A Review of the Correctional System's Delivery of Health Services

May, 1994

Submitted to
Hillsborough County, Florida

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May 11, 1994

Mr. Fred Karl
County Administrator
Hillsborough County
PO Box 1110
Tampa, FL 33601

Hon. Cal Henderson
Sheriff
Hillsborough County
PO Box 3371
Tampa, FL 33601

Dear Mr. Karl and Sheriff Henderson:

Enclosed is ILPP's completed review of the Hillsborough County jail medical program. This report identifies several areas crucial to cost-effective and quality delivery of medical services in a correctional setting.

It must be stated, however, that ILPP's ability to thoroughly identify and assess the key jail medical service issues in Hillsborough County could not have occurred without the Sheriff's Office and the county who originally instigated this review and openly participated in it. As a result, I feel certain that the county has been saved a great deal and now stands one step closer to a cohesive and cost saving public health system.

The Sheriff's Office is to be commended for not waiting for the final report of this study to be released before making important changes. These include negotiating a better hospital rate and reducing, by nearly one million dollars, the detention system's medical services contract without compromising any services.

Thank you for the opportunity of working with you both; it was a pleasure to review a system led by agencies committed to positive change. Good luck in your ongoing efforts to implement changes which improve cost savings and quality of care.

Sincerely,

Alan Kalmanoff
Executive Director

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Introduction

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BACKGROUND

Health care is the topic of a heated debate occurring at all levels and in all places in American society. At stake are billions of dollars and, equally important, the determination of the right to an acceptable standard of care. Nowhere is this debate more important and influential than in the correctional setting.

The local jail system houses a typically high risk population in close quarters, saddling correctional administrators with the difficult dilemma of balancing detention costs with containing infectious diseases. Unfortunately diseases like tuberculosis and hepatitis are not discriminating, and the people who work in jails are just as at risk as the people detained in them. In turn, the families, neighbors and communities of the people who spend time in jail – be it as employees or as inmates – provide a ready source for epidemics in the general population. This hypothesis has already been borne out in places like Reiker's Island where a serious rate of tuberculosis in the jail has in turn produced a disproportionately high rate of the disease in the surrounding population.

Aside from the threat of infectious diseases, the correctional setting presents a unique administrative challenge. A crucial prerequisite to effective health care is access. This concept takes on new meaning within the secure perimeters of a detention system. Access within the system to nurses, doctors and medication, and outside of the system to hospitals and specialty clinics requires extraordinary planning to minimize potentially major costs while maximizing quality of care.

SCOPE AND PURPOSE

The Hillsborough County detention system sees tens of thousands of people enter – and exit – its doors each year. A multi-million dollar correctional medical services budget attempts to identify those with health risks, treat them effectively and limit the likelihood of disease and injury among the rest of the population.

Hillsborough County and the Sheriff's Office retained the Institute for Law & Policy Planning (ILPP) to perform a brief review of the delivery of medical

services in the county's detention system. The county contracts out these services to a private provider, currently ARA Health Services - Correctional Medical Services (CMS).

ILPP's team visited the county detention system and observed medical procedures, met with correctional and medical personnel, and interviewed some inmates. Additionally, an extensive review of available medical records, both kept on-site and reported to a regional headquarters office, was performed.

The goal of this review is four-fold, as follows:

1. To identify major sources of health care expenditures documented in the current CMS and Hillsborough County Sheriff's Office Detention Department (HCSDD) budgets;

2. To identify "hidden" medical costs of the Hillsborough County detention system which are not or cannot be documented;

3. To recommend ways of achieving greater cost efficiency in health care delivery; and,

4. To promote quality health care within the current range of expenditure.

These goals, taken together, seek to provide the county and the Sheriff's Office with an overall understanding of the correctional medical system. This will enable both offices to more precisely measure how spending and treatment decisions affect both the jail and general population.

Methodology

Methodology

This management and performance review relied primarily on interviews with key employees, managers and administrators of Correctional Medical Systems (CMS) as well as medical liaisons from the Hillsborough County Sheriff's Office. The study also involved site visits to both the Orient Road and the Morgan Street Jails, inmate interviews, extensive records reviews, data collection and follow-up interviews with several key community health care providers. During site visits, ILPP also observed medical procedures at each site.

Substantial supplementary documentation was solicited from both the Sheriff's Office and CMS concerning budgetary information and administrative data. However, most of CMS data are kept at CMS corporate headquarters and require clearance; thus, some of the requested materials were delayed and some were not available.

The review was done by a public health physician/health service researcher with prior experience evaluating correctional medical care, and an experienced correctional administrator with extensive expertise in the area of medical care delivery in the correctional system. Their credentials can be found in the appendix.

In performing this review, ILPP used the health services contract between the county and CMS and standards developed by the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA). It must be noted, however, that many of the national standards are goal- rather than process-oriented. For example, a standard may require that inmates be given physical examinations. However, the standard will not include a definition of "physical examination" nor a description of what should be accomplished in the examination.

Where this is the case, the county may indeed be in compliance with accreditation standards, but in truth, the quality of currently contracted care could well be improved, sometimes with little or no additional cost. Given the county's interest in cost and service efficiency, ILPP's contract review is based on public health standards commonly employed by public health and medical professionals in the community.

Administration & Organization

Administration & Organization

Hillsborough County's corrections program is located in four facilities: the Orient Road Jail, the Morgan Street Jail, the Work Release Facility and the Falkenburg Road Temporary Jail. At the time of this review, the facilities had an average daily population of approximately 2,200 with an average annual booking of 44,000 inmates. Hillsborough County's correctional medical facilities are accredited through the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA).

Since 1989, inmate medical services have been privately contracted with ARA Health Services – Correctional Medical Systems (CMS). The internal management of the medical program is overseen by an RN program administrator who is employed by CMS and is on-site. This administrator reports to a regional manager.

A medical service coordinator from the Sheriff's Office, who functions as a Detention Liaison, is assigned to supervise the CMS medical contract, specifically in the areas of emergency room referrals, daily incident reports, length of hospital stays and medical record reviews and quality assurance meetings.

CMS staffing is 75.25 full time equivalent (FTE) staff for an average daily population of 2,200 inmates. This is adequate staffing given the norm of approximately 28 to 30 health care staff per 1,000 inmates among accredited jails.[1]

The CMS staffing plan[2] appears to allocate 51.25 FTE medical personnel for the Orient Road Jail to service approximately 1,344 inmates (versus 39 per 1,344 inmates needed, although a reception center is expected to have more). In contrast, the older (and less efficient) Morgan Street Jail is staffed with 24 FTE staff positions for 508 inmates. It is difficult to extrapolate total FTEs from daily staffing schedules because there are staffing personnel changes day to day (part-timers and per diems).

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1 Juvenile and Criminal Justice International, Survey Report of Accredited Correctional Health Care Systems.

2 The last available staffing plan was from 1989.

FINDINGS

1. On-site CMS administrators have little fiscal control. Major budget planning, decision making and expenditure authority are at the corporate level. Except in emergency situations, many off-site medical services require corporate office authorization.

2. The Sheriff's Office medical coordinator, while a proactive manager, may be at a disadvantage in evaluating health care costs because she often functions on the "sidelines" and does not have complete access to CMS information.

3. The relationship between the Sheriff's Office and CMS administrators appears to be satisfactory to the parties. However, there have been problems in tracking inmates at the jails, perhaps due in part to communication problems between correctional and medical staff and a low priority given to updating the computerized tracking system.

