

27. Newman v. Alabama, 503 F. 2d 1320 (C.A. 5, 1975).

28. Birdwhistle, p. 390.

29. Estelle v. Gamble, 429 U.S. 97 (1976).

30. Newman v. Alabama, Supra.

31. *Federal Standards for Prisons and Jails*, U.S. Department of Justice, Office of Public Affairs, (1980).

32. Herbert S. Miller, "The Legal Status of Prisoners," *American Criminal Law Review*, 14, No. 3 (1977), p. 378.

APPENDIX

Commonwealth of Kentucky
Court of Justice
KRS 31.120

AFFIDAVIT OF INDIGENCY

Appendix A

Case No. _____
Court _____
County _____
D.O.B. _____

In the _____Court of _____County

Affiant _____, being first duly sworn says that he is not now represented by private counsel and that he does not have the money or assets out of which to employ one; that he is indigent and request the court to appoint counsel.

Affiant states that his income is _____: that he owns the following property:

Description	Value
_____	_____
_____	_____
_____	_____

that he has the following dependents:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

and that he has the following obligations:

To Whom Owed	Amount Owing
_____	_____
_____	_____
_____	_____

_____
Signature of Affiant

CONTINUED

1 OF 2

APPENDIX B

MEDICAL EXPENSES OF NEEDY PERSONS HELD IN COUNTY JAILS

AFFIDAVIT

Name and Address of Provider of Services _____

_____

_____

_____

Name of Needy Person _____

* *

Comes _____, and after being duly sworn states
(Provider or Physician)

as follows:

1. I am a physician, duly licensed to practice medicine in the Commonwealth of Kentucky in accordance with KRS Chapter 311.
2. That on the date or dates included herein I treated the aforementioned person for:

_____

_____

_____

_____

3. The condition of such person was such that medical care could not be postponed until after the period of confinement without hazard, the procedures were limited to those necessary to preserve the life or health of the person, and were not of an elective nature, except for the initial examination to determine whether medical care was needed.
4. My fee for the services described in the attached statement are my usual and customary charges for such services and are reasonable and in line with the prevailing medical fees for like services in this county.

(Signed) _____

COMMONWEALTH OF KENTUCKY)
)SS
COUNTY OF _____)

Subscribed and sworn to before me by _____

on this the _____ day of _____, 19___.

My Commission expires: _____

_____
(Signed) Notary Public

APPENDIX C

STATE AND LOCAL EXPENDITURES FOR COUNTY JAILS
FY 1980

County (Number)	Average Daily Population	Fees Paid By State	Expenditures[a] By County	Total	Percent Of[c] Total Paid By State	Medical Payments By State	Medical Payments[d] By County	Medical Payments By Jailer	Total Medical	Percent Medical Paid by State
Average Daily Population of 15 or Less										
Adair	10	$ 34,268	$ 11,173	$ 45,441	75	$ 0	$ 18	$ 0	$ 18	0
Boone	13	53,166	19,416	72,582	73	2,989	919	0	3,908	77
Harrison	8	27,729	*	*		141	*	*	*	
Mercer	15	34,292	14,965	49,257	70	0	145	200	345	0
Monroe	10	39,725	11,780	51,505		0	139	0	139	0
Nelson	10	40,538	37,482	78,020	52	1,712	470	0	2,182	79
Trigg	14	30,806	9,670	40,476	76	2,578	0	0	2,578	100
Wayne	10	37,039	27,832	64,871	57	1,287	20	0	1,307	99
Wolfe	5	30,964	19,163	50,127	62	0	0	0	0	0
Sub-Average (9)	10.5	$ 36,503	$ 18,935	$ 55,438	66	$ 967	$ 214	$25	$1,206	80
Average Daily Population of Over 15 but less than 30										
Boyd	30	$ 96,907	$ 93,554	$190,461	51	$4,111	$ 0	$ 0	$ 4,111	100
Boyle	30	83,283	39,000	122,283	68	0	60	1,000	1,060	0
Bullitt	20	57,480	*	*		297	0	450	747	40
Carter	17	41,753	22,000	63,753	66	0	0	0	0	
Graves	25	71,446	8,150	79,596	90	406	1,250	0	1,656	25
Grayson	20	51,928	24,440	76,368	68	1,396	0	0	1,396	100
Greenup	25	59,759	33,858	93,617	64	0	473	0	473	0
Harlan	30	120,288	7,203	127,491	94	12,083	0	0	12,083	100
Lincoln	25	40,445	9,522	49,967	81	0	330	8	338	0
Mason	18	55,069	25,759	80,828	68	212	146	0	358	59
Montgomery	20	69,982	18,568	88,550	79	0	0	0	0	
Rockcastle	25	56,397	6,961	63,358	89	1,929	2,761	0	4,690	41
Powan	17	39,163	16,432	55,595	70	0	0	0	0	
Sub-Average (13)	23	$ 64,915	$ 25,454	$ 90,369	72	$1,572	$ 386	$ 112	$ 2,070	76

