THE LEGISLATURE — STATE OF NEW YORK

Legislative Commission On Expenditure Review

State Prison Inmate Health Services

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Program Audit
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SUMMARY AND CONCLUSIONS

Since 1974, state inmate health care delivery systems have been increasingly under legal challenge. In seven states, prison health care was found constitutionally "impermissible," and the courts have ordered systemwide improvements.

In New York's first major challenge, Todaro v. Ward, medical care at a single institution--the Bedford Hills Correctional Facility--was declared unconstitutional. Another case, Milburn v. Coughlin, originated in Green Haven, and was in litigation during 1980. But at any moment, more than 100 cases could be pending against New York State's prison health care system.

Court ordered improvements to prison health care in New York and other states have been mandated despite those states' financial conditions. And New York's correctional system, in many ways a model of penal reform, must resolve opposing forces: economy and efficiency of operation, and the demand for improved health care stemming from inmate law suits.

It is recognized that when there is a crisis of prison overcrowding, correctional management priorities may be focused elsewhere than in the health system. But the costly potential of adverse judicial decisions on systemic health care also requires priority attention by both the Administration and the Legislature.

There are 33 correctional facilities in New York State, overseen primarily by the Department of Correctional Services (DOCS). In 1979-80, the State spent $33.5 million to provide health services to an average 20,403 inmates, or $1,644 per inmate. Employee fringe benefits would add $8.9 million, or $435 per inmate, to this amount.

LCER staff visited 13 correctional facilities, and reviewed the medical records of 379 inmates for the period May through July 1980. It was found that each of these facilities had a health service unit; all health personnel were licensed, with current registrations; all health service units were generally staffed 24 hours per day in maximum and medium security facilities, and part-time in minimum security facilities. But LCER also found many inadequacies and inconsistencies in both the delivery of health care services to inmates and the administration of inmate health care programs.

Inmate Health Care Delivery

Statute requires that the physical, mental and emotional condition of each inmate entering the correctional system be evaluated by DOCS to determine the inmate's appropriate correctional placement. It was found that all facets of this initial evaluation were not always performed, because DOCS lacked a central system or procedure for classifying inmates.

Inmates were not completely aware of available health care services. Contrary to national standards, DOCS did not inform inmates orally or in writing of its health policies and procedures.

There was wide variation in the utilization of inmate health care services at the institutions visited by LCER staff. Two-thirds of the inmates in the LCER survey did not use inmate health services while about 18 percent drew heavily on those resources.

In general, inmates had access to health services through facility health service units. In non-emergency situations, access to health care was through sick call, with nurses screening health problems to determine priority and level of treatment needed. Hours of sick call varied, however, with two facilities failing to meet the minimum standard. Outside of sick call, access to health care was at the discretion of the corrections officer (CO).

Staffing of health units differed greatly from institution to institution. But inconsistencies were not related to need, as the following example shows:

Institution	Population	Physician Hours Per Week
Elmira	1,521	55
Attica	1,786	15
Auburn	1,583	40

There was a high percentage of vacant health positions. Almost 29 percent of DOCS full-time physician positions were vacant as of October 6, 1980. DOCS' difficulty in recruiting and retaining qualified physicians has been said to result from low salaries, inflexible work-week and pay packages, and the negative aspects of working in a prison.

The high rate of vacant health care positions means that inmates sometimes are used to provide health services, and COs used to administer medication--contrary to national recognized health care standards.

Medical records, generally accepted indicators of health care quality, were not always found in order. Sometimes records were not available at the initial inmate screening, and, therefore, could not be notated. In other instances, required health history or physical information was not filled in on records. And about 20 percent of required laboratory tests were not given.

Though inmates over 40 years old are required to receive physical exams annually, and younger inmates biennially, 24 percent of these periodic physicals were overdue, some by four years or longer.

Inmates' case management was insufficiently detailed, and follow-up was discontinuous.

The State's five-year-old medical fee schedule impeded the establishment of specialty clinics at correctional facilities. On-site services would be less costly than the alternative off-site services requiring the transportation of and security escort for inmates.

State Program Administration

DOCS is charged with "[Providing] for health and safety of every person in custody." The State departments of Mental Hygiene, Health and Education as well as the Commission of Correction and the Health Planning Commission also have statutory responsibility for the health care of inmates.

Department of Correctional Services

DOCS provides inmate health care through its central office Division of Health Services (DHS). But the priority accorded inmate health care has varied. A 1973 plan to develop central office leadership and oversight of inmate health care was implemented, but then abandoned in 1977, with the expiration of federal funds. Strong medical leadership, professional staff development, health services advisory committee oversight, management information system and program evaluation efforts were discontinued or de-emphasized. During 1980 DHS again developed its central office capacity to plan, monitor and control inmate health services.

DHS's management role is subject to modification, given changes in DOCS leadership or direction. However, fluctuation in the priority given inmate health care can result in unavailable or uneven inmate health care which, in turn, may stimulate lawsuits.

Oversight of facility environmental health was divided between two units in DOCS. This created problems in assuring compliance with DOH food service recommendations. DOCS also has not followed up on facility compliance to DOCS directives:

DOCS Standard	Percent of Facility Compliance
Food Service Reports	73
Food Service Inspection	5
Housekeeping Inspection	8
Fire & Safety Committee	13
Health & Safety Audit	33

Department of Mental Hygiene

Inmate mental health care was transferred to the Department of Mental Hygiene in 1977; its Office of Mental Health (OMH), Bureau of Forensic Services provides mental health services at the correctional facilities through seven satellite centers, seven non-satellite health units and the Central New York Psychiatric Center (CNYPC).

OMH's budgeting, accounting and management information systems were not providing adequate program information or expenditure, staffing and program workload data which might allow cost effectiveness comparisons among satellite center or other units.

Contrary to Commission of Correction recommendations, OMH had not yet promulgated a standard satellite center procedure manual. Nor had the bureau required satellite centers to review and evaluate their own facilities, procedures and staff performance. However, a joint OMH-DOCS review and evaluation of the satellite unit was initiated July 1980. The report was not available as of March 1, 1981.

Difficulties in OMH-DOCS coordination were apparent. First, because satellite and health records were separate, information in one chart may not have been available to providers using the other chart. This situation led to inappropriate treatments documented in Commission of Correction mortality reviews. Second, inmate psychiatric clients had been transferred without notifying satellite units, and with loss of continuity of care--again documented by the Commission. Both difficulties were discussed in joint OMH-DOCS meetings, and an agreement is anticipated in early May. (See OMH response.) Not under discussion, however, is DOCS unilateral closing of the Attica satellite center inpatient ward. According to OMH officials, this closing led to a decline in OMH service at Attica and other satellite units.

Department of Health

DOH has broad authorization to monitor environmental health conditions at the 33 facilities. Its inspections focus on narcotics control, x-ray machines, and food service areas.

LCER staff inspections indicate that improved surveillance of environmental health conditions is needed. Based on compliance with DOCS requirements, facility environmental health monitoring, housekeeping, and fire and safety committees are not functioning as intended.

Commission of Correction

Empowered to oversee the entire State and local penal system, the commission's supervision extends to inmates' physical, mental and environmental health, is to be exercised through inspections, responses to inmate complaints, investigations of conditions leading to inmate mortality, promulgation of inmate health standards and evaluation of inmate health care delivery systems. However, the commission is a reactive body, whose involvement in inmate health care is generally initiated by inmate deaths, complaints or grievances. And despite statutory authority, the commission has not promul-

gated standards of inmate health care or initiated a program to evaluate the quality of that care.

State Education Department

The department performs a limited role through two of its units: (1) the Office of Vocational Rehabilitation which furnishes health and rehabilitation services to inmates, and (2) the State Board of Pharmacy, which oversees pharmacy operations at the correctional facilities.

LCER found that pharmacy inspections have not regularly occurred, with long lapses between inspections at some prisons.

State Health Planning Commission

The commission is mandated to review all State agency plans relating to provision of health care; however, the commission has not required such plans for DOCS and OMH, nor has it included the State's correctional facility inmates in State planning endeavors. By omitting State prison inmate health needs, the commission is not taking account of the drain on community health resources by inmate health care, nor is it providing alternatives for improving health care services in State correctional facilities.