   An additional problem has been the release of inmates without clearance from the medical staff. While the Sheriff's Office notes that a medical alert system has been instituted since the research was completed for this study, it is not clear if the system provides medical staff the time needed to prepare for safely releasing an inmate with medical problems.

4. In Hillsborough County's detention system, with its multiple facilities, there is a duplication of both staff and services, at considerable cost to the county.

5. The total of 75.25 FTEs provided by CMS includes only 4.5 FTEs dedicated to mental health or 196 hours. This falls far short of the standard of 14 mental health staff per 1,000 inmates developed by leaders in the correctional health care field.[3] (Even if five substance abuse social workers from the county's Detention Department staff are included in this calculation, mental health staffing appears to be far short compared to surveyed jurisdictions.)

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3 The standard was developed by Juvenile and Criminal Justice International (JCJI) in consultation with the Federal Bureau of Prisons and the Menninger Clinic (Topeka, Kansas). This staffing ratio existed in recognized facilities surveyed or provided consultation to by JCJI.

6. There are discrepancies in the number of total FTEs and the amount of scheduled staff time. Part of the problem can be due to the difficulty in tracking the staffing plan since some workers are full- or part-time salaried and others work sporadically at different hourly rates. In addition, a problem in the high turnover rate among nurses in recent years was identified by those interviewed. This could be adding to the variability of actual staff time compared to the number of total FTEs in the contract.

7. There appear to be inconsistencies in job titles and actual work responsibilities. For example, the designated pharmacy technician[4] is not functioning as her title indicates, but rather is employed as a billing clerk whose services benefit CMS and not the inmates.

RECOMMENDATIONS

1. Establish a case manager position or case workers to ensure proper channeling of care within the correctional system. If medically trained, the case manager could conduct regular reviews of inmate medical records, observe medical procedures (particularly health assessments), and participate in developing treatment plans. As part of this last responsibility, the case manager should also handle discharge planning to outside community clinics to ensure more continuous care between the correctional setting and the community. Community providers interviewed for this study have shown enthusiasm for such an approach.

2. Updates of the computerized inmate tracking system should be made a priority for correctional staff. Information on inmate location and movement is crucial to effective management, both for CMS and the Sheriff's Office. If CMS staff members cannot currently operate the tracking system (for inquiries only), the Sheriff's Office should provide training.

   There should be greater communication between Sheriff's Office and CMS medical staff prior to an inmate release from the jail. The new

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4 Sheriff's Office staff indicate that there are two pharmacy clerks, one employed as a pharmacy technician and the other providing billing clerk services. However, ILPP interviews and review of the personnel list document only one such position.

medical alert system is a good beginning, but must be supplemented with clear lines of communication to ensure adequate time for medical action and approval, if necessary, and not simply to provide notice.

The objective of notifying medical staff of an impending release is to ensure that the inmate is also *medically* cleared to be released, with consideration given to provision of adequate medication and/or discharge planning in the community.

3. Consolidation of facilities would minimize costly duplication of staff and services.[5] Applicable standards (NCCHC) require "minimal" medical services to be available to inmates at all facilities. This could include either a main medical center with minimal services and personnel located at all detention sites or with these services easily accessible to each site.

3. Improve the initial nursing orientation to address the issue of high turnover among nurses. As ILPP suggested to Sheriff's Office staff during a site visit, simply involving the spouses of potential nurse applicants in the orientation process may alleviate the turnover problem as many among the nursing staff could be leaving due to pressure from spouses with a magnified sense of the danger in the correctional setting.

4. Convert some medical staff positions to mental health staff whenever vacancies occur. This can reduce the use of psychotropic medications (discussed later) and bring earlier attention to mental illness problems with fewer inmates having to use sick call or the clinics.

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5 A separate study completed recently for the county recommends closure of the Morgan Street Jail and exploration of the possibility of expanding capacity at the Orient Road Jail (i.e., a one-facility system). In any case, should the county decide to develop the Falkenburg Road Jail site, primary medical services should be consolidated at one site with only the minimal services necessary at all other sites to ensure quality care.

Correctional Health Care Expenditures

Correctional Health Care Expenditures

The 1992-93 annual budget awarded to CMS was $5,351,487. Using a 1992 average daily population of 2,285,[6] this results in a cost per inmate of $2,342.[7] The Sheriff's Office incurs significant additional medical-related expenses for services not provided by CMS, such as non-emergency transportation. In 1992-93, the Sheriff's Office's annual cost for these services was an additional $538,275, thus bringing the county's total annual correctional health care cost to nearly $5.9 million, or a total cost per inmate of $2,577. Hillsborough County's medical cost per inmate is below the adjusted national per capita cost of $2,820.[8]

Table 1
Annual Hillsborough County Correctional Health Care Expenditure

Year	CMS Annual Budget	(% increase)	Non-CMS Cost	# of inmates (ADP)
2/89-1/90	$3,433,404	-	not available	1,988
2/90-1/91	4,238,149	(19%)	not available	1,900
2/91-1/92	4,927,782	(14%)	$472,904	2,156
2/92-1/93	5,351,487	(8%)	$510,275	2,100
2/93-1/94	5,784,957	(8%)	not available	2,200
2/94-1/95 (prop.)	6,167,426	(6%)	-	?

CMS' budget has increased by an average of 10 percent each year from 1989-90 to (proposed) 1994-95. This is in agreement with the average yearly increase nationally.

It must be noted, however, that CMS workload did not appear to rise consistent with the county's rise in expenditures. In fact, the numbers of receiving screens and health assessments performed both decreased from 1990 to 1993 (Table 2). Additionally, there were large, inexplicable fluctuations in the number of clinical and segregation visits, both by nursing and physician staff (Table 3).

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6 February 1, 1992 to January 31, 1993.

7 $5,351,487/2,285 inmates.

8 The National Commission on Correctional Health Care (NCCHC) has not updated its survey of criminal justice health care costs since 1989. According to the NCCHC survey, the cost of health care increased an average of 13.6 percent annually from 1985 to 1989. Based on a conservative 12 percent annual increase, the $1,906 per capita cost nationally in 1989 would be $2,820 for 1993.

Table 2
Total Receiving Screens and Health Assessments, 1990-1993

	1990	1991	1992	1993
Receiving screens	47,392	44,590	44,988	42,409
Health assessments	15,744	15,568	15,504	15,316

Table 3
Total Clinical and Segregation Visits, 1990-1993

	1990	1991	1992	1993
Clinical Visits				
Non-MD	72,721	60,846	31,324	53,495
MD	25,335	16,864	6,140	8,142
Total	98,056	77,710	37,734	61,637
Segregation Visits				
Non-MD	5,391	6,941	17,674	9,843
MD	612	3	128	919
Total	6,003	6,944	17,802	10,762

FINDINGS

1. CMS' budget increased by 10 percent yearly from 1989 to 1993.

2. CMS' workload has not increased correspondent to budget increases, but has in fact, decreased.

3. At the time of this review, Hillsborough County did not keep data on price compositions for CMS contracts (i.e., breakdowns of cost allocations by services/department such as medical or dental).

RECOMMENDATIONS

1. The Sheriff's Office should more closely monitor the CMS medical budget and improve CMS' accountability for personnel and administration costs. The first step would be to examine prior years' price compositions and review the areas where cost is increasing. The table below was proposed by CMS for 1994-95. The actual 1994-95 budget was subsequently renegotiated to $5.2 million (or about 15 percent less) during the course of this study, suggesting the potential for significant

savings in existing medical contracts.[9] ILPP includes below the contract price composition (Table 4).