County (Number)	Average Daily Population	Fees Paid By State	Expenditures[a] By County	Total	Percent Of[c] Total Paid By State	Medical Payments By State	Medical Payments By County[d]	Medical Payments By Jailer	Total Medical	Percent Medical Paid by State
Average Daily Population of Over 30 but less than 100										
Barren	44	$ 97,651	$ 22,271[b]	$ 119,922	81	$ 3,398	$ 471	0	$ 3,869	88
Calloway	32	54,703	45,556	100,259	55	4,912	91	0	5,003	98
Campbell	57	163,923	94,332	258,255	64	3,856		0		
Christian	65	150,832	51,602[b]	202,434	75	0	17,404	0	17,404	0
Franklin	36	85,759				0	722	0	722	0
Henderson	50	136,683	62,243	198,926	69	2,041	325	0	2,366	86
Hopkins	50	140,025	0[b]	133,069	105	0	663	0	663	0
Laurel	53	136,931	17,110	154,041	89	0	0	0	0	
Letcher	50	100,395	*	*		5,595	*	*	*	
Lyon	69	177,318	*	*		6,481	*	*	*	
Pike	45	137,786	*	*		0	*	*	*	
Sub-Average (11)	50	$ 125,637	$ 41,873	$ 166,701	75	$ 2,389	$ 2,811	$ 0	$ 5,200	56
TOTAL AVERAGE (33)	27.8	$ 75,685	$29,095	$ 104,774	72	$ 1,643	$ 1,137	$46	$ 2,826	58
Fayette	410	$942,505	$747,980	$1,690,485	56	$ 0	$ 40,000			

SOURCE: Program Review and Investigation Committee Survey.

a As estimated by counties for survey conducted for this study, minus excess fees received.
b County pays all expenditures.
c Based on fees and medical paid by state.
d Includes dental care.

* Indicates data not available.

APPENDIX D

MEDICAL EXPENSES PAID UNDER KRS 441.010
FOR A SAMPLE OF COUNTIES
FY 1980

BARREN COUNTY

		TYPE OF SERVICE									
Diagnosis	Total Charges	Hospital	Emergency Room	Ambulance Charge	Drugs	Physician's Charge	Jail Visit	X-Ray/ Lab	Misc.	Date Treated	Date Received	Date Paid
Infection	$ 19.20	$	$	$	$19.20	$	$	$	$		4/21/80	5/07/80
Abrasion,Forehead	25.00		25.00							6/04/79	3/03/80	3/20/80
Asthma	124.10		25.00		9.10	90.00				6/11/79	3/03/80	3/20/80
Sore Throat	50.25		30.00		7.50	10.00			2.75	1/01/80	3/03/80	3/20/80
Numbness in Head	46.55		25.00		1.55			20.00		8/27/79	3/03/80	3/20/80
	25.90		25.00		.90					7/23/79	3/03/80	3/20/80
Stomach Pain	33.20		30.00		3.20					11/20/79	3/03/80	3/20/80
Gonorrhea	43.85		25.00		8.60			10.25		8/08/79	3/03/80	3/20/80
Hysteria	32.10		30.00						2.10	10/08/79	3/03/80	3/20/80
	32.90		30.00		2.90					10/17/79	3/03/80	3/20/80
Psychosis/Anxiety/Dep.	470.10	354.00	35.00		52.95		10.00	14.00	4.15	12/01/80	3/03/80	3/20/80
Gonococcal Urethritis	51.00		25.00		8.75			17.25		7/30/79	3/03/80	3/20/80
Tenderness of Testicles	21.75				9.75	10.00		2.00		11/12/79	3/03/80	3/20/80
Abdominal Pain	24.00					20.00		4.00		9/5 and 9/28/79	3/03/80	3/20/80
Skin Rash/Resp. Inf.	102.30				62.30	20.00	20.00			12/79and 2/80	3/03/80	3/20/80
Faint(Assumed High Blood Pressure)	10.00					10.00				1/31/80	3/03/80	3/20/80
Respiratory Infection	34.99				14.99		20.00			9/28/79	3/03/80	3/20/80
Gastro-Intestinal Bleeding	155.00			45.00		110.00				8/18and 8/22/79	3/03/80	3/20/80
Mass in Neck/ Arthritis	17.20				7.20	10.00				10/16/79	3/03/80	3/20/80
	41.64				31.64	10.00				10/16/79	3/03/80	3/20/80
	2.72				2.72					9/29/79	3/03/80	3/20/80
Hepatitis	8.00						8.00			10/30/79	3/03/80	3/20/80
Congenital Toroplasmosis	35.00					35.00				8/21/79	3/03/80	3/20/80
Fractured nose bone	26.80				6.80		20.00			3/08/80	5/21/80	5/28/80
Peptic Ulcer	17.05				7.05		10.00			4/30/80	5/21/80	5/28/80
Seizure disorder	39.70				19.70	20.00				5/19/80	6/23/80	7/09/80
Peptic Ulcer/Probable	31.85				21.85		10.00			5/02/80	6/23/80	7/09/80
Peptic Ulcer/Probable	16.70				6.70		10.00			4/30/80	6/23/80	7/09/80
High Blood Pressure	28.60				28.60						6/23/80	7/09/80
Gastric Neurosis	89.55		35.00		17.00	12.00		21.00	4.55	5/14and 5/16/80	6/23/80	7/09/80
Rash All Over Body	79.38				54.38	25.00				3/11;3/20 & 4/18/80	6/23/80	7/09/80
Spitting up Blood	34.75		30.00		4.75					4/12/80	6/23/80	7/09/80