Financing Inmate Health Care

DOCS inmate health care expenditures in 1979-80 were $14.0 million or approximately $687 per inmate. When security costs, fringe benefits, and the expenditures incurred by other agencies--OMH, the Office of Mental Retardation and Developmental Disabilities, DOH, the State Education Department and the Commission of Correction--are counted, it is estimated that the State spent more than $42.4 million in 1979-80, or an average of $2,079 per inmate for the 33 State correctional facilities. LCER found that each 1979-80 dollar spent by the State was distributed as follows: 50 cents for direct inmate health care; 27 cents for security, 21 cents for fringe benefits and two cents for administration and oversight.

Accurate and complete financial and performance data are not available in the absence of an integrated program budget to identify inmate health expenditures made by DOCS, and by other State agencies. The development of such a budget would allow the Legislature to decide the financial priority of inmate health care and would allow the measurement of program accomplishments in the future.

Conclusion

Inmate health care in State correctional institutions was found wanting when measured against nationally accepted standards for inmate health care. For example, the 13 correctional facilities visited by LCER staff met standards for health care in only 86 of a possible 208 cases. (See Exhibit I, Chapter II.) While medical care in all State prisons is available through health care units, inmates often experienced delays in obtaining physical examinations and other types of non-emergency care. In some respects, inmate health care may be no different than the medical services available to many citizens in the community. However, this audit also found that inmate health records, generally accepted indicators of health care quality, often did not contain required physical information or complete health histories.

Insufficient attention has been given to the planning, organization, management and oversight of State prison inmate health services. The result is an inefficient system which costs almost $2,100 per inmate to operate. Constant pressure of inmate lawsuits may force an upgrading of health care, perhaps based upon judicial rather than legislative standards. On the other hand, innovative program management and oversight may result in more effective distribution and use of inmate health care resources.

Findings for Comment by New York State Agencies Reviewed

Chapter 58 of the Laws of 1980 requires heads of audited agencies to report within 180 days of receiving the final program audit to the Chairman of the Legislative Commission on Expenditure Review and the Chairman and Ranking Minority Members of the Senate Finance and Assembly Ways and Means Committees on steps taken in response to findings, and, where no steps were taken, the reason why.

Department of Correctional Services

1. Contrary to the intent of law, DOCS did not have a program and classification procedure to evaluate the physical, mental and emotional conditions of each inmate entering the system. (See pp. 11-13.)

2. Orientation of inmates to available health services was minimal. The American Medical Association (AMA) and The American Correctional Association (ACA) recommend that such orientations be both oral and in writing so that the inmate can act in his own best health interest. (See pp. 13-14.)

3. DOCS had no special programs or treatment for retarded and developmentally disabled inmates despite statutory authority to provide special placement and care for these individuals. (See pp. 6.)

4. Health records were not being maintained properly, nor were they always consulted. Many health encounters were never recorded. Given the increasing number of health-related inmate lawsuits, complete record keeping is essential. (See pp. 41-43.)

5. Having outside medical specialists come to a correctional facility saves the State money by reducing security and escort costs. An out-of date fee schedule, however, provides little incentive for specialists to come to a correctional facility. (See pp. 24-26.)

6. The number of hours "full-time" physicians were available varied among the institutions. There was no correlation between the number of inmates at a facility and physician availability. (See pp. 34-35.)

7. Facility inmate health services management should rest with a designated facility health authority according to standards set by the ACA, the AMA and the United States Department of Justice. Morever, despite AMA and American Public Health Association standards recommending internal and external evaluation of the facility health care services, no such reviews were conducted. (See pp. 38-40.)

8. Noncompetitive State salaries, shortage of physicians in certain geographic areas, and inflexibility in physician coverage were obstacles to filling facility physician vacancies. (See pp. 48-50.)

9. The absence of an integrated inmate health services budget within DOCS made it difficult for the Legislature to focus attention on inmate health needs and priorities. (See pp. 50-51.)

10. Improved management of the inmate health care system could result in reduced security costs and associated fringe benefits through: (1) increasing utilization of secure wards, (2) upgrading infirmary staff and facilities so that inmates can be transferred from community hospitals to infirmaries for recuperation, (3) increasing the use of "in facility" specialty clinics and reconstructive surgery programs, and (4) reviewing inmate use of inpatient hospital care by central staff. (See pp. 90-92.)

Office of Mental Health

11. Operating guidelines and standard procedures for the satellite center programs had not been promulgated. The result was a lack of uniformity in the access to and availability of inmate mental health services. (See p. 59.)

12. Improved OMH-DOCS coordination was needed to resolve health program deficiencies. (See pp. 60-61.)

Commission of Correction

13. The commission's approach to oversight of State inmate health care was primarily reactive--initiated by inmate deaths, grievances or complaints. (See pp. 62-69.)

14. Though authorized by statute to do so, the commission had not established standards for assessing the quality of inmate health care and prison environmental health. (See pp. 69-71.)

15. Evaluation of the State's correctional facility health services system had not been a priority of the Commission of Correction's Medical Review Board. (See pp. 71-72.)

Department of Health

16. DOH viewed its role as monitor of the health environment at DOCS facilities as purely advisory with no powers of enforcement. However, the DOH Commissioner is mandated to enforce the Public Health Law and the Sanitary Code. (See p. 78.)

Health Planning Commission

17. HPC is required to review the plans of State agencies providing health and mental health services, but no State health plan has been required of DOCS for inmates. (See p. 78.)

ABBREVIATIONS

Agencies/Subunits

BNE--Bureau of Narcotics Enforcement in DOH
BSCFR--Bureau of State Correctional Facility Review of the Commission of Correction
CERT--Correctional Emergency Response Team in DOCS
DHS--Division of Health Services in DOCS
DOCS--State Department of Correctional Services
DOH--State Department of Health
DSO--Division of Support Operations in DOCS
HPC--State Health Planning Commission
HSU--Health Systems Unit of the State Commission of Correction
LCER--Legislative Commission on Expenditure Review
MRB--Medical Review Board of the State Commission of Correction
NYCDOH--New York City Department of Health
OMH--State Office of Mental Health
OVR--State Education Department's Office of Vocational Rehabilitation

Standards Used

AACP--American Association of Correctional Psychologists, Standards for Psychology Services in Adult Jails and Prisons, September 1979.
ACA--American Correctional Association, Revised Standards for Adult Correctional Institutions, 1976
AMA--American Medical Association, Standards for Health Services in Prisons, July 1979
APHA--American Public Health Association, Standards for Health Services in Correctional Institutions, 1976.
USDJ--United States Department of Justice, Federal Standards for Corrections, Draft, June 1978

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FOREWORD

The Legislative Commission on Expenditure Review was established by Chapter 176 of the Laws of 1969 as a permanent legislative agency for among other duties, "the purpose of determining whether any such department or agency has efficiently and effectively expended the funds appropriated by the Legislature for specific programs and whether such departments or agencies have failed to fulfill the legislative intent, purpose and authorization," and to make a comprehensive and continuing study of . . . the program of and expenditures by state departments." This program audit, State Prison Inmate Health Services is the eighty-eighth staff report.

The audit reviews New York's multi-agency system to provide needed medical, psychiatric and environmental health services to over 22,000 State correctional facility inmates. Findings encountered include excessively high health services staff position vacancies, inadequate health record and inmate case management, an outdated medical fee schedule inhibiting the ability to provide "in facility" speciality care, the potential for improved intra- and interagency coordination in the financing and management of health programs and the high and growing costs of inmate health care. As noted in several of the agency responses presented in Appendix D, there is general concurrence with the report's findings and remedial efforts are underway. Noted in particular are the Department of Correctional Services' attempts to fill vacant health positions and to improve health services planning and management. The outcome of these and other ongoing program improvements will be addressed in our six month agency follow up.

Appreciation is expressed to the personnel of the Departments of Correctional Services and Health, the Health Planning Commission, the Office of Mental Health, and the Commission of Correction. A special note of thanks is extended to the Superintendents and personnel of correctional facilities visited by LCER staff during the study: Arthur Kill, Attica, Clinton, Coxsackie, Downstate, Elmira, Fishkill, Lincoln, Mt. McGregor, Queensboro, and Woodbourne.