Table 4
Medical Contract Price Composition for Proposed Year 94-95

Personnel Costs			
Fees/Salaries	$2,560,192		
benefits	397,470		
Malpractice Insurance	172,968		
Federal & State Taxes	121,400		
(additional positions)	114,656		
Administrative Costs			
On-Site	155,648		
Off-Site	371,994		
CMS Profit	307,371		
Performance Guarantee Pool	50,000	*Subtotal*	*$885,013*
Inmates' Health Care Cost			
Medical Expenses	1,545,936		
Medical Supplies	93,136		
Pharmaceuticals	376,655	**Total**	**$6,167,426**

The table breaks down the total budget into personnel, administrative and inmates' health care costs. The Sheriff's Office should require at least this minimum level of detail when considering budget renewals or new bids for a medical contract.

The Sheriff's Office and CMS should begin to compile data to monitor spending, attempting to match as closely as possible the price composition proposals considered in awarding a medical contract. The ability to ask questions regarding line items in the price composition gives the Sheriff's Office a tool to manage health care spending, as evidenced in the reduction of the 1994-1995 budget by $1 million.

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9 The Sheriff's Office has also come to an agreement with Tampa General Hospital to pay a reduced county rate for in-patient care.

Third Party Reimbursements

Third Party Reimbursements

The county and CMS have had an excellent track record of financial reimbursements for CMS medical services from third party payers, alleviating some of the cost burdens on the county. The CMS billing clerk reported that up to 30 percent of inmates have some form of health insurance coverage (e.g., private insurance, SSI, medicare, medicaid, VA/GI coverages or workers compensation).[10] On occasion, health care cost for juveniles was redeemable from parental insurance coverage. In addition, the billing clerk has been able to recover reimbursements from other counties and states for treatment of out-of-county inmates.

As per the county/CMS medical service contract, CMS is responsible for the collection of payments from third party sources. The Sheriff's Office is then credited for 50 percent of all payment obtained by CMS. Following are the amount of third party reimbursements credited to the Sheriff's Office.

Table 5
Third Party Reimbursements Credited to Sheriff's Office

Fiscal Year	Amount
1991-92	$23,368
1992-93	$34,883
Jan.-Oct. 1993	$21,022

The Sheriff's Office is now exploring a policy which solicits reimbursement from inmates for medical care rendered while in a Hillsborough County jail. Rising medical costs may justify policy and legislative changes in order to generate revenue. One correctional medical facility which implemented the policy of charging inmates for medical services demonstrated a reduction in sick call by 50 percent in two years (*American Jail*, July/August, 1993).

Although the reimbursements may be difficult to recover and not administratively cost effective, the potential positive impacts are: a) a reduction in overuse by inmates of medical care; b) a reduction in the number of medical staff; c) the promotion of inmates' self-care responsibility for health care; and d) monetary gain. Copayments or deductibles in community

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10 The Sheriff's Office states that this figure is 20 percent.

health systems have been shown to reduce the number of unnecessary requests for medical evaluation.

Current Health Care Delivery

Current Health Care Delivery

INTAKE & SCREENING PROCESS

At the Orient Road Jail's Central Booking and Intake (the reception center through which all county inmates are admitted), health data collected via interview is entered onto a standardized intake form. The medical staff inquires about specific health complaints, medication usage, drug allergies and medical history, and screens for substance abuse and suicide risk. Necessary treatment and special housing recommendations are noted on the intake form.

This interview method of initial health screening is particularly effective as it can determine the need for appropriate medical personnel (emergency room, infirmary or sick call) and proper housing placement (general population, psychiatric housing, or isolation unit) immediately at booking.

A nurse (LPN) with the supervision of a registered nurse (RN) performs the initial medical screening on newly admitted inmates. Medical staff is available for intake screening on a 24-hour basis.

After booking, newly admitted inmates are held in one of two holding units for one to three days prior to being assigned to a permanent housing unit (unless in need of special housing assignment as noted by the intake screening nurse). Once assigned to a housing unit, an inmate is given a health assessment, which involves a review of the inmate's medical history and a physical examination. NCCHC standards require that health assessments be performed within 14 days after booking.

CMS policies and procedures do not detail the steps involved in a physical examination; ILPP did, however, observe health assessments during a site visit. They are performed in examination areas at the housing units and include:

- Review of initial screening notes and available history;
- Interviewing regarding any existing wounds or other conditions (e.g., pregnancy, communicable diseases, respiratory problems);
- Examining the inmate's mouth;

- Listening to the inmate's heart beat and breathing; and
- Drawing blood for syphilis and tuberculosis screening.

ILPP calculated that CMS performed health assessments on only 33 to 36 percent of inmates between 1990 and 1993.[11] The county did not compile data regarding when the assessments were performed relative to booking date.

Table 6 below shows the percentage of booked inmates released at the time intervals central to health assessments. The table was generated using representative population samples from February and August, 1993.

Table 6
Releases Relative to Health Assessment Eligibility

Released w/in:	3 days	3-14 days	14+ days
February, 1993			
#	1,430	379	781
% of booked	55%	14.6%	30%
August, 1993			
#	1,764	664	1,166
% of booked	49%	18.4%	32%

Data above indicate that roughly half of the booked population is released within the three days required for permanent housing assignment. It is safe to assume that this population does not receive a health assessment. For the rest of the population – roughly 50 percent of bookings – health assessments could be performed (excepting inmates who have received health assessments within the last 90 days).

11 Percentages were calculated by dividing the total number of health assessments by the number of receiving screens performed.

Findings

1. Nationwide surveys have shown CMS' method of initial screening to be particularly effective. An inmate can be triaged[12] to appropriate medical personnel (emergency room, infirmary or clinic) and special housing needs can be determined immediately at booking.

2. Based on the contract and limited available data, CMS does not appear to be performing enough health assessments relative to the number of receiving screens performed. Booking and release data show that 45 to 50 percent of inmates booked are "eligible" to receive health assessments (since they are in jail longer than three days). However, CMS performs health assessments on only 33 to 36 percent of inmates receiving intake screens by the NCCHC deadline of 14 days after booking, meaning many potentially infectious individuals are released without testing for such diseases as tuberculosis and hepatitis, placing both staff and inmates at risk.

3. Inmates housed in infirmary units as a result of intake screening recommendations are not given priority for health assessments. Indeed, it appeared that this group had the least priority for assessments, despite medical indications which warrant special housing assignment.

4. In many observed cases, the assessments are incomplete, or improperly conducted or documented. Below are anecdotes from sampled cases which individually, may be anomalies, but which taken together, point to a need to prioritize health assessments.

   - A patient/inmate admitted to the jail infirmary from Tampa General Hospital with serious injuries was not evaluated by a CMS physician for three days.

   - A history and physical exam performed on a patient in the infirmary by a physician was incomplete. A complete list of current medication was omitted. There was no notation of the clinical diagnosis or a treatment plan while in the infirmary.

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12 Triage is the sorting out and classification of patient-inmate health complaints to determine priority of need and proper place of care.

- An inmate was transferred to the jail infirmary from Tampa General Hospital with bleeding from the nose and head lacerations. No health assessment (history and physical) was done for six days after transfer. There was no discharge summary or transfer note from the physician at Tampa General Hospital, nor was there an admitting or progress note from a CMS physician.

  This omission suggests that a medical evaluation and/or the stabilization of any medical problem had not occurred for six days while the inmate/patient was in the infirmary.

- There were several indications that old medical records (from prior incarceration) were not reviewed during the initial health screening or subsequent health assessment. For example, an inmate initially screened in October, 1992 was noted to have a positive PPD skin test of 13 mm with negative chest x-rays, indicating prior TB exposure but not an active infection requiring prophylactic TB treatment with medication.