BARREN COUNTY

Diagnosis	Total Charges	Hospital	Emergency Room	Ambulance Charge	Drugs	Physician's Charge	Jail Visit	X-Ray/ Lab	Misc.	Date Treated	Date Received	Date Paid
Cyst/Ear	$ 10.00	$	$	$	$	$	$10.00	$	$	3/20/80	6/23/80	7/09/80
Abrasion/Contusion in Lower Back	10.00					10.00				5/21/80	6/23/80	7/09/80
Acute Respiratory Infection With Vomiting	27.85				15.85	12.00				3/15/80	6/25/80	7/09/80
Ear	1139.60	594.00	15.00		303.70			191.00	35.90	5/8 and 5/13/80	6/25/80	7/09/80
Sacroiliac strain/ Malingering	36.25		10.00		3.25	23.00				4/18/80	7/07/80	7/23/80
Fractured Toe	22.00		10.00			12.00				2/12/80	7/07/80	7/23/80
Chronic Seizure Dis.	40.00		30.00						10.00	5/04/80	7/07/80	7/23/80
Seizure Disorder	76.15		35.00					30.00	11.15	3/31/80	7/07/80	7/23/80
Spasm of Colon	40.00		30.00		1.25			8.75		6/12/79	7/07/80	7/23/80
Stomach Pain	50.46		30.00		20.46					6/12/80	7/14/80	8/05/80
Seizure	27.50		15.00		9.20				3.30	6/08/80	7/14/80	8/05/80
Nosebleed	35.45		30.00						5.45	6/07/80	6/23/80	8/05/80
Abscess Cyst	20.00					20.00				6/03/80	7/17/80	8/05/80
Hepatitis	20.00						20.00			4/28/80	7/14/80	8/05/80
Office Visit from Previous Illness	12.00					12.00				5/06/80	7/23/80	8/13/80
TOTAL FOR SERVICE	$3,338.39	$948.00	$575.00	$45.00	$763.79	$271.00	$338.00	$318.25	$69.45			
Percent of Grand Total		28%	17%	1%	23%	8%	10%	9%	2%*			

HARLAN COUNTY

Chest Pains	160.90		40.00	62.00	1.90			57.00		8/06/79	10/23/79	11/05/79
Head/Chest/Back Injuries	271.40		40.00	52.00	7.10			167.00	5.30	9/23/79	10/23/79	11/05/79
Cut on Leg	61.05		50.00		2.40				8.65	8/05/79	10/23/79	11/05/79
Gastritis	62.90		50.00		5.90				7.00	8/03/79	10/23/79	11/05/79
Withdrawal Symptoms	44.90		37.00		7.90					6/19/79	10/23/79	11/05/79
Weak/Arm-Leg Lacerations/EMT	124.90		37.00	54.00	5.50			26.50	1.90	6/19/79	10/23/79	11/05/79
Abdom. Pain/Peptic Ulcer	95.40		40.00	52.00					3.40	9/23/79	10/23/79	11/05/79
Severe Back Pain	43.50							43.50		8/29/79	10/24/79	11/05/79
Slashed Wrists	30.00					30.00				7/23/79	10/24/79	11/05/79
Facial Lacerations/ Possible Concussion	54.00		40.00			14.00				7/23/79	10/24/79	11/05/79
Head Infection	62.00			62.00						1/28/80	4/04/80	4/15/80
Blood Infection	91.00		40.00	42.00	3.70				5.30	2/11/80	4/04/80	4/15/80
Chest Pains	129.40			62.00	2.40	65.00				3/10/80	4/04/80	4/15/80
Slashed Wrists/Throat	109.50			42.00	6.50	44.00			12.00	3/17/80	4/04/80	4/15/80
Smoke Inhalation	530.00	184.00	40.00	46.00	260.00					2/22/80	4/04/80	4/15/80
Electric Shock	92.00		40.00	52.00						2/24/80	4/04/80	4/15/80
Perforated Ulcer	208.00			46.00		162.00				3/08/80	4/04/80	4/15/80
Mental Problems/Violent	52.00			52.00						2/19/80	4/04/80	4/15/80
Broken Foot	107.15		40.00	42.00	3.65			21.50		2/25/80	4/04/80	4/15/80
Acute Chest Pain	42.00			42.00						3/17/80	4/04/80	4/15/80