In accordance with Commission policy, this report focuses on factual analysis and evaluation. Recommendations and program proposals are not presented since they are in the realm of policymaking and therefore the prerogative of the Legislature.

The audit was conducted by James Haag, Chairman; Joan Deanehan, Robert Fleischer, Frank Jackman, and Irving Wendrovsky. Research assistance was provided by John Baer and Joel Margolis while computer programming was performed by Robert Lowinger. Bernard Geizer served as general editor. Word processing services were provided by Barbara Harrison and Nancy Neubauer. Overall supervision was the responsibility of the Director.

The law mandates that the Chairmanship of the Legislative Commission on Expenditure Review alternate in successive years between the Chairman, Senate Finance Committee and the Chairman, Assembly Ways and Means Committee. Senator John J. Marchi is Chairman for 1981 and Assemblyman Arthur J. Kremer is Vice-Chairman.

June 19, 1981

Sanford E. Russell
Director

I INTRODUCTION

This program audit assesses the effectiveness of New York State's prison inmate health services. It evaluates State correctional facility health services management and estimates its costs at $42.4 million or $2,079 per inmate for the 1979-80 fiscal year. Included in the audit's scope are physical, mental and environmental health services. This chapter provides background by discussing (1) recent inmate health care litigation, (2) legislative intent for State inmate health care in New York, (3) the most pressing health care needs of inmates, and (4) this program audit's scope.

Inmate Health Care Litigation

Since the 1974 federal court found that Alabama's prison health care system was constitutionally impermissible,[1] cases have been brought with increasing frequency against state prison systems and the health care segment of the systems. The finding of unconstitutionality has been made against seven other states.[2] Two prisons have been closed and health care systems, procedures and staffing have been revised.

Todaro v. Ward is a case in point for New York State.[3] The judgment declared the inmate medical care system at Bedford Hills Correctional Facility unconstitutional. The court outlined changes to be made in: infirmary and sick call procedures, record keeping requirements, and minimum staffing and mandated capital improvements to the sick wing. The Department of Correctional Services (DOCS) estimates that mandated improvements cost $101,741 annually for added personnel and $56,192 for capital improvements. The court order also required that qualified State personnel inspect and report findings to plaintiffs. The Office of Health Systems Management performed four audits in 1978, three in 1979, two in 1980 and two more are scheduled during 1981.

In New York State, during the 11 month period from January through November 1980, DOCS Office of the Counsel recorded receipt of 235 legal actions related to inmate health care issues--an average of 21 per month. This did not include all actions brought against the department, because correctional facilities may be served directly without notice to the central office.

No one has documented the resources required for legal defense of the State in inmate health lawsuits. However, Legislative Commission on Expenditure Review (LCER) staff interviews at DOCS central office and at correctional facilities indicate that a large amount of staff time is diverted in this endeavor. Depending upon the issues in a case, such litigation can involve DOCS and the Department of Health (DOH), the Office of Mental Health (OMH), the Commission of Correction, the Attorney General's Office and other State agencies. Each court case requires facility staff to compile information in defense and to give testimony. Implementation and follow up of court decisions can be costly and time consuming.

The following summarize some of the major prison inmate health care cases and highlight the role of the courts in determining "adequacy of prison inmate health care." Also presented are examples of standards of care enforced by the courts.

Background

Before 1926, medical care issues were not addressed by the courts to any great degree. Rather, the concern with the "cruel and unusual punishment" clause of the Eighth

Amendment pertained to sentences disproportionate to the offense. In the 1926 Spicer decision, the U.S. Supreme Court reiterated the common law right to medical treatment for prisoners: "that the public be required to care for the prisoner who cannot, by reason of the deprivation of his liberty, care for himself."[4] After 1926, cases were brought on the basis of medical maltreatment and sought monetary or punitive damages. In the cases which were won, the prisoner proved mistreatment by the medical care providers, by interference from prison administrators, or by both.[5]

As a result of court challenges during the early 1970s, a definition of the rights of prisoners evolved and was repeated in many decisions:

> Though his rights may be diminished by the needs and exigencies of the institutional environment, a prisoner is not wholly stripped of constitutional protections when he is imprisoned for crime. There is no iron curtain drawn between the Constitution and the prisoners in this country.[6]

In the much quoted 1976 Estelle decision, the U.S. Supreme Court drew on lower court decisions, to indicate the medical care an inmate was entitled to:

> Medical malpractice does not become a constitutional violation merely because the victim is a prisoner. 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."[7]

The Supreme Court has not yet given a further definition of its "deliberate indifference" standard.[8] A district court case may have given a more usable standard: "To reach constitutional proportions, there must have been elements of willful, wanton, or reckless conduct by prison officials."[9] In other words, a demonstration of bad faith is necessary; the court will not assume intentional cruelty on the part of the prison administration.[10] Imprisonment is, in itself, the punishment for crime. When it is compounded by the deprivation of medical care, the result is an excessive sentence and may constitute cruel and unusual punishment.[11]

In 1977, the question of psychiatric treatment was brought up in Bowring v. Godwin.[12] The court's landmark decision made it clear that prison officials' neglect of inmates' needs for psychiatric care violated the Eighth and Fourteenth Amendments. This decision has been confirmed in several subsequent cases.

Systemwide Challenges

Several cases brought since 1969 were class actions against entire prison systems, the medical care of a system, or medical care within one prison.[13] Isolated instances of inadequate or improper medical treatment often are not sufficient to comprise a constitutional violation. However, such incidents taken cumulatively may establish systemwide inadequacy.[14]

The courts have had a "hands off" tradition where prisons are concerned. This first operated in dismissal of cases without hearing; now it serves to keep the court as uninvolved in the daily administration of prisons as possible, even in cases where an entire system has been declared unconstitutional. The decisions are couched in such broad terms that the option of how to implement them is left to the State. The judges do not establish

the formulas for the type of medical care that is acceptable. Instead, they have relied on the standards of professional organizations and government agencies such as the American Correctional Association (ACA), the American Public Health Association (APHA), and the U.S. Department of Health, Education, and Welfare.[15]

In cases where a class action or suit against the entire system followed a series of individual cases, or where prisoners continued litigation after a favorable decision in order to obtain redress, the courts sometimes have appointed a special master to oversee the implementation or have required that the agency devise a plan acceptable to the court and report back at frequent intervals, showing implementation.

Court Mandates for Provision of Adequate Prisoner Health Care

Litigation has dealt with inadequate diagnostic procedures, lack of qualified medical personnel, a filthy environment which included vermin in both living and food preparation areas, administrative procedures which effectively denied access to medical care, and obsolete facilities. The courts have required that provision be made for adequate maintenance of prisoner health. For example:

--Sick call to be run by a medically qualified person;

--No interference with access to medical care, medication or orders of a physician by inmates or staff members;

--Only professionals to handle medication at any time;

--Only medically qualified employees in the medical care areas;

--Round-the-clock, seven days/week medically qualified personnel on duty;

--Emergency medical procedures and equipment;

--All medical procedures in writing;

--Transfer of inmates to outside providers for treatment or diagnosis on a timely basis;

--Medical records to be available to other providers in, or connected with, the prison medical system;

--Medical records to be complete and legible;

--Intake medical and psychiatric examinations, annual follow-up;

--Complete laboratory and diagnostic facilities in good operating condition;

--Medical and religious diets available at all times to any inmate who requires them;

--Classification on intake, follow up as necessary;

--Treatment for drug and alcohol dependencies;

--Treatment for the mentally retarded and mentally ill;

--Segregation of violent or highly aggressive inmates;

--Environmental sanitation that meets public health standards;

--Fire and safety inspections, implementation of the recommendations;

--Food preparation area inspections, implementation of the recommendations, training of food handlers;

--Either license or certify the infirmary/hospital in the prison;

--Provision of care regardless of budgetary restrictions.[16]

Legislative Intent

New York State has a "custodial" inmate health care delivery system.* DOCS has full authority and responsibility for inmate physical and environmental health, while OMH provides inmate psychiatric care at the correctional facilities. The Commission of Correction monitors and oversees the State's inmate health care delivery system, among other duties relative to management and operation of the entire State and local penal system. DOH exercises a relatively minor role as the State's regulator of environmental health. The State Education Department's Board of Pharmacy inspects correctional facility pharmacies. The State Health Planning Commission (HPC) could exercise a planning and oversight role, but it does not.