  Apparently, the inmate was then released before a medical evaluation could be performed, and TB treatment was not initiated. The same inmate was subsequently incarcerated in July, 1993. During that period of incarceration, the inmate's TB status was again missed by the medical staff. The inmate was again arrested later in 1993, but still had not been identified by the medical staff as a patient requiring TB prophylaxis at the time of this medical record review.

  This case is a prime example of the potential for major public health cost to the free community if infectious diseases such as tuberculosis are not adequately monitored and treated within the correctional facility.

Recommendations

1. Priority should be given to promoting efficient and effective use of health assessments, particularly for inmates who: a) will likely be released before 14 days and b) are at the infirmary or in other special housing. It should be emphasized that health assessments protect not only other inmates, but also jail and health staff, from infectious diseases.

2. Organize health assessments around the following goals:

   - The prevention of transmittable diseases within the facility (to staff and inmates) and in the community (e.g., sexually transmitted diseases, HIV, tuberculosis, hepatitis);

   - The assessment of acute illnesses (e.g., wound infections, bladder infections, acute depression);

   - The stabilization of chronic diseases (e.g., diabetes, hypertension, angina); and

   - The screening for potentially life threatening illnesses (e.g., gastrointestinal bleeding, cancer screening: colon, cervical, breast, prostate and testicular).

3. To improve the attainment of these objectives and more closely comply with the contract and NCCHC standards, ILPP recommends, where possible, the following efforts.

   - Compile Detailed Medical Histories

     For the medical history to be most informative, the health provider should review and cross-check old medical records on the inmate (if available) prior to health assessment. Inconsistency in medical information or lack of detailed medical history can be addressed concurrently at the time of the health assessment to allow for more efficient use of time.

     The detailed medical history should include information on previous medical, surgical and psychiatric evaluations and information on recent health care encounters (e.g., doctor visits, hospitalizations, emergency room visits, injuries and medications). In addition, medical problems previously noted in the record but not properly followed up can be addressed during current incarceration.

     To aid in establishing medical histories, community physicians interviewed for this study recommended that the county design and implement a medical record release form to be used at the time of booking. This form would facilitate timely gathering of any medical

information already existing on the inmate from clinics in the community.

- Perform Thorough Physical Examinations as Required by Standards

  The more complete the entrance physical examinations are, the more valuable they become in providing the introductory profile of the inmate's health status. Where possible, complete physical examinations should be provided for the inmates comparable to community practice during the health assessment process. This is required by the standards and the contract, but it is not done regularly, and when it is done, it is often done incompletely.

  The caselaw calling for community standards and the CMS contract are tied to the standards which define and describe a physical examination/health assessment. These examinations are to be determined by the age, sex and "health needs" of the inmates and are further defined by protocols of "established professional organizations." In this way, the county is paying for exams that are described in Appendix J of the NCCHC standards, but are not followed by CMS.[13] For example, pap smears, pelvic exams, breast exams and rectal exams are specifically mentioned in Appendix J, but are not done by CMS as recommended.

TUBERCULOSIS SCREENING & TREATMENT

Currently, tuberculosis (TB) screening is achieved by means of a PPD skin test during the time of health assessment. Results are available 48 to 72 hours later. For those inmates with positive skin tests, an in-house x-ray machine confirms the skin test, and then treatment begins. Separate housing is provided for inmates with confirmed TB, although existing county detention facilities do not have specialized housing for these cases (e.g., negative pressure rooms).

Additionally, intake medical staff review inmate medical records for prior diagnoses and continue treatment if warranted.

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13 Appendix J is the American Academy of Family Physician Sample Health Assessment Protocol.

Findings

1. ILPP observed a few cases where there were delays in diagnosis and treatment. Generally, however, among inmates with positive PPD skin tests, those with active tuberculosis are sought out aggressively within the correctional facility, despite limited assistance from public health agencies. All positive PPD skin tests are monitored and tracked by the in-house Infection Control Committee (one nurse).[14]

   However, due to the sheer number of cases and the other clinical and administrative responsibilities of the nurse, there is an apparent backlog of patients needing evaluation and treatment.

2. During the initial week, all new inmates (except those determined to be in need of special housing by intake screening nurses) are housed together in two holding units without protective airflow systems. As inmates with tuberculosis are not likely to be diagnosed at intake screening (unless previously diagnosed during a prior incarceration), they may infect other inmates during confinement in the holding units.

3. Interviews and review of medical records indicate that CMS staff do not regularly review prior inmate medical records during intake screening, and thus do not note previous TB diagnoses (see page 16).

4. Many potentially infectious individuals are released back into the community prior to diagnosis or treatment due to the delays and omissions in CMS health assessment procedures resulting in part from understaffing at the Infection Control Committee.

5. Though the PPD system currently used for TB screening meets NCCHC requirements, it is not adequate in a modern correctional setting for the following reasons.

   - The skin test is not administered until the time of health assessment, which occurs at the earliest three days after intake.

   - PPD test results are received 48 to 72 hours after administration of the test, often after an inmate's release.

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14 Since the research for this study was completed, a second nurse has been assigned to the committee.

- The test produces a high number of false negatives.

- If the skin test is positive, an X-ray test is necessary to confirm it, resulting in another delay because although films are available within 24 hours, results may not be available for up to one week (awaiting review of the films by a radiologist).

Recommendations

1. If there continues to be a backlog of inmates requiring screening, continue to increase staffing at the Infection Control Committee so that priority can be given to timely evaluation of inmates for tuberculosis and other infectious diseases.

2. Since TB symptoms are not always easily identifiable, consider screening for tuberculosis earlier, perhaps during intake screening, rather than waiting until the time of the health assessment. This would reduce the possibility of spreading the disease while potentially infectious individuals await permanent housing placement.

3. For inmates released before test results are available, there should be a system of notification, particularly if test results are positive. The Sheriff's Office and CMS, with significant input from community public health agencies, should develop a follow up system whereby the Sheriff's Office forwards test results to the community agency. The community agency could then notify the releasee by letter of the test results and include information regarding treatment options.

SICK CALLS

On-site medical care is provided through a triage/sick call system. According to this system, CMS medical staff (RN/LPN) who are on medication rounds in the housing units confer with inmates who have medical complaints. If the RN/LPN is able to treat the inmate at that time (e.g., by simply giving advice or dispensing OTC medication), s/he does so.

Inmates with problems requiring further evaluation are referred to medical staff at the on-site clinics. There an inmate sees either a nurse practitioner or a physician. If the inmate must see a specialist off-site, the medical staff makes an appointment and the Sheriff's Office transports the inmate to the off-site clinic or office. Should inmates require emergency treatment, they are

transported to the emergency room at Tampa General Hospital. Inmate hospitalization requires approval from CMS headquarters (for non-urgent cases).

The two main county correctional facilities (Orient Road Jail and Morgan Street Jail) have medical coverage 24 hours a day, seven days a week. There are full day clinics with doctors and nurse practitioners five days each week. On the remaining two days, a provider is available to come into the facility for urgent evaluation, thus avoiding emergency room referral.

On-site services and specific procedures include simple suturing, splints, casts and minor surgical procedures. Except for dental, routine OB/GYN, chronic disease and psychiatric services, all other specialty and emergency services are referred to selected outside clinics.

Prenatal services are referred to the Lee Davis Health Clinic at Tampa General Hospital. Routine gynecological services are provided by a GYN trained ARNP (a limited service is also provided by a nurse practitioner midwife, alternating one weekend day).