HARLAN COUNTY

Diagnosis	Total Charges	Hospital	Emergency Room	Ambulance Charge	Drugs	Physician's Charge	Jail Visit	X-Ray/ Lab	Misc.	Date Treated	Date Received	Date Paid
Pain/Lower Abdomen	$ 52.00	$	$	$52.00	$	$	$	$	$	1/21/80	4/04/80	4/15/80
Burns/Face & Hands	3,927.00	1,812.00	55.00		2,060.00					2/18/79/		
Chest Pains	42.40		40.00							1/07/80	4/04/80	4/15/80
Old Compound Fract.	104.00	72.00			2.40					3/10/80	4/04/80	4/15/80
Back Pain	14.00							32.00		10/15/79	4/04/80	4/15/80
Second Degree Burns/ Smoke Inhalation	3,912.00	2,872.00				14.00				11/17/79	4/04/80	4/15/80
Seizure	62.00								40.00	12/18/79/		
	41.95			42.00	20.00					1/07/80	4/04/80	4/15/80
Chest Pain	99.00		30.00		7.95					3/17/80	4/04/80	4/15/80
Self-Inflicted Throat Wound	108.70		40.00	57.00	2.00			4.00		3/20/80	6/09/80	7/17/80
Overdose/Valium	148.00					100.00				5/07/80	6/09/80	7/17/80
Contusion/Chest	123.00		40.00			108.00			8.70	4/08/80	6/09/80	7/17/80
Lesions/Arm & Genital	20.00		40.00		2.50					4/23/80	6/09/80	7/17/80
Follow-up/Burns At Jail	232.00	214.00			20.00			80.50		2/28/80	6/09/80	7/17/80
										4/30/80	6/09/80	7/17/80
									18.00	12/18/79/		
Kidney Failure/T & R	20.00									12/19/79	6/09/80	7/17/80
Hemorrhage/Ulcer	30.00					20.00				4/02/80	6/09/80	7/17/80
Alcoholic Shock	35.00			30.00						4/10/80	7/28/80	8/13/80
Alcoholic Shock	175.45		50.00	35.00						5/17/80	7/28/80	8/13/80
Gunshot Wound	182.00				3.40			113.50	8.55	5/29/80	7/28/80	8/13/80
				56.00		126.00				4/01/80/		
Auto Accident After Arrest	30.00									4/04/80	7/28/80	8/13/80
Seizure	57.00					30.00				5/22/80	7/28/80	8/13/80
Infected Foot	57.00			57.00						6/10/80	7/28/80	8/13/80
Epileptic Seizure	47.00			57.00						5/31/80	7/28/80	8/13/80
Wound From Fight/Jail	57.00			47.00						6/01/80	7/28/80	8/13/80
Abdominal Pains	57.00			57.00						4/04/80	7/28/80	8/13/80
Venereal Disease	57.00			57.00						5/16/80	7/28/80	8/13/80
				57.00						4/18/80	7/28/80	8/13/80
TOTAL FOR SERVICE	$12,057.50	$6,154.00	$789.00	$1,312.00	$2,425.20	$713.00		$545.50	$118.80			
Percent of Grand Total		51%	6%	10%	20%	5%		4%	1%			