Department of Correctional Services

DOCS is responsible for confinement and treatment[17] of about 22,000 persons. It runs 33 correctional institutions and employs almost 12,000. In operating these institutions DOCS, by statute, must:

--Provide for the safety and security of the community;

--Give due regard to the right of every person in custody to receive humane treatment; and

--Provide for the health and safety of every person in the custody of the department.[18]

Correction Law delegates broad authority to the Commissioner of Correctional Services to meet the physical and mental health needs of prison inmates. He is authorized to:

*Authorities identify three basic models of inmate health care.

(1) The custodial agency (department of correction or analogous entity) provides health services.
(2) A health agency (department of public health, or other state agency) is charged with the responsibility to provide health services.
(3) A community provider of health services enters into a contractual agreement to care for prisoner population. (e.g., a hospital or medical center.)[19]

--Organize the department;[20]

--Appoint its staff, including superintendents of correctional institutions, health staff, and other institutional personnel;[21]

--Contract for outside professional services including prison health services;[22]

--Permit inmates to receive medical diagnosis and treatment at outside hospitals;[23]

--Transfer prisoners from one institution to another;[24]

--Classify the correctional facilities with respect to inmate age and sex, level of security and function;[25]

--Establish, in cooperation with the Commissioner of Mental Hygiene, programs for the treatment of mentally ill inmates, who do not require hospitalization;[26]

--Maintain and establish correctional institutions for the purpose of the care, treatment, training and custody of inmates found to be mental defectives;[27] and,

--Cause inmates to be removed to a place of security and treatment in case of any pestilence or contagious disease.[28]

Statute also requires that the Commissioner establish:

> program and classification procedures designed to assure the complete study of the background and condition of each inmate . . . and the assignment of such inmate to a program that is most likely to be useful in assisting him to refrain from future violations of the law. Such procedures shall be incorporated into the rules and regulations of the department and shall require among other things: consideration of the physical, mental and emotional condition of the inmate; consideration of his education and vocational needs; consideration of the danger he presents to the community or to other inmates; the recording of continuous case histories including notations as to apparent success or failure of treatment employed; and periodic review of case histories--and treatment methods used.[29] [Emphasis added.]

No such procedure had been incorporated in the department's official "Codes, Rules and Regulations" as of December 1980. Yet, the statute requires inmates to be diagnosed, evaluated, classified and placed in correctional facilities and programs, with full consideration of their health and physical needs. This statute also requires that inmates who suffer from mental illness or mental retardation receive special care and treatment.

Delegation of Authority. Pursuant to Correction Law, Section 18(3), the Commissioner delegates management authority and responsibility to superintendents of the 33 correctional facilities. They are appointed by, and serve at the pleasure of the Commissioner, and are responsible for facility security, administration, financial management, plant maintenance and operation, and inmate education and rehabilitation programs. The Commissioner supervises the facility superintendents through Deputy and Assistant Commissioners in specific fields of responsibility.[30]

The Assistant Commissioner for Health Services, for example, manages all matters related to inmate health. He exercises authority over facility superintendents and their health staffs through the Deputy Commissioner for Facility Operations.

Environmental Health Concerns. Statute mandates that inmates be provided with "clothing suited to the season and weather," "a sufficient quantity of wholesome and nutritious food," and, if space is available, "a separate cell or room."[31] This establishes a minimum standard for inmate care and environmental health.

Special Confinement of Inmates. The Legislature has provided safeguards for monitoring the health of inmates confined in special housing units, or housed apart from the general prison population.

> Where such confinement is for a period in excess of twenty-four hours, the superintendent shall arrange for the facility health services director, or a registered nurse or physician's associate . . . to visit such inmate at the expiration of twenty-four hours and at least once in every twenty-four hour period thereafter, during the period of such confinement, to examine into the state of health of the inmate, and the superintendent shall give full consideration to any recommendation that may be made by the facility health services director for measures with respect to dietary needs or conditions of confinement of such inmate required to maintain the health of such inmate.[32]

The facility superintendent is required to report to the Commissioner (1) at least once a week concerning the condition of the confined inmate, and (2) any recommendations relative to health maintenance or health care delivery made by the Facility Health Services Director "that is not endorsed or carried out, as the case may be, by the superintendent."[33] Adequate sanitation is required to maintain the health of the special confinement inmate.[34]

Mentally Retarded Inmates. The department is authorized to establish and maintain special institutions to care for, treat and train retarded inmates.[35] Several institutions for retarded inmates were in operation in 1970: Beacon, Eastern, Napanoch and Albion; however, these were phased out by 1975 as treating and caring for retarded individuals shifted from isolation in State schools to mainstreaming and community placement. Although statute intends that DOCS provide special placement and care according to the needs of retarded inmates, no DOCS program or separate institution existed to accomplish this as of December 1980.[36]

Statute empowers the Commissioner to transfer certain mentally retarded inmates to the jurisdiction of the Department of Mental Hygiene. This may occur "whenever it appears to the satisfaction of the commissioner of correction that such person will substantially benefit from care and treatment in a state school and the interest of the state will be best served thereby."[37] According to the Assistant Commissioner for Health Services, this section of the law has not been used for years.[38]

The department has no special programs or treatment for an estimated 1,750 retarded and developmentally disabled inmates presently in the system. Approximately 450-650 of these inmates are retarded.

Office of Mental Health

Before 1976, inmates needing psychiatric care were housed, cared for, and treated in DOCS' hospitals for the mentally ill. As a result of lawsuits brought by prisoners and

the gradual recognition that DOCS was not staffed, equipped or oriented to adequately care for the mentally ill, these hospitals were phased out--Dannemora in 1972 and Matteawan in 1976.

Chapter 766, Laws of 1976 vested responsibility for care and treatment of mentally ill inmates with the Department of Mental Hygiene--an umbrella for the Office of Mental Health (OMH), the Office of Mental Retardation and Developmental Disabilities, and the Office of Alcoholism and Substance Abuse--now delegated to OMH. It required that the commissioners of DOCS and OMH cooperate in establishing programs "for the treatment of mentally ill inmates confined in state correctional facilities who are in need of psychiatric services but who do not require hospitalization."[39] A due process procedure was specified whereby a seriously mentally ill inmate could be transferred to the jursidiction of OMH for treatment.

OMH established forensic psychiatry programs for mentally ill inmates, known as satellite units, at correctional facilities. These satellite units are at Attica, Auburn, Bedford Hills, Clinton, Elmira, Fishkill and Green Haven.

Central New York Psychiatric Center (CNYPC), an accredited forensic psychiatric hospital, serves mentally ill DOCS inmates who are committed by the court to OMH. Of 6,001 inmates served in the seven satellite centers in 1979-80, 448 were committed to Central New York for long term care.

Commission of Correction

The Legislature intends that the Commission of Correction "monitor the performance of correctional facilities" and "assist in the formulation of enlightened correctional policies to improve what is and has been a thoroughly inadequate and counter productive correctional system." The commission was envisioned as "a strong and vigorous watchdog organization," which would "make our correctional system accountable to the people."[40] Its oversight extends both to State correctional facilities and to local jails.

The commission's duties are to:

> --Visit, inspect and appraise the management of correctional facilities with specific attention to matters such as safety, security, health of inmates, sanitary conditions, rehabilitative programs, disturbance and fire prevention and control preparedness, and adherence to laws and regulations governing the rights of inmates.
>
> --Promulgate rules and regulations establishing minimum standards for the care, custody, correction, treatment, supervision, discipline and other correctional programs for all persons confined in correctional facilities.
>
> --Close any correctional facility which is unsafe, insanitary or inadequate to provide for the separation and classification of prisoners required by law or which has not adhered to or complied with the rules or regulations promulgated . . . .
>
> --Collect and disseminate statistical and other information and undertake research, studies and analyses . . . in respect to the administration, programs effectiveness and coordination of correctional facilities.[41]

The commission visits and inspects State correctional facilities--primarily in response to inmate complaint, grievance or mortality--and has compiled some statistical data on allocation of State prison health and mental health personnel. As of December 1980, the commission had not promulgated minimum standards for State correctional facilities, nor had it ever closed a State prison.