Findings

1. The combined triage/sick call process at the housing units provides the inmates with increased and expedited access to medical care and personnel. This streamlining of medical services is an efficient method of handling a large number of sick calls with a varied degree of medical problems, from mundane services such as distributing aspirin to more serious medical illnesses such as chest pain.

   However, many of the providers to whom inmates are referred by the "triage RN/LPNs" are critical of improper triaging procedures. Apparently, referrals are made for minor medical complaints, and there is inadequate medical information on the referral slips.

2. It appears that the on-call provider is not always available for urgent evaluation. From a utilization review of Detention Department and CMS data, ILPP found a high utilization rate of emergency room services. The Sheriff's Office explains that ER services are often used during off hours or on weekends, the period when a provider should be on call. (For recommendation, see recommendation #3, pages 32-33.)

3. The lack of needed on-site specialty clinics adds to the cost of off-site transportation and results in less timely evaluation of medical problems (e.g, a two-month waiting period for a dermatological appointment or inappropriate use of emergency room for minor ailments).

4. In some observed cases, the nursing staff displayed a callousness towards female inmates that carried into the quality of care given. This could be one reason that such routine measures as breast examinations and pap smears are not performed routinely although they are in the "essential" category in the NCCHC standards (J-35, p. 43) and are considered among standard medical practices by the American Medical Association and American College of Obstetrics/Gynecology.

Recommendations

1. Develop a procedure for referrals. This procedure should be a training item for all new medical staff; it should also be posted or incorporated into a procedures manual.

2. Review data to determine if there are services which are highly utilized but not provided on-site. Consider opening on-site specialty clinics for these services if it is determined that it is more cost-effective than transporting inmates, utilizing emergency room services and paying for community providers.

3. Physician and nursing staffs should receive periodic training regarding the treatment of female inmates who are at high risk for sexually transmitted and other infectious diseases due to their lifestyles. Training should encompass attitudes and sensitivity towards these inmates and stress the objective of the medical staff in treating the female inmates – namely to identify and prevent the spread of infectious disease and limit the county's liability.

   This forum also provides an opportunity to allow staff to vent frustrations (and thus improve morale) and identify any more fundamental problems which could undermine the overall quality of care.

INFIRMARY UNITS

The Orient Road Jail has a 44-bed infirmary unit which provides IV therapy – usually for hydration or IV antibiotics. The infirmary also provides services for convalescent care, assistance with activities of daily living for disabled inmates, and diabetic monitoring. In addition, interviewees and county data note that the infirmary houses HIV positive inmates, as well as some inmates with communicable diseases (e.g., respiratory diseases or hepatitis).

The Morgan Street Jail has a 16-bed infirmary which is mainly used for females and juvenile inmates. A nurse practitioner and a physician make infirmary medical rounds five days per week and hold sick call five times weekly. Many of the services at Morgan Street infirmary are similar to that at the Orient Road Jail.

Findings

1. There is duplication of service between the infirmary units at Orient Road and Morgan Street.

2. The 200C1 cells at County Jail West (Morgan Street), which house HIV patients, were determined unsanitary and considered a public health hazard by the Director of Nursing and the Infection Control nurse.

   At ILPP's November, 1993 site visit, 30 HIV positive inmates were housed in a unit originally built for 16 inmates. Four double-bunk beds had been placed in the dayroom, drastically reducing leisure time space. Six inmates slept on mattresses on the floor. During site visits, detention personnel reported that these conditions were temporary. However, the QA Committee has made the Sheriff's Office aware of the problem at several meetings, indicating that the conditions are regularly crowded at 200C1.

Recommendations

1. Consider centralizing infirmary services at one facility.

2. Without clear medical indication, discontinue separation of HIV positive inmates. There is no legal or medical rationale for such separation which results in crowded and unsanitary conditions.

PHARMACY SERVICES

Since July 1993, the pharmacy services at the correctional facilities have utilized a prime vendor service agency. An amount of $9.75 per inmate per month is currently allocated for pharmaceutical cost. An established pharmacy and therapeutics committee provides a mechanism for adding and deleting medications from the formulary and sets policies on medication administration procedures and treatment protocols.

The pharmacy is computerized and maintains patient profiles to monitor drug interactions, allergies and contraindications. The pharmacy also reviews utilization data for prescribing practices, tracking monthly formulary and non-formulary medications, and monitoring pharmaceutical costs. This method allows for a mechanism to: double check an order prior to administration, maximize efficiency and reduce future escalation in pharmaceutical cost. In fact, there is an apparent reduction in nonformulary expenses from $12,000 a month to $8,000 a month since the initiation of its service.

An in-cell medication program has been initiated recently on certain medications, primarily antibiotics. This method insures that the inmate receives the full course of treatment, even when away from the housing unit, or if the inmate is released prior to completion of the course of treatment. The in-cell medication program promotes self-care, reduces staff-time required for drug administration and limits abuse of sick call.

The pharmacy also maintained statistics on the daily volume of prescriptions.

The pharmacy service is now exploring the unit dose method of drug delivery. In addition to reducing medication errors, the unit dose method of drug delivery will reduce costs by virtually eliminating the need to dispose of unused medications and by decreasing the need to purchase a large inventory of drugs. This program also results in fewer medications reaching the expiration dates and thus needing to be destroyed.

Currently, inmates are required to seek services from medical personnel to receive over-the-counter (OTC) medications that are only marginally medically related (e.g., antacids, tylenol/aspirin, cough drops).

Findings

1. The pharmacy system has been steadily improving its cost effectiveness. Pharmacy staff appear to be proactive in looking for ways to make service more efficient without sacrificing quality of care.

2. It appears that inmates have a high utilization rate for psychotropic medications. Medical statistics from 1993 show an average of 228 inmates per month (11%) were on psychotropic medications. Normally, a maximum of five percent of the total inmate population should be on psychotropics and prescription analgesics combined.[15] This high rate and staff comments such as "inmates get what they ask for" suggest that there may be inadequate treatment and activities programs.

Recommendations

1. The inmates should be able to purchase OTC medications on their own via the commissary to treat headaches, common colds, heartburn or constipation in much the same manner as one would purchase bandages, shampoo or cosmetics.

   Other correctional facilities have had success with placing certain OTC medications in the housing area so that they are readily accessible to inmates. Making OTC medications readily available enables inmates to be responsible and to participate in self-care, and to receive relief from minor physical ailments leading to better use of medical resources.

2. Increase monitoring of the use of psychotropic and analgesic medications. Data should be available to determine how many inmates per day are on these medications; the percentages should be reviewed against inmate medical records to determine appropriateness of prescriptions.

3. Conduct research on existing mental health programming among correctional institutions. Such programming could provide an alternative to medicating inmates.

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15 Juvenile and Criminal Justice International, Survey Report of Accredited Correctional Health Care Systems.

HOSPITAL ADMISSIONS AND DISCHARGES

As mentioned earlier, the utilization of hospital admissions needs prior approval from CMS headquarters in non-urgent cases. Inmates approved for hospitalization are transported by Sheriff's Office staff to Tampa General Hospital.

Findings

1. Remote decision making on such matters as hospitalization hampers CMS management.

Recommendations

1. Staff who are most knowledgeable about inmate problems should be able to make decisions regarding treatment. Thus, the Sheriff's Office should re-examine CMS policies which center major decision making at out-of-state headquarters rather than with on-site administrators, focusing on the medical staff's goals of appropriate and timely treatment.

2. Maintain a monitoring system to promote quality care and reduce medical expenditures. The following are components of such a system.