HENDERSON COUNTY

Diagnosis	Total Charges	Hospital	Emergency Room	Ambulance Charge	Drugs	Physician's Charge	Jail Visit	X-Ray/ Lab	Misc.	Date Treated	Date Received	Date Paid
Acute Congestive Failure	$1,078.35	$831.00	$15.00	$	$11.60	$25.00		$195.75	$	7/03/79	8/16/79	9/21 79
Hemorrhoids	30.00		15.00			15.00				9/18/79	10/12/79	11/05 79
Contusion to Head	41.00		15.00			15.00		11.00		11/27/79	1/03/80	1/22 80
Urinary Tract Infection	56.98		15.00		9.58	15.00		17.40		1/30/80	3/21/80	4/10 80
Urinary Tract Infection	34.94		15.00		4.94	15.00				2/07/80	3/21/80	4/10 80
Urinary Tract Infection	5.00							5.00		2/12/80	3/21/80	4/10 80
Swallowed End of Lighter	41.00		15.00			15.00		11.00		8/10/79	3/21/80	4/10/80
Piece of Metal In Abdomen	89.65		15.00	35.00	11.15	15.00		13.50		1/15/80	3/21/80	4/10 80
Wire in Foreleg	42.65		15.00			15.00		12.65		12/22/79	3/21/80	4/10 80
Possible Gastritis	38.31		15.00		2.60	15.00			5.71	2/07/80	3/21/80	4/10 80
Athletes Foot	40.11		15.00		10.11	15.00				1/21/80	3/31/80	4/15 80
Infected Toes/ Athletes Foot	47.62		15.00		17.62	15.00				3/08/80	6/19/80	7/09 80
Contact Dermatitis	39.44		15.00		9.44	15.00				5/15/80	6/19/80	7/09 80
Insect Bites	30.00		15.00			15.00				5/30/80	6/19/80	7/09/80
Probable Gall Bladder Disease	86.38		15.00	35.00	12.68	15.00		8.70		4/27/80	6/19/80	7/09/80
Probable Choleocystitis	36.95		15.00		1.95	15.00		5.00		4/26/80	6/19/80	7/09/80
Rash	38.60		15.00		8.60	15.00				3/26/80	6/19/80	7/09/80
Urinary Tract Infection	54.73		15.00		11.03	15.00		13.70		5/31/80	6/30/80	7/16/80
Muscularskeletal Strain	35.09		15.00		5.09	15.00				5/20/80	6/30/80	7/16/80
TOTAL FOR SERVICE	$1,866.80	$831.00	$270.00	$70.00	$116.39	$280.00		$293.70				
Percent of Grand Total		44%	14%	3%	6%	14%		15%				