The Medical Review Board (MRB) is the major arm of the commission charged to:

--Investigate all inmate deaths and report findings to the commission;

--Investigate the condition of systems for the delivery of medical care to inmates of correctional facilities and recommend improvements in the quality and availability of such care.[42]

The MRB is a four-member, part-time body.[43] Board members are appointed for staggered five year terms by the Governor, with the advice and consent of the Senate and serve without compensation. The membership must include an attorney, a certified forensic pathologist and a certified forensic psychiatrist. The board issues a report on each inmate mortality.

Department of Health

DOH has broad authority to monitor physical and environmental health conditions and to enforce the State's Sanitary Code and Public Health Law within State institutions, including correctional facilities.[44] DOH inspectors have access to all food storage, preparation and service areas to insure that such places conform to the State Sanitary Code.[45] DOH is required by statute to inspect "the sanitary condition of each state institution" and "all labor camps and enforce the provisions of the sanitary code relating thereto."[46] The findings and recommendations of food service and sanitary inspections are sent to the Commissioner of DOCS and are deemed by DOH to be "advisory reports." Other than periodic reinspection no formal process exists for interagency follow-up and review.

DOH also licenses, supervises and regulates the distribution and use of narcotics.[47]

DOH supervises and regulates x-ray equipment. Annual or biennial inspections are conducted at DOCS' radiological installations.[48]

Health Planning Commission

Chapter 769, Laws of 1977 required integrated statewide planning to phase out unnecessary hospital facilities and services, to encourage needed facilities and services and to assure that changing health needs are recognized. "An adequate supply of properly utilized health and health supportive services is the basic goal of a constructive and humane program of planning for meeting the health related needs of the people of the State."[49]

To date, the health needs of State correctional institution inmates have not been included in the health planning process. This exclusion is discussed in Chapter III.

Inmate Health Needs

Prisoners appear to have certain special health needs in addition to those in common with the non-incarcerated population.

> Prisoners are at increased risk for health problems related to their criminal and addictive life-style and their sporadic utilization of medical services, [d]rug and alcohol abuse . . . [and their] . . . long term sequelae . . . [t]rauma, psychiatric problems and seizure disorders.[50]

Prevalence rates of the following diseases have been found to be greater among prisoners: hepatitis and chronic liver disease, sexually transmitted diseases, hypertension, tuberculosis and seizure disorders.[51]

Hepatitis and Chronic Liver Disease. Increased incidence of hepatitis and chronic liver disease is related to drug and alcohol abuse. LCER's survey of inmate health records found that a history of narcotic use was reported by 50.7 percent. Alcohol use was reported by 61.5 percent of the inmates. A history of hepatitis was reported by 8.4 percent of the sample.

Hypertension. Hypertension occurs with much greater frequency among blacks than whites.[52] Prison populations have a disproportionate number of blacks compared to their representation in the general population. The sample showed 5.3 percent of the inmates to have histories of hypertension.

Sexually Transmitted Diseases. Included among the sexually transmitted diseases are gonorrhea, syphilis, chancroid, lymphogranuloma venereum and granuloma inguinale. A history of syphilis was reported by 5.3 percent of the sample, and other sexually transmitted diseases were reported by 17.4 percent.

Tuberculosis. Active tuberculosis and high rates of positive tuberculin skin tests occur in inner city communities and correctional facilities.[53] "Among prisoners in diverse institutions and regions, rates of tuberculin skin test positivity have remained consistently high in relation to general populations."[54] A history of tuberculosis was reported by 3.2 percent of the inmates.

Seizure Disorders. One estimate is that 0.5 percent of the U.S. population has a history of seizure disorders.[55] A history of seizure disorder was reported by 2.1 percent of the LCER sample inmates. "Important etiologic factors for epilepsy including prenatal and peri-natal morbidity and head trauma, appear to be correlated with poverty [and the poor are] . . . the great majority of prisoners."[56]

Program Audit Scope

This program audit describes and evaluates the New York State prison inmate health care delivery system, as of October 1980. For this study, health care includes medical, dental, psychiatric and environmental health, following closely recent court judgments and the underlying philosophy of inmate health care standards promulgated by the American Medical Association (AMA), the American Correctional Association (ACA) and the American Public Health Association (APHA).

Thirteen State correctional facilities were selected for detailed review. The rationale for selection of these facilities and the methodology for random sampling of inmates are discussed in Appendix B. The 13 selected facilities are a microcosm of the entire 33 facility State system.

Chapter II analyses the inmate health care from access, resource allocation, utilization and performance perspectives. Chapter III describes the roles, responsibilities,

functions and workloads of the six State agencies involved in State inmate health care. Chapter IV discusses system costs and financial issues.

Chapter Summary

● Since 1974, legal actions have been brought against state prison systems and the health care services provided by the systems. The courts have mandated that inmates must be provided with adequate health care and they have relied on the standards of professional organizations and government agencies to define acceptable medical care.

● DOCS estimates that court mandated improvements in health service at Bedford Hills Correctional Facility cost $101,741 annually for added personnel and $56,192 for one time capital improvement.

● Inmate legal actions against the State inmate health care system averaged 21 per month during 1980.

● DOCS had no special programs or treatment for an estimated 1,750 retarded and developmentally disabled inmates presently in the system despite statutory authority to provide special placement and care for these individuals. Approximately 450 to 650 of these inmates were borderline or more severely retarded.

II INMATE HEALTH SERVICES DELIVERY SYSTEM

This chapter details the range and type of health services available to prison inmates. Presented are analyses of how an inmate gains access to services, patterns of health service use, the allocation of health service resources among correctional facilities, variations in management and availability of such resources, and several perspectives on the quality of care.

LCER sample correctional facility adherance to inmate health care performance criteria is presented in Exhibit I. These nationally recognized standards will be referred to throughout this chapter.

Initial Assessment of Inmate Health

As mentioned in Chapter I, DOCS has not established "program and classification procedures designed to assure the complete study of the background and condition of each inmate "as required by statute.[1] There is no systematic central administration of the classification process, or uniform classification procedures. DOCS' classification process is designed primarily for security purposes with major emphasis upon availability of cells or bed space.[2] This, however, was not always the case.

In 1945, the State Department of Corrections established the first reception center at Elmira. The principle underlying its creation was the "provision of the individualized treatment of all inmates based on all available facts."[3] The center was to provide:

--Effective classification and treatment of all inmates within correctional institutions,

--Treatment services to inmates within the classification process, and

--Diagnostic and prescriptive treatment plans for all inmates supported by the development and diversification of specialized institutional programs based on their needs.

The center operated as a separate facility within the correctional system. Physical/mental health screening were considered essential parts of the classification process; medical histories and clinical staff observations identified inmates with physical/emotional and mental retardation problems. Assembled inmate health data were reviewed by a physician, psychiatrist and psychologist and other members of the classification team to assess the inmate's ability to adjust to a physical/mental health treatment plan and to designate placement.[4]

Classification Process in 1980

Some 10,000 persons were sentenced and admitted to the State correctional system in 1980. Each was processed through one of six reception centers. The process varies depending upon sex, age and residence of the inmate:

Exhibit I

Adherence of LCER Sample Facilities to Standards for Delivery of Health Care

Standard/ Guidelines	Security Level: Maximum					Medium				Minimum				Total Meeting Standard	Standard Codes
	Attica	Auburn	Clinton	Coxsackie	Elmira	Arthur Kill	Fishkill	Queensboro	Woodbourne	Bayview	Camp Adirondack	Lincoln	Mt. McGregor		
Staffing:															
-Physicians	--	--	x	--	--	x	--	x	--	x	--	x	--	5	ACA 4257.04
-Nurses	--	--	--	--	--	--	x	x	--	x	--	x	--	4	ACA 4257.04
-Dentists	--	--	--	--	--	--	x	x	--	--	x	--	x	4	ACA 4257.04
-Dental Assistant	--	--	--	--	--	x	--	--	--	--	--	--	--	1	ACA 4257.04
-Dental Hygienists	--	--	--	--	--	--	--	--	--	--	x	--	--	1	ACA 4257.04
-Clerical Support	--	--	--	--	--	--	--	--	--	--	--	--	--	--	ACA 4257.04
Licensure	x	x	x	x	x	x	x	x	x	x	x	x	x	13	AMA-122, ACA 4258.06
Frequency/Sick Call	--	x	x	x	--	x	x	x	x	x	x	x	x	11	AMA-146, ACA 4262.02 USDJ-016
Inmates:															
-Not Provide Care	x	--	--	--	--	x	x	x	x	x	--	x	x	8	AMA-133
-Not Have Access to Records	x	--	--	--	--	x	x	x	x	x	x	x	x	9	AMA-133
Management															
-Health Authority With Full Responsibility	--	--	--	--	--	--	--	--	--	--	--	--	--	--	AMA-101; ACA 4253.01 USDJ-001
-Independent Peer Review/Evaluation	--	--	--	--	--	--	--	--	--	--	--	--	--	--	AMA-109, 110; APHA X
Health Records:															
-Complete/Accurate	--	--	--	--	--	--	--	--	--	--	--	--	--	--	AMA-164; ACA 4279 USDJ-030
-Include All Encounters	x	x	--	x	--	x	x	--	x	--	--	--	--	6	[Same As Above]
Emergency Care Procedure	x	x	x	x	x	x	x	x	x	x	x	x	x	13	AMA-154
Medication Administered only by Medical Personnel	--	--	x	x	x	x	x	x	x	x	x	x	x	11	AMA-163; APHA VIII
Total	5	4	5	5	3	9	9	9	7	8	7	8	7	86	

x=Adherence to standard.

Source: LCER Staff.

Center	Reception	Classification	State Area Served
Males Over 21 Years			
Attica	X	X	Western
Ossining	X	--	Downstate
Downstate	--	X	Downstate
Clinton	X	X	Northern
Males Under 21			
Elmira	X	X	Statewide
Females All Ages			
Bedford Hills	X	X	Statewide

DOCS' Division of Classification and Movement was established in 1972 to provide inmate population control, and to approve initial inmate classification, subsequent reclassification and/or extraditions. As of December 1980, the division was primarily responsible for inmate movement to and from correctional facilities, and it did not plan, administer or give written approval for an inmate's initial classification. Its responsibilities had not been clearly defined in writing.[5]

ACA standards maintain that "Written policy and procedures for identification of special needs inmates" (drug addicts, alcoholics, mentally ill, mentally retarded) are essential.[6] Such policies are nonexistent at five of the centers; the Downstate Center adopted reception and classification standards in April 1980.

The reception/classification process gives little attention to physical/mental health problems of inmates. Such considerations seldom provide the basis for placement in special correctional facilities' programs. For example, correctional facilities' health services personnel told LCER staff that previous hospital medical history records generally were not requested by classification staff unless the problems were obvious, i.e., abnormal or bizarre behavior.[7]

Inmate Orientation to Health Services

The classification process is the initial step in determining physical/mental health problems of inmates and the services required. In field visits at 13 correctional facilities, LCER staff found that:

--During the classification process inmates were not made aware of DOCS policies with regard to health services;

--The "Inmate Rule Book" did not contain written health service policies or procedures which would inform inmates about access to and availability of health services;

--Inmates generally learn about health services from other prisoners or through peer group counseling.

DOCS has not developed a policy to carry out the AMA and ACA standards which require:

> Written policy and procedures to provide for unimpeded access to health care and for a system for processing complaints regarding health care. These policies are communicated orally and in writing to the inmates upon arrival in the facility and are put in language clearly understandable by each inmate.[8]

As a result, inmates were sometimes unaware of departmental policies relative to regular periodic examination and access to outside health providers. Lacking such knowledge, inmates may find it difficult to request health services or to act in their own best health interests. For example, to overcome this and other related inmate "access" problems, North Carolina's correctional department furnishes to each inmate a "Statement on a Patient's Bill of Rights."

Inmate Access to Health Care

The ability of inmates to gain access to health care varied based upon each institution's policies, procedures, staffing and other resources. This section highlights the differences that exist among the 13 sample prisons in the availability and/or conduct of sick call, triage, emergency care, dental care, pharmacy, physicians, visits to specialists/consultants or other outside facilities, infirmary and in-hospital care.

Sick Call

Each of the facilities had some form of sick call which had triage (screening to determine proper priority in treatment and level of treatment needed), as a necessary element. Triage decisions are also involved when unscheduled requests for care are made. Inmate access to sick call usually involves some combination of steps:

--The inmate notifies some person in authority, either security or program personnel,

--Staff at the health unit are contacted,

--The medical record may be pulled,

--The inmate is sent/brought to the health unit or a staff person from the health unit goes to the inmate area.

At all facilities, initial contact at sick call was with a nurse who determined the need for evaluation and management of inmate problems by physician's assistants or doctors.

Maximum Security Facilities. Auburn, Clinton and Coxsackie held sick call each week day morning for approximately 2.5 hours. Elmira held sick call four days a week two hours per day, while Attica held sick call three days a week two hours per day. Elmira and Auburn also have one hour sick calls on Saturdays and Sundays. The AMA, ACA and the U.S. Department of Justice (USDJ) standards recommend sick call be available a minimum of five times per week at institutions the size of the five named.[9]

At Attica and Clinton prisons sick call was held on the cell block. At the other three facilities it took place at the health unit.

Good medical practice requires that the health record be available at every medical encounter and that all health contacts be recorded in the medical record.[10]

Complete record keeping is made essential by the increasing number of health care related inmate lawsuits which have been brought. Moreover, good record keeping is also needed because of the frequency with which inmates are transferred from one facility to another.

At Clinton, the dispensing of nonprescription (over the counter) drugs was not recorded on the AHR or otherwise although the medical record was available. A record of over the counter preparations dispensed was not kept at Elmira nor was the medical record made available until after the nurse had screened the inmate and decided that further care was needed. Eye care, dressing changes and other daily treatments were carried out without the chart being pulled. Obviously, in these instances no entries were made in the AHR.

Medium Security Facilities. Arthur Kill, Fishkill, Queensboro and Woodbourne met or exceeded the minimum ACA and AMA standards for frequency of sick call.[11] The USDJ standard that sick call be held at least five times per week[12] was met at Queensboro and Woodbourne. In all four, sick call was conducted at the health service units. At Arthur Kill and Queensboro "routine" sick call visits were not recorded in the medical record or the AHR. At Arthur Kill, less serious problems were entered in a log book. Universal consistent use of the medical record was not enforced.[13]

Minimum Security Facilities. Bayview, Camp Adirondack, Lincoln and Mt. McGregor exceeded the recommended minimum standard of three sick calls per week.[14] In all cases sick call was held at the health service area. At Bayview, Lincoln and Mt. McGregor medical records were not pulled for each health encounter nor were all health contacts recorded. At Bayview a record was made only if the inmate was seen by the physician or if it appeared that the illness might be serious. Routine visits were not recorded at Lincoln if medication was not prescribed. No record was kept of the dispensing of over the counter medications at Mt. McGregor.

Emergency Care

All 13 facilities reported having 24 hour per day, seven day week emergency care available. The DOCS Policies, Procedures and Guidelines Manual memorandum of August 12, 1974 establishes the procedures to be followed when emergency admission to either the prison infirmary or the local community hospital is necessary. The facilities appeared to meet the minimum criteria established for provision of emergency care.[15] However, shortcomings were noted regarding emergency equipment:

> Arthur Kill--the emergency kit was in a locked crash cart and was disordered. The oxygen tank had last been filled 1/28/77.
>
> Coxsackie--the combined suction and oxygen units (essential to adequate emergency care) were in a locked closet. The key to the closet was locked in the pharmacy. The combined unit was too cumbersome and heavy to be carried up and down stairs.
>
> Elmira--the suction machine had neither tubing nor suction cannula making it useless. The emergency eye tray had medication on it which were years outdated; e.g., April 1967 and 1976.
>
> Fishkill--the suction machine weighed close to 30 lbs. and would be difficult to carry up and down stairs.

Dental Care

All 13 facilities had some provision for inmate dental care. However, the dentist position at Mt. McGregor was vacant making services temporarily unavailable. At Camp Adirondack many fillings and other procedures had been delayed for up to six months, due to an inoperable x-ray machine. The dental care at Arthur Kill was criticized by both inmates and facility staff who agreed that the dental waiting list was at least six months long. While emergency care was available at Arthur Kill, a 1978 superintendent's memorandum defined emergency as: hemorrhage, fractured jaw, fractured tooth and acute infection resulting in swollen face. In the memorandum, pain was not considered an emergency.