    - **Quality Assurance.** Randomly selected reviews of previous hospital admissions should be performed for acute hospital placement, medical emergencies and elective hospital admissions. In particular, emergency admissions requiring 911 or ambulance transport should be evaluated to identify avoidable emergency cases and determine whether a proper chain of events occurred prior to transport.

    - **Utilization Review.** This is an evaluation of whether any randomly selected hospital admissions could have been avoided or whether the length of stays of particular hospital admissions could have been shortened. In many cases, shortening hospital length of stay and decreasing hospital admissions can be accomplished simply by increasing confidence in correctional medical facilities. In-jail staff can thus be assured that quality care can be provided in the corrections setting, leading to less reliance on hospital services; similarly, hospital staffs confident in jail medical facilities are more likely to release inmates at the earliest appropriate moment.

The Sheriff's Office and CMS should consider inviting community medical providers on an annual tour of the jail infirmary as a first step towards gaining this confidence.

- **Promote Early Discharge.** Average length of hospital stay has not changed dramatically in the past three years. CMS should investigate and establish methods to promote early discharge of inmates from hospitals whenever possible.

  Below are methods which would promote early discharge from the hospital thereby decreasing inpatient hospitalization cost:

  - Active participation in hospital rounds by CMS physicians or nurse practitioners;[16]

  - Encouraging CMS physicians to resume the responsibility of admitting inmates to Tampa General Hospital for medical admissions.

  - Encouraging subspecialists to make rounds at the facility's infirmary units upon hospital discharge (thereby paying specialists for medical services and reducing payment to hospital).

  - Arrange and re-negotiate contracts for medical services with subspecialists in the community and with Tampa General Hospital. Volume contracts with a guaranteed large number of inmates as potential patients may offer better rates than are currently available. The Sheriff's Office is currently undertaking some of these efforts and should be commended.

CONTINUITY OF CARE

ILPP conducted telephone interviews with providers in the community who also directly or indirectly provide medical service to inmates. These interviews identified additional areas in need of improvement. Although the community health care providers agreed in part that many of the hospital

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16 The Sheriff's Office notes a possible conflict of interest if CMS physicians provide services at Tampa General Hospital to jail inmates. However, ILPP sees no reason for concern on this issue.

admissions from the correctional facility are unavoidable, they noted some practical measures which could be modified or enforced for operational efficiency and improvement in quality of health care without additional cost. These are set forth below with recommendations.

1. Improve verbal and written communications between the hospital/subspecialty clinic and the correctional facility. All inmate transfers to the emergency room (ER) or hospital admissions from the jail (or vice versa) should be accompanied by a parallel courtesy telephone call to the on-duty physician to discuss case management. In addition, the transfers should be accompanied by detailed transfer summaries from the physicians or nurse practitioners, initial laboratory workup, problem lists, medication lists, discharge plan and a working diagnosis which will aid in the continuity of care in the receiving facility.

   This procedure may currently be called for in CMS or Sheriff's Office policies. ILPP interviews and medical record review, however, demonstrate that the policy is not consistently followed. Additional training for new medical staff and "refresher" courses for permanent staff may help alleviate the problem.

2. Review previous ER admissions to identify unnecessary utilization of hospital services. Providers interviewed noted that inmates were seen in the ER for such routine procedures as suture removals, acute pharyngitis (sore throat) or orthopedic X-rays which do not require urgent evaluation. Periodic communications (via quarterly meetings) with the ER director, hospital admitting physicians, or subspecialty physicians would help monitor wasteful utilization of medical services.

3. Community physicians who are subcontracted by the CMS to admit inmates to the Tampa General Hospital are often not reachable by the hospital staff. Although CMS pays subcontractors for services provided in the hospital, much of the patient care is performed by the medical or surgical service teams which consist mainly of physicians-in-training. In essence, the county pays twice for the same service: once to the CMS subcontractor and once to Tampa General Hospital.

   CMS should consider contracting directly with Tampa General Hospital's Medical and Surgical Department to admit patients from the correctional facilities rather than utilizing its current subcontractors. This arrangement is beneficial to CMS, the hospital and the inmates. CMS

and the county would save money and be able to depend on medical providers being present and m ore accessible at the hospital. The hospital's teaching departments receive additional revenue for their staff as well as benefit from the educational experience. The inmates benefit from the attentive care provided by the physicians-in-training who often are available in the hospital on a 24-hour basis.

4. An alternative to the above arrangement is to consider renewing hospital privileges for Dr. Marlowe and Dr. Encarnacion.[17] Encouraging CMS providers to admit inmates to the Tampa General Hospital will alleviate miscommunication, decrease overall provider costs, improve continuity of care, facilitate early discharge from the hospital to the correctional facility and provide accountability of services rendered outside the facility.

5. County health care dollars spent in correctional medical services are "wasted" to some degree without proper medical follow-up care in the community. In terms of communicable disease, the financial and human cost to the community is enormous.

   Thus, the county and CMS should work more closely with community health clinics for follow-up care for inmate patients. Many health centers have shown enthusiasm for integrating corrections and community medical services as they often provide services to the same patient population as the county's correctional system. Below is a list of some community health clinics.

   a. Dr. Toni Mitchell, Director of Emergency Room, Tampa General Hospital, (813) 251-6911.

   b. Dr. Mark Lorenzo, Medical Director, Family Care Medical Clinic, (813) 239-1186.

   c. Dr. Penzell, Rushkin Migrant Health Clinic, (813) 845-4681.

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17 The Sheriff's Office states that such an arrangement does not now exist due to concerns over conflict of interest. It is not clear, however, what conflict granting admitting privileges would create. Clear explanation of any potential conflicts should accompany estimation of cost savings possible through elimination of duplicative, delayed and superfluous administrative procedures in making an overall determination to implement this recommendation.

d. Bea Dreier, Executive Director, Judel Christian Coalition, (813) 879-5964.

e. Dr. Lewis Meranda, Department of Public Health, Hillsborough County Public Health Clinic, (813) 272-6300.

f. Mr. Clark, Executive Director, Hillsborough County Medical Association, (813) 253-0471.

g. Dr. William Wood, Medical Director, Psychiatric Services, Tampa General Hospital, (813) 972-7075.

CONCLUSION

The local jail system constitutes one of the most important elements of the county health dynamic. Many reasons account for this, including the fact that a local jail population is constantly cycling in new inmates while releasing old ones. Jail facilities, which house in close quarters a typically high risk population for many infectious diseases such as hepatitis, tuberculosis and AIDS, thus carry the potential of exposing tens of thousands (over 50,000 people were booked in 1993) of people each year to these health hazards and then returning them to the community.

The effectiveness in managing exposure and contagion in a jail has a direct correlation with the presence of these diseases in the community. Conversely, limiting contagion and providing effective treatment in the jail and in the community produce significant cost savings for correctional and community health agencies. It is in this way that the medical services provided in jail are inextricably linked with an impact on the larger public health system and vice versa.

The Sheriff's Office has had, to some degree, awareness of and relationships with the community organizations listed above. There is, however, no working relationship or professional familiarity between these offices and the Detention Department which would facilitate the ability of these agencies to work as effectively as possible in creating and implementing a county-wide public health strategy. Interaction should be aggressively sought so that the public health burden is proactively and creatively managed and correctional medical costs are kept at a reasonable level over the long run.

Utilization Review: CMS Medical Data

Utilization Review
CMS Medical Data[18]

Hillsborough County-CMS claims activity for 1993 include information on the provider names, claims numbers, diagnostic codes (ICD9), diagnostic descriptions, and types and dates of service.