MADISON COUNTY

Diagnosis	Total Charges	Hospital	Emergency Room	Ambulance Charge	Drugs	Physician's Charge	Jail Visit	X-Ray/ Lab	Misc.	Date Treated	Date Received	Date Paid
Linder	$ 14.95	$	$	$	$ 2.95	$ 12.00	$	$	$	7/02/79	8/07/79	8/21/79
Back/Wrist Injuries	203.55		29.00			94.50		66.30	13.75	6/26/79	8/07/79	8/21/79
Pulmonary Disease	22.95				14.95	8.00				7/26/79	8/24/79	9/04/79
Hand/Wrist Laceration	20.00					20.00				7/24/79	8/24/79	9/04/79
Hypertension	19.30				7.30	12.00				7/18/79	8/24/79	9/04/79
Vaginal Infection	12.00					12.00				6/22/79	8/24/79	9/04/79
Wrist Lacerations	12.00					12.00				7/16/79	8/24/79	9/04/79
Drug Withdrawal	40.20		15.00		10.20	15.00				7/23/79	8/24/79	9/04/79
Boil on Arm	18.85				6.85	12.00				7/13/79	8/24/79	9/04/79
Drug Withdrawal	57.15		19.00		5.90	19.00		1.80	11.45	6/02/79	8/24/79	9/04/79
Acute Dysteria	100.35		15.00	50.00	10.80	15.00			9.55	9/12/79	11/16/79	11/23/79
"Facial Contusion"	31.30		15.00			15.00		1.30		10/16/79	11/16/79	11/23/79
"Unconsciousness"	72.80		15.00			21.00		31.80	5.00	8/15/79	11/16/79	11/23/79
Epididimytis	173.50		37.00	50.00		30.50		51.00	5.00	8/19/79	11/16/79	11/23/79
Blunt Trauma to Penis	90.95		15.00		11.95	61.00		3.00		10/09/79	11/16/79	11/23/79
Chest Pain/Pleurisy	120.95		15.00	50.00	4.95	21.00		30.00		9/24/79	11/16/79	11/23/79
Gastroenterenitis	145.85		15.00	50.00		21.00		49.00	10.85	8/27/79	11/16/79	11/23/79
Alcohol Withdrawal	37.70		15.00		2.60	15.50			4.60	7/05/79	11/16/79	11/23/79
Drug OD/Haldral	94.35		15.00	60.00	3.85	15.50				9/05/79	11/16/79	11/23/79
Acute Conjunctivitis	15.75				5.75	10.00				9/10/79	11/16/79	11/23/79
Possible Seizure	393.05	208.00	20.00			21.00		54.05	90.00	8/21/79	11/16/79	11/23/79
Chest Pain	96.00		15.00	60.00		21.00				9/25/79	11/16/79	11/23/79
Toxic Inhalation	134.70		15.00	85.00	1.20	15.50		18.00		9/24/79	11/16/79	11/23/79
Follow-Up	25.15		7.50		2.15	15.50				9/25/79	11/16/79	11/23/79
External Otitis	20.60				10.60	10.00				1/17/80	2/06/80	2/28/80
Scabies	55.60				35.60	20.00				1/17/80	2/12/80	2/28/80
Alcoholic Gastritis	163.98		15.00	50.00	59.98	21.00		18.00		10/25/79	2/14/80	2/28/80
Nervousness	18.90				6.90	12.00				1/22/80	3/07/80	3/18/80
Conjunctivitis	14.90				4.90	10.00				2/07/80	3/07/80	3/18/80
Scalp Laceration	134.35		15.00	50.00		20.00		15.00	34.35	12/13/79	3/07/80	3/18/80
Questionable DT's	58.60		15.00		27.85	15.50		21.30	6.80	10/26/79	3/07/80	3/18/80
Arm Abscess	85.50		15.00		18.00	21.00		10.00	11.65	11/1/79	3/12/80	3/18/80
Folliculitis	51.00		15.00		4.25	18.00				2/14/80	3/12/80	3/18/80
Teno Synovitis	34.25				3.55	30.00				1/24/80	3/12/80	3/18/80
Asthma	63.55			60.00	7.20					1/27/80	3/12/80	3/18/80
Costochonsitis	40.20		15.00		16.50	18.00				2/04/80	3/12/80	3/18/80
Abdominal Pain	86.50		15.00			23.00		32.00		2/25/80	3/12/80	3/18/80
Acne	10.00					10.00				2/29/80	3/12/80	3/18/80
Wrist Sprain	67.75		15.00			23.00		8.00	21.75	1/18/80	3/12/80	3/18/80
Abdominal Pain	98.00		15.00	50.00		23.00		10.00		2/18/80	3/12/80	3/18/80
Lip Laceration	50.00			50.00						1/12/80	3/12/80	3/18/80
Scalp Laceration	72.30		15.00			22.00		31.00	4.30	2/05/80	3/12/80	3/18/80
Nerve Neuropathy	45.00					45.00				1/28/80	3/12/80	3/18/80
Forehead Laceration	44.30		15.00			18.00			11.30	2/28/80	3/12/80	3/18/80
Flu	8.95				8.95					11/28/79	3/12/80	3/18/80
Conjunctivitis	17.90				7.90	10.00				2/12/80	3/12/80	3/18/80
Abdominal Pain	77.50		15.00		49.50	18.00				2/14/80	3/12/80	3/18/80
Chin Laceration	61.30		15.00			20.00		13.00	13.30	2/13/80	3/12/80	3/18/80
Conjunctivitis	50.50		18.00		10.00	7.50		10.00	5.00	11/11/79	3/12/80	3/18/80

MADISON COUNTY

Diagnosis	Total Charges	Hospital	Emergency Room	Ambulance Charge	Drugs	Physician's Charge	Jail Visit	X-Ray/ Lab	Misc.	Date Treated	Date Received	Date Paid
Gastroenterenitis	$ 54.00	$	$ 15.00	$	$13.00	$ 23.00	$	$ 3.00	$	3/17/80	4/11/80	4/22/80
Internal Bleeding	75.00					30.00		45.00		3/20/80	4/11/80	4/22/80
Acute Bronchospasm	1,624.55	971.10		50.00	190.85	249.50		89.00	74.10	3/18/80	4/11/80	4/22/80
Asthma	105.00		15.00			23.00		36.20	30.80	3/18/80	4/11/80	4/22/80
Tonsillitis	8.00					8.00				3/10/80	4/11/80	4/22/80
N/A	135.00	135.00								3/18/80	4/11/80	4/22/80
Duodenal Ulcer	20.00					20.00				4/03/80	5/13/80	5/28/80
Scalp Laceration	34.50		15.00			18.00			1.50	3/10/80	5/13/80	5/28/80
Picondal Abcess	85.05		15.00		19.95	23.00		13.00	14.10	4/18/80	6/05/80	6/17/80
Pilonidal Cyst	30.00					30.00				4/17/80	6/05/80	6/17/80
Urinary Infection	59.50		15.00		16.50	18.00		10.00		3/24/80	6/05/80	6/17/80
Seizures	83.00		15.00	50.00		18.00				4/10/80	6/16/80	6/23/80
Dilantin Toxicity	92.40		15.00	50.00	9.40	18.00				4/01/80	6/16/80	6/23/80
Seizures	109.50		15.00	50.00	.50	23.00		21.00		4/02/80	6/16/80	6/23/80
TOTAL FOR SERVICE	$5,900.28	$1,314.10	$610.50	$865.00	$608.18	$1,431.50	$	$691.75	$379.15			
Percent of Grand Total		22%	10%	14%	10%	24%		11%	6%			