Pharmacy

Each of the maximum security facilities had pharmacist coverage. The pharmacist at Coxsackie was a part-time employee. Of the four medium security facilities, Queensboro had no pharmacist and Woodbourne was operating an illegal unregistered pharmacy. None of the four minimum security facilities operated pharmacies.

The DOH Bureau of Narcotic Enforcement (BNE) criticized the pharmacy practices at Attica for absence of a policy and procedure manual and inadequate record keeping. General recommendations were made that a single, uniform pharmacy management system be developed for use in all facilities and that it be formalized in a policy and procedures manual. This manual had not been developed as of December 1980. BNE found that controlled substance administration records were incomplete with regard to number of doses remaining, signature of person administering the medication to the inmate, and the date the prescription was received. There was no way to match the vial of medication with the administration card. The source of the problem was that at Attica, as at Auburn, corrections officers were administering controlled substances and other medications. DOCS' policy states that "all controlled drugs will be administered by professional nursing staff."[16] Best medical practice requires that medication and especially controlled substances be given by health professionals.[17]

Two members of Attica's security staff expressed concern about the lack of accountability regarding controlled substances. They said that administering medication is not a proper security function.[18]

Infirmary

Only three of the minimum security prisons, Camp Adirondack, Mt. McGregor and Lincoln, did not have a 24 hour a day seven days a week infirmary. At Elmira Correctional Facility no nurse was in the infirmary during the day except to attend medical rounds, do treatments and give medications.

Utilization of Health Care Services

This section presents an analysis of prison inmate use of health care. Included are primary care services rendered by correctional facility medical and psychiatric staffs; consultant and specialty care clinics and the reconstructive surgery program within facilities; and inmate care provided outside the facility by specialists, in community hospitals or at CNYPC.

Ambulatory Health Care Within the Facility

To ascertain inmate use of health care services, LCER staff studied a random sample of inmate health records. (See Appendix B for details regarding survey method.) Exhibit II shows the department's standard "Ambulatory Health Record" (AHR). It is a convenient three-copy summary of the reason for and the outcome of each inmate health service encounter. A coding system identifies (1) the health problem, (2) the inmate, (3) the facility, (4) the health provider, and (5) the date of the encounter. The original copy is retained in the inmate's health record; the second is a prescription, if needed; and the third is transmitted via computer to Albany as part of the AHR information system (discussed further in Chapter III).

Exhibit II

STATE OF NEW YORK–DEPARTMENT OF CORRECTIONAL SERVICES

AMBULATORY HEALTH RECORD

INMATE NUMBER	NAME	FACILITY NO.

SUBJECTIVE

OBJECTIVE

ANALYSIS

PROBLEM

PLAN OR RX

SIGNATURE

CODE NO. | FAC. NO.

INMATE NO.

SHORT NAME

PROVIDER NO. | DATE

Source: DOCS.

Non-personally identifiable AHR data were extracted for each LCER sample inmate. The months of May through July 1980 were selected as a representative period to ascertain inmate health services utilization: i.e., number and type of health services used, level of service provider, extent of prescription and "over the counter" drug usage.

Though intended to be a complete record of each inmate's health encounters with DOCS providers, LCER staff found that at the sampled correctional facilities all medical, dental and psychiatric encounters were not recorded on the AHR. Moreover, LCER staff found careless and improper recording of AHRs by providers. These data were corrected by LCER staff for use in the survey. Thus, the AHR data provided less than the originally intended complete record of inmate ambulatory care. The potential for accurate and comprehensive use of the AHR remains high, however, if systemwide information management techniques were applied to assure complete and proper recording of

information. Furthermore, the system with minor changes could be expanded to include outside ambulatory health care encounters as well.

Inmate Health Encounters. The LCER sample of 379 inmates had 902 health encounters during May through July 1980. This averaged 2.4 encounters per inmate. During the three month study period, 106 inmates of the 379 (28 percent) did not use any health services. The remaining 273 inmates had from one to 19 health service encounters as shown in Table 1.

Table 1

Frequency of Inmate Health Services Encounters
May through July 1980

Number Encounters	Inmates Using Service: Number of Inmates	Inmates Using Service: Percent of Total	Health Service Encounters: Total Number Encounters	Health Service Encounters: Percent of Total
1	88	32.2	88	9.7
2	54	19.8	108	12.0
3	42	15.4	126	14.0
4	22	8.0	88	9.7
5	14	5.1	70	7.8
6	15	5.5	90	10.0
7	16	5.9	112	12.4
8	6	2.2	48	5.3
9	6	2.2	54	6.0
10	7	2.5	70	7.8
14	1	0.4	14	1.5
15	1	0.4	15	1.7
19	1	0.4	19	2.1
Total	273	100.0	902	100.0

Source: LCER Inmate Health Records Survey.

Over half of the inmates using health services had one or two encounters accounting for 22 percent of the 902 encounters and 67 inmates (25 percent) had five or more encounters for 55 percent of the total.

Of the 88 inmates who had a single encounter, 17 (19 percent) had physical examinations with no disease detected. Similarly, 12 of 54 inmates (22 percent) having two encounters, had physical examinations for one of those visits.

Of 185 inmates having two or more encounters, 82 percent had repeat visits for the same problem:

Inmate Visits for Same Problem	Number of: Inmates	Number of: Encounters
Two	45	90
Three	16	48
Four	9	36
Five or More	12	83
Total	82	257

Two or more visits for recurring problems accounted for 257 of the 814 encounters in the two or more range--almost one-third.

The tendency for a few inmates to draw heavily on the health services delivery system, while other inmates seldom use it, may have important ramifications for the planning, management and allocation of inmate health services resources. Would redistribution of high risk inmates, for example, help to conserve scarce health care staff and equipment, while affording inmates improved health care? A later section of this chapter will demonstrate that health staff resource allocations could be improved.

Table 2 shows variation in the frequency of inmate health encounters among correctional facilities, grouped by security level. Inmates in maximum security facilities average fewer encounters than those in medium and minimum security facilities. The inverse relationship between use and security level suggests that security considerations may curtail inmate access to and use of health services.

Table 2

Average Number of Inmate Health Encounters
by Facility and Security Level
May through July 1980

Correctional Facility by Security Level	Number: LCER Sample Inmates	Number: Inmate Health Encounters	Average Encounters per Inmate
Maximum			
Attica	57	121	2.1
Auburn	76	179	2.4
Clinton	54	120	2.2
Coxsackie	18	53	2.9
Elmira	41	31	0.8
Subtotal	246	504	2.0
Medium			
Arthur Kill	27	77	2.9
Fishkill	54	136	2.6
Queensboro	11	42	3.8
Woodbourne	23	67	2.9
Subtotal	115	324	2.8
Minimum			
Bayview	3	19	6.3
Lincoln	2	8	4.0
Mt. McGregor	4	29	7.3
Camp Adirondack	9	18	2.0
Subtotal	18	74	4.1
Total	379	902	2.4

Source: LCER Inmate Health Records Survey.

Type of Encounter. Table 3 presents the number of inmate encounters by type of health problem or disease. The first seven categories capture 71 percent of inmate health encounters:

Skin--boils (8), dermatitis (6), corns and calluses (9), acne (24), pomapholyx and sweat gland disease (8), rash (41), other (15).

Respiratory--upper respiratory infection (64), asthma (18), sinusitis (12), other (12).

Orthopedic--limb and joint pain (28), sprain and strains (58), other (10).

Medical Examinations--physicals, no disease detected (89).

Administrative Procedures--letters, forms, prescriptions, no examination (69), referral without examination (8).

Circulatory System--hypertension (32), chest pain (17), phlebitis and thrombophlebitis (5), hemorrhoids (9), varicose veins (3), other (6).

Trauma--lacerations (18), abrasions, scratches, blisters (10), burns and bruises (11), foreign body in eye (6), other (13).