Aside from services required for chronic renal dialysis, orthopedic services were the most utilized off-site subspecialty service for the HC-CMS. Thus, for the purpose of simplifying the health care utilization data, only the diagnoses related to orthopedic services were selected for review. Although the budget for this portion of medical service was requested, it was not made available.

The following important facts emerged upon review:

1. There were 143 all-cause emergency room visits to the Tampa General Hospital listed in the 1993 HC-CMS claims data.

2. 49 of these claims were orthopedic cases.

3. Of the 49, only 5 cases required hospitalization, with 2 cases having a length of stay less than one day.

4. Only 9 of the 143 cases required emergency transport by the AM STAT Medical Transport Service (provided by CMS). The rest of transport duty was handled by the Sheriff's Office.

The question arises: Were these orthopedic injuries truly urgent enough to require emergency room care or could any of the orthopedic evaluations have been deferred to the next medical or orthopedic clinic? According to the Sheriff's Office, in many cases, the injury is a broken bone; the inmate must be taken to the emergency room, but emergency transport is not warranted.

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18 January to August, 1993.

Data further revealed that:

1. There were 75 HC-CMS visits to the Tampa General Hospital-Subspecialty Clinic during the same eight-month period.[19]

2. Most of the services were provided by physicians-in-training, resulting in zero to minimal claims for (more costly) physician services.

3. There were 57 ER physician service claims from Emergency Associates for Med (Tampa General-ER physician group) compared to 17 physician service claims from University Medical Service (Tampa General-Subspecialty Department) for orthopedic services provided in the emergency room and/or hospital.

FINDINGS

1. There was a high volume of orthopedic injuries during the period studied.

2. Treatment for these injuries is provided at the Tampa General Hospital Emergency Room with transportation provided by the Sheriff's Office.

3. Some orthopedic cases were also treated at the Tampa General Hospital Subspecialty Clinics at a lower cost to the county.

RECOMMENDATIONS

1. The high volume of orthopedic cases and resultant needs for inmate transportation and ER visits suggests it may be cost-effective to develop plans for an on-site orthopedic specialty clinic.

2. Alternatively, the county should explore the cost effectiveness of increasing use of the Tampa General Hospital Subspecialty Clinics.

3. CMS may also consider subcontracting with an orthopedist[20] who can go to the jails to evaluate injuries and perform triage duties (that is, to determine whether to defer the inmate's problems to the next clinic, to

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19 January to August, 1993.

20 If current CMS physicians are confident in managing orthopedic cases, CMS may not need to hire an additional orthopedist.

cast immediately in the jail, or to transfer to the hospital for admission). Having an orthopedist on-staff would eliminate transportation costs, ER visits and of-site physician cost.

In addition, since the correctional facility has its own x-ray machine, the x-ray technician should also be on-call during off hours for emergency cases, thus eliminating the need to transport an inmate to Tampa General Hospital for evaluation.

4. This utilization review of orthopedic services suggests that a further in-depth review of all other off-site medical services is necessary to evaluate cost and service efficiency.

Utilization Review: HCSDD Medical Data

Quality Assurance

Quality Assurance of Medical Services Delivery

EVALUATION OF MINUTES FROM THE 1993 QUALITY ASSURANCE MEETINGS[22]

CMS has an established Quality Assurance (QA) Committee, in accordance with NCCHC standards, which is designed to monitor and evaluate the delivery of health care to the inmates.

ILPP reviewed the QA Committee meeting minutes from January to September, 1993. Following are findings and recommendations for improving the overall function of the committee.

FINDINGS

1. In general, there was variability in the extent of participation from various clinical services. Most notably, there was a complete lack of participation from the Sheriff's Office and the CMS program administrator only attended twice during the nine-month period reviewed.

   The result of poor representation and attendance is that medical service problems raised in QA meetings are not adequately communicated to respective clinical departments, and timely corrective measures are not initiated. For example, lack of proper documentation in medical records (e.g., medications, allergies, diagnosis and treatment plan), improper filing of laboratory results and inefficient triaging of medical requests were issues that had been repeatedly raised in several QA meetings without successful resolution over several months.

2. The Infection Control nurse should be commended for her active participation in the committee. ILPP notes that she consistently communicated problems to the committee, initiated internal audits,

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22 While these minutes are taken from confidential meetings, a summary of issues is presented here per NCCHC standards which state, "Periodic reviews by outside groups such as grand juries, public health departments and county medical societies undertaking peer review may be included in the quality assurance program." (NCCHC, Standards for Health Services in Jails, 1992)

examined problem sources and provided timely progress reports to the committee.

RECOMMENDATIONS

1. The QA Committee should involve the active participation of representatives from the Sheriff's office (e.g., medical services director), CMS administrative staff (e.g., program administrator, director of nursing, the medical director), and health care providers from other clinical services (e.g, medical, midlevel practitioners, nursing, dental, mental health, pharmacy, radiology, infectious disease control and medical record). At a minimum, the permanent membership should include the Sheriff's medical service director, the CMS medical director, the CMS program administrator and the CMS director of nursing. The QA Committee should meet monthly as is currently being done.

2. Participation in Quality Assurance Committee meetings should be mandatory. All who attend the meetings should have decision making power so that issues brought up at the meetings can be resolved in a timely manner.

Corrections Impact on Public Health

Corrections Impact on Overall Public Health

The Hillsborough County detention system is one of the most important points in the public health spectrum. This is true for three reasons. First, the inmate population is composed largely of indigents and others who neither have health insurance nor practice preventive health care, and in fact, tend towards high risk behaviors. Second, the length of time spent in the local jail system is generally very brief, which means there is a heavy and frequent turnover of high risk people through the jail's doors and back into the general population.

Third, a visit to the jail's physician could easily be the first contact an inmate has with the medical profession. Furthermore, the medical treatment received in jail is likely to be the best and most regular medical attention the average inmate experiences. Thus not only does the jail system take in and release that segment of our overall population which poses the highest risk to public health, but **the jail system is likely to be the best and perhaps the only opportunity to identify, quantify and minimize this risk.** The Hillsborough County detention system therefore acts as a screening agency for the overall public health system.

Current national standards for correctional health care, however, are geared toward minimum health needs of inmates and do not address the context of public health and the major impact the jail population inevitably has on it. This raises the following questions:

1. Is it the responsibility of the local correctional system to address issues of public health?

2. Is it the responsibility of the local correctional system to bear any of the costs of an overall public health strategy?

The local correctional system by definition is addressing public health issues in every decision it makes in the area of correctional health care and is also therefore bearing some of the public health cost. ILPP's recommendations throughout this report to increase the participation of the correctional medical system in the planning and coordinating of a county-wide public health system aim to maximize cost-efficiencies in the expenditures that already occur.

If an inmate with tuberculosis is released from the jail before correctional medical personnel have received a test result, before treatment is initiated or without alerting public health agencies, then the opportunity to eradicate the disease at the earliest and least costly moment is lost, and the value of ever having initially screened for TB with it. This is only one example which expands on previous coverage of TB in this report.

In other words, the dollars that the county **already** spends on correctional health care could produce more value, if they were managed in conjunction with the public health agencies outside of the correctional health care system. The ability to create continuity of care from the point of booking through release and into the general population will save the jail system money in even the short term, given a low average length of stay and high recidivism rates.

The Hillsborough County Sheriff's Office medical personnel have long recognized the importance of the jail's link in the public health chain and continue to identify ways of strengthening it. In order to realize the major cost savings possible in coordinating similar but dispersed efforts, however, the Hillsborough County correctional medical system must evaluate all of its policies and procedures not simply in light of complying with applicable standards but in the context of overall public health and a community standard of care.

Appendix

Candice Chin Wong, M.D., M.P.H.