WAYNE COUNTY

Possible Grandmal Seizures	$ 54.60	$	$ 25.00	$	$ 9.60	$ 10.00	$10.00	$	$	7/23/79 7/31/79	10/24/79	11/05/79
Stab Wound/Abdomen	1,779.15	919.40	45.00	75.00	15.00	360.00		95.80	268.95	10/21/79	6/23/80	7/08/80
TOTAL FOR SERVICE	$1,833.75	$ 919.40	$70.00	$75.00	$24.60	$370.00	$10.00	$95.80	$268.95			
Percent of Grand Total		50%	3%	4%	1%	20%	.05%	5%	14%			

SOURCE: County Fee Systems Claims Received.

* Figures are rounded, and therefore do not equal 100%.

APPENDIX E
NATIONAL STANDARDS FOR MEDICAL CARE IN DETENTION FACILITIES

United States Department of Justice Medical Standards	American Correctional Association Standard No.	American Medical Association Standard No.	American Bar Association Standard No.	Supported By Case Law
Safe and healthful place to live.	5128			Holt v. Sarver, 309F. Supp. 362 (E.D. Ark. 1970)
Court access for presentation of issues concerning constitutional violations.				
Policy and procedures ensuring right to medical and dental care.	5157	143	23-5.1	Estelle v. Gamble, 429 U.S. 97 (1976)
Designated health authority, either physician, health administrator, or agency, with final judgment the responsibility of a physician.	5153	101		
Responsible physician under no restrictions imposed by facility administrator regarding medical decisions.	5154	102		Battle v. Anderson, 376F. Supp. 402 (D. Okla. 1974)
Quarterly report on health delivery and environment with an annual status report.	5156	104		

United States Department of Justice Medical Standards	American Correctional Association Standard No.	American Medical Association Standard No.	American Bar Association Standard No.	Supported By Case Law
Written policies and procedures approved by health authority to govern the provision of standard medical care to inmates.	5157	105		
In facilities lacking full-time qualified health personnel, a health-trained staff member to coordinate health delivery service under the joint supervision of the responsible physician and facility administrator.		108		
Health care personnel hold appropriate state and federal licenses.	5158	122	23-5.1	Newman v. Alabama, 503F 2d 1320 (5th Cir. 1974)
Written job descriptions outlining the duties and responsibilities of health care personnel approved by the health authority.	5159	123		Newman v. Alabama, Supra
Permission for nurse practitioners and physician assistants to practice within the limits set by applicable laws and regulations.	5160			Newman v. Alabama, Supra

United States Department of Justice Medical Standards	American Correctional Association Standard No.	American Medical Association Standard No.	American Bar Association Standard No.	Supported By Case Law
Adequate space for private exams and treatment, and adequate staff, equipment and materials if medical service is rendered in facility.	5161	107		Gates v. Collier, 349F. Supp. 881 (1972); aff'd 501 F.2d 1291 (1974)
For infirmary care, written policies and procedures defining scope of services and requiring a physician on call 24 hours per day, nurse or physician's assistant directing nursing care, health care personnel on duty 24 hours per day and a manual on nursing care procedures.		151		
In facility operated hospital, fulfillment of all legal requirements for a licensed general hospital.		152	23-5.1	Gates v. Collier, Supra.
Available 24-hour emergency medical and dental care or a written plan by health authority outlining arrangements for emergency evacuation from facility, use of hospital emergency room, use of emergency vehicle, emergency on-call medical and dental service in absence of a nearby health facility, and personnel on each shift who are fully informed of emergency treatment.	5170	154	23-5.2	Barnes v. Government of Virgin Islands, 415F. Supp. 1218 (1976)