Training

1991	MPH, Epidemiology, School of Public Health, University of California, Berkeley
1986 - 1989	Internal Medicine Residency, Pacific Presbyterian Medical Center, San Francisco, California
1986	M.D., George Washington University, Washington, D.C.

Awarded honors in:

- Clinical Cardiology
- Primary Care Medicine
- Obstetrics and Gynecology
- Internal Medicine-Sub internship
- High Risk Obstetrics, Los Angeles County/University of Southern California Medical Center
- Pediatric Infectious Diseases, Children's Hospital of Bangkok, Thailand

1982 B.S., Physiology, University of California, Berkeley

Recent Employment

1993 - present	Assistant Adjunct Professor, School of Nursing, University of California, San Francisco
1991 - present	Clinical Physician, University Health Service, Cowell Memorial Hospital, University of California, Berkeley
1989 - present	Senior Medical Consultant, Institute for Law and Policy Planning, Berkeley, California. Assess correctional health care delivery. Evaluate areas of inefficiency and recommend improvements. Recently completed correctional medical services assessment and evaluation study for Orange County Division of Corrections, Florida. Currently completing similar study for Hillsborough County, Florida.
1989 - 1990	Teaching Faculty, Pacific Presbyterian Medical Center, San Francisco, California. Directed ambulatory medicine training for house staff.
	Primary Care Physician, Senior Citizens Community, Mill Valley, California.
	Primary Care Physician, Pacific Heights Medical Group, San Francisco, California.

Publications Submitted

Wong CC, Ragland DR, Syme SL. Evaluation of gender differences in coronary angiographic outcomes.

Publications In Preparation

Wong CC. Physical activity and pregnancy outcomes.

Presentation

Wong CC, Ragland DR, Syme SL. Evaluation of gender differences in coronary angiographic outcomes. Conference on Cardiovascular Disease Epidemiology, American Heart Association. Memphis, Tennessee, March 1992.

Awards and Fellowships

1990 - present	Post-Doctoral Fellowship, 1990-1993, Cardiovascular Risk Factors Research/Health Services Research
1990 - 1991	Research Training Fellowship, National Heart, Lung and Blood Institute, National Institute of Health, 1990-1993.
1988	Pathology Department House Staff Recognition Award, Pacific Presbyterian Medical Center.
1985	Rueland Tropical Medicine Fellowship. Consulted with Southeast Asia refugee medical centers.

Memberships

Physicians for Human Rights
California Medical Association
Kane-King Obstetrical Honor Society

Languages

Chinese (Mandarin, Cantonese, Hakka), Thai, Burmese

Joseph Rowan

Education

1954	Masters in Social Welfare, University of California, Berkeley.
1950	Masters in Correctional Administration, University of Notre Dame, Indiana.
1948	BA in Penology, San Jose State University, California.

Experience

1984 - present	Director/Chair, Juvenile and Criminal Justice International (JCJI), Roseville, Minnesota. Provide surveys, consultation, master plans, staff training, expert witness testimony, pre-architectural planning/consultation, and administer institutions on a temporary basis. Recently completed correctional medical services assessment and evaluation study for Orange County Division of Corrections, Florida. Currently completing similar study for Hillsborough County, Florida.
1981 - 1984	Vice President, American Health Care Consultants/National Commission on Correctional Health Care, Chicago, Illinois. Worked with national agencies devoted to improving health care in criminal and juvenile justice facilities through consultation, surveys, training and standards implementation/accreditation (jail/prison/juvenile surveys).
1975 - 1981	Director, American Medical Association Health Care in Correctional Institutions Program. Directed a national project to upgrade health care and standards in adult and juvenile detention-correctional institutions and to develop a system of national accreditation. Conducted surveys of many jails, prisons, and juvenile facilities.
1973 - 1975	Director, Florida Division of Youth Services. Responsible for administering a 67-county intake, detention, probation/aftercare, delinquency prevention, court consultation and correctional institutions program for offenders committed to state custody under age 18. (Voted best juvenile justice system in the U.S. in national survey, 1975).
1967 - 1973	Executive Director, John Howard Association, Chicago, Illinois. Directed organization emphasizing criminal and juvenile justice, master plan work, consultation to architects, citizen involvement and public information. (Voted best managed of 61 Chicago Community Fund agencies, 1971).

1962 - 1966	Chairman, Youth Conservation Commission (paroling body) and Deputy Commissioner of Corrections, State of Minnesota. Administered/supervised probation and parole services in 84 counties and seven state correctional institutions, including two for young adults to age 25 (one maximum, one minimum security).
1955 - 1962	Consultant and Western Director, National Council on Crime and Delinquency. Supervised organization, staffing and administration of five state councils on crime and delinquency and survey-consultation work in overall criminal/juvenile justice field.
1941 - 1955	Jail/Detention Officer/Supervisor, Probation and Parole Officer. Adult/Juvenile, Medical/Mental Health Social Worker, Army Military Police/Stockade/Criminal Investigation and Counter-Subversive.

Surveys / Master Plans

Conducted and/or directed surveys of health care or total system of over 280 jails, 155 prisons, 55 juvenile detention facilities, 55 juvenile correctional facilities, 20 hospitals (medical and/or mental health); directed 14 county and 19 state master plan studies. Foreign facilities: England, 11, Puerto Rico 22, Australia 3, Canada 1, New Zealand 4, China 5, Russia 4.

Training

Conducted training for over 800 federal, state, county, city and foreign detention/correctional facilities/agencies in a variety of subject areas, usually awarded a rating of "outstanding/excellent." Specialties: Suicide prevention; professionalization of staff, mental health and administration/supervision.

Expert Witness Experience

Since first being recognized as an expert witness in 1967, have served in that capacity over 300 times in federal, state and foreign courts. In four cases was selected by attorneys from both sides to survey conditions alleged in the lawsuits. Was expert witness on winning side in four landmark cases: Federal District Court denial of inmate suit for non-smoking cell block; two jail suicide jury trials involving $1,000,000 and $1,900,000 judgments; and a prison $4.9 million structured settlement, largest in history. Upon request, testified before committees of Congress three times.

Membership and Honors

American Correctional Association (ACA) Board Member, 1969 - 1971.

Commission on Accreditation for Corrections, ACA; Charter/Elected Member, 1974 - 1980; helped develop all adult/juvenile standards/accreditation program.

American (now International) Association of Correctional Officers, Board Member, 1980 - present; was volunteer executive director for four years.

Former national committee member; American Bar Association; Child Welfare League of American; American Public Welfare Association.

Suicide in Jails Advisory Committee, National Center for American Indian and Alaska Native Mental Health Research.

American Association of Correctional Officers, Distinguished Service Award, 1983.

American Jail Association, 1986: "The Joe Rowan Small Jail Administrator of the Year Award," in perpetuity.

Who's Who Among Human Services Professionals, 1986 - 1992.

American Friendship Award for work with minorities.

National Juvenile Detention Association outstanding service award, 1990.

ACA, E.R. Cass Award for outstanding service, 1992.

Publications

Author of numerous monographs, manuals, articles for American Jail Association, American Correctional Association, National Sheriff's Association, National Institute of Corrections, American Medical Association, International Association of Chiefs of Police, International Association of Correctional Offices, Council of State Governments, National Council on Crime and Delinquency, National Council of Juvenile and Family Court Judges, Encyclopedia of Social Work, Encylopedia of American Prisons, and Encyclopedia Britannica. Eight of the major national documents were firsts of their kind. In 1988 - 1991, was primary author of one and sole author of three national training manuals on suicides in custody.