United States Department of Justice Medical Standards	American Correctional Association Standard No.	American Medical Association Standard No.	American Bar Association Standard No.	Supported By Case Law
Emergency medical kits available in facility.	5162	116		
Written policy on delousing procedures.		141		
Written policies and procedures on receiving and screening to be performed by health personnel prior to placement in general population.	5163	140	23-5.3	Laaman v. Helgemoe, 437F. Supp. 269 (D.N.H. 1977)
Collection of health appraisal data within 14 days.	5164	142	23-5.3	
Written policies and procedures for collecting and recording health appraisal data.	5165	126		Rodriguez v. Jimenez, 409 F. Supp. 582, 589 (1976).
Written and oral notification to inmates of health care procedures and access thereto.	5166	137		
Written policies and procedures requiring daily triaging of inmate health complaints.	5167	145	23-5.2	

United States Department of Justice Medical Standards	American Correctional Association Standard No.	American Medical Association Standard No.	American Bar Association Standard No.	Supported By Case Law
Written policies and procedures advising that sick call is a right and not a privilege, and requiring that sick call be available at least four days a week in facilities of 100 or more and 1 day a week in facilities of less than 100.	5168	146		Wayne Co. Jail Inmates v. Wayne Co. Bd. of Comm. (Wayne Co.; Mich. Circuit Court., May 17, 1971) at 161.
Facility personnel trained in emergency health care.	5171	128		
Staff trained in basic first aid.	5172	129		
One person per shift trained in cardiopulmonary resuscitation.	5173	115		
Written policies and procedures requiring that chronic and convalescent care is provided.	5174	155		
Written policies and procedures requiring that medical preventive maintenance is provided.	5174	153		Newman v. Alabama, Supra.
Written policies and procedures requiring that dental prostheses is provided.	5175	160		Hines v. Anderson, 439 F. Supp. 12 (Minn. 1977)

United States Department of Justice Medical Standards	American Correctional Association Standard No.	American Medical Association Standard No.	American Bar Association Standard No.	Supported By Case Law
Written policies and procedures requiring screening and referral of the mentally ill and retarded whose adaptation to the institution is impaired.	5177	144		Laaman v. Helgemoe, Supra.
Special programs for the disabled, handicapped and chronically ill; the emotionally disturbed and the retarded; with written individualized treatment plans for each outlining the role of medical and non-medical personnel in care.	5179	112		
Written policies and procedures that an inmate at facility in need of additional treatment for chronic illness be transferred to a facility having it available.		113	23-5.1	Barnes v. Government of Virgin Islands, Supra.
Written policy and procedures requiring that detoxification be conducted under medical supervision or at a hospital.	5180	149		
Standard operating procedures for proper management of pharmaceuticals.	5181	163	23-5.6	Williams v. Edwards. 547 F. 2d 1206 (5th Cir. 1977)

United States Department of Justice Medical Standards	American Correctional Association Standard No.	American Medical Association Standard No.	American Bar Association Standard No.	Supported By Case Law
Written policies and procedures that psychotropics be used only when clinically indicated and part of treatment plan.		148	23-5.8	Clay v. Martin. 509 F.2d 109 (2d Cia. 1975).
Pharmacy administrator trained, responsible and accountable.	5182	127	23-5.6	Williams v. Edwards, Supra.
Policies and procedures detailing any duties that may be performed by inmates regarding health services.		133		Williams v. Edwards, Supra.
Detailed health record file containing specific items.	5183		23-5.4	Hines v. Anderson, Supra.
Separation of health file from confidential records.	5185	164	23-6.11	Hines v. Anderson, Supra.
Inmate access to non-evaluative material in medical and dental records.	5184			
Physician access to confinement record whenever it may affect medical treatment.		111		
Certification of clearance to travel with appropriate medication and care procedures.				

United States Department of Justice Medical Standards	American Correctional Association Standard No.	American Medical Association Standard No.	American Bar Association Standard No.	Supported By Case Law
Copies or summaries of health files forwarded to transferral facility.	5186	166		
Inmates have some rights of informed consent.	5187	168	23-5.5	D.F. Runnels v. Rosendale. 499 F. 2d 733 (9th Cir. 1974)
Policies and procedures specifying conditions for periodic lab and medical re-examinations.				Laaman v. Helgemoe, Supra.
Inmates receive medication in form and at time prescribed.				Sawyer v. Sigler, 320 F. Supp. 690 (D. Neb. 1970)
Written policies and procedures requiring that next of kin be informed of serious illness or death.	119			
Written policies and procedures regarding inmate deaths.		120		
Medical services to meet the health care needs of females.			23-5.7	
Written policies and procedures prohibiting experimental medical or pharmaceutical testing for research purposes.			23-5.8	Runnels v. Rosendale, Supra.

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