Table 3

Inmate Health Encounters
by Problem/Disease Diagnosed
May through July 1980

	Problem/Disease Diagnosed	Health Encounters Number	Percent of Total	Percent Cumulative
1.	Skin	111	13.0	13.0
2.	Respiratory	106	12.4	25.4
3.	Orthopedic and Connective Tissue	96	11.2	36.6
4.	Medical Exam	89	10.5	47.1
5.	Administrative Procedure	77	9.0	56.1
6.	Circulatory	69	8.1	64.2
7.	Trauma	58	6.8	71.0
8.	Gastrointestinal	54	6.3	77.3
9.	Neuromuscular/Neuro	37	4.3	81.6
10.	Eye/Ear/Nose/Throat	35	4.1	85.7
11.	Neuroses	31	3.6	89.3
12.	Infections	17	2.0	91.3
13.	Metabolic	13	1.5	92.8
14.	Genitourinary	13	1.5	94.3
15.	Venereal	7	0.8	95.1
16.	Parasitic	4	0.5	95.6
17.	Psychoses	3	0.4	96.0
18.	Addiction	2	0.2	96.2
19.	Other	32	3.8	100.0
	Subtotal	854	100.0	
20.	Unknown	48		
	Total	902		

Source: LCER Inmate Health Records Survey.

Type of Provider. A triage system is used to screen patients. At sick call, a nurse interviews each patient and directs him or her to the appropriate health service provider: physician, physician's assistant, nurse, dentist, etc. The AHR is signed and coded by the highest level of health provider who treats the patient.

Table 4 shows inmate health encounters at LCER sample correctional facilities, by security level. Of the 902 inmate health encounters 35.4 percent were handled by physicians, 47.1 percent by nurses, eight percent by physician's assistants and 1.8 percent by other health providers. Physicians handled 19.5 percent of the encounters at maximum security facilities, 54.9 percent at medium security facilities, and 58.1 percent at minimum security facilities. Due to triage, most inmates examined or treated by a physician or physician's assistant previously had been screened by a nurse.

There was variation in physician coverage of health encounters at maximum security facilities (see Table 4). Handling the smallest percentage of health service visits were physicians at Attica (9.9 percent) and Clinton (6.7 percent), where they were aided by physician's assistants. At Coxsackie, physicians provided 15.1 percent of the services while physicians at Auburn and Elmira, respectively, handled 33.5 percent and 32.3 percent of the inmate encounters. Such interfacility variations raise concerns about (1) adequacy of physician oversight of inmate medical care, (2) the distribution of physician resources among the facilities and (3) inmate access to a physician's care. These elements are discussed in the next section "Allocation of Inmate Health Resources."

Medication

For the 902 encounters, 774 medications were provided; 368 (47.5 percent) prescription drugs and 406 (52.5 percent) "over the counter" drugs. Table 5 details the type and frequency of drugs dispensed.

As might be expected, heavy use of prescription antibiotics and respiratory agents and the non-prescription cold/sinus preparations indicates the high incidence of respiratory problems (see Table 3). Similarly, almost 42 percent of the nonprescription drugs are non-antibiotic external applications reflecting the frequency of skin problems in prison.

Psychiatric Care of Inmates

That State inmate mental health care needs are pervasive is illustrated by survey results. Almost one-third of LCER sample inmates in the (124 of 379) had used or were using OMH satellite center services. This proportion, however, may be an understatement; OMH services were unavailable at five of the 13 facilities. Also, inmates receiving psychiatric help from DOCS programs such as Merle Cooper (Clinton) and RAP (Attica) were not included in the sample statistics.

Table 6 compares 1978-79 and 1979-80 satellite center workloads: numbers of clients, office visits and total services. The latter category includes all services to individual clients, i.e., intake interviews, evaluations, the group or individual therapy sessions, medications provided, etc.

Over the one year period, the number of clients increased by 29.2 percent while total visits increased 70.8 percent. Variations occurred among the individual satellite centers, and OMH staff stated that in some of the satellite centers, increases are attributable more to improved reporting than to workload. Particularly, the Total Visits

Table 4

Inmate Health Encounters by Type of Provider and by Facility at Different Security Levels May through July 1980

Correctional Facility by Security Level	Type of Health Provider: Physician	Physician's Assistant	Registered Nurse	Other	Providers Not Indicated	Total
Maximum						
Attica						
Number	12	27	71	4	7	121
Percent	9.9	22.3	58.7	3.3	5.8	100.0
Auburn						
Number	60	3	105	1	10	179
Percent	33.5	1.7	58.7	0.5	5.6	100.0
Clinton						
Number	8	25	62	6	19	120
Percent	6.7	20.8	51.7	5.0	15.8	100.0
Coxsackie						
Number	8	--	40	--	5	53
Percent	15.1	--	75.5	--	9.4	100.0
Elmira						
Number	10	--	17	--	4	31
Percent	32.3	--	54.8	--	12.9	100.0
Subtotal						
Number	98	55	295	11	45	504
Percent	19.5	10.9	58.5	2.2	8.9	100.0
Medium						
Arthur Kill						
Number	51	3	14	--	9	77
Percent	66.2	3.9	18.2	--	11.7	100.0
Fishkill						
Number	66	--	59	3	10	138
Percent	47.8	--	42.8	2.2	7.2	100.0
Queensboro						
Number	23	5	13	1	--	42
Percent	54.8	11.9	30.9	2.4	--	100.0
Woodbourne						
Number	38	2	22	1	4	67
Percent	56.7	3.0	32.8	1.5	6.0	100.0
Subtotal						
Number	178	10	108	5	23	324
Percent	54.9	3.1	33.3	1.6	7.1	100.0
Minimum						
Bayview						
Number	18	--	1	--	--	19
Percent	94.7	--	5.3	--	--	100.0
Lincoln						
Number	4	--	4	--	--	8
Percent	50.0	--	50.0	--	--	100.0
Mt. McGregor						
Number	6	7	15	--	1	29
Percent	20.7	24.1	51.7	--	3.5	100.0
Camp Adirondack						
Number	15	--	2	--	1	18
Percent	83.3	--	11.1	--	5.6	100.0
Subtotal						
Number	43	7	22	--	2	74
Percent	58.1	9.5	29.7	--	2.7	100.0
Grand Total						
Number	319	72	425	16	70	902
Percent	35.4	8.0	47.1	1.8	7.7	100.0

NOTE: Attica and Clinton were the only LCER sample facilities to employ physician's assistants. Sample inmates at other facilities shown may have received health services from physician's assistants prior to transfer to the LCER sample facility.

Source: LCER Inmate Health Records Survey.

Table 5

Medications Provided Inmates LCER Sample May through July 1980

Prescription Type/Agent	Number
Antibiotic	67
Analgesic	53
Respiratory	42
Tranquilizing	34
Antihypertensive	23
Muscle Relaxant	21
Diuretic	16
Antihistaminic	16
Corticosteroid	16
Antidiabetic	13
Cardiovascular	6
Anticoagulant	5
Gastrointestinal	5
Anticonvulsant	4
Genitourinary	3
Other	44
Total	368

Non-Prescription Type/Agent	Number
Topical Nonantibiotic	117
Cold/Sinus Preparation	90
Aspirin	33
Analgesic Balm	31
Acetaminophen	28
Other Antacid	25
Desenex	21
Vitamins	16
Coricidin D	8
Eye Drops/Ointment	8
Topical Antibiotic	8
Gelusil M	7
Milk of Magnesia	5
Suppositories	4
Cepacol	3
Vaseline Intensive Care	1
Other	1
Total	406

Source: LCER Inmate Health Records Survey.

Table 6

Numbers of Psychiatric Clients, Visits and Services Provided by Satellite Centers 1978-79 and 1979-80

Individuals Served	1978-79	1979-80	Percent Increase
Attica	1,180	2,183	85.0
Auburn	574	673	17.2
Bedford Hills	398	427	7.3
Clinton	1,045	1,262	20.8
Elmira	732	759	3.7
Fishkill	602	624	3.7
Green Haven	567	660	16.4
Total	5,098	6,588[a]	29.2
Total Visits			
Attica	6,259	12,580	100.9
Auburn	5,515	7,493	35.9
Bedford Hills	3,347	5,009	49.7
Clinton	6,907	8,765[b]	26.9
Elmira	7,161	17,819[b]	148.8
Fishkill	5,485	7,407	35.0
Green Haven	5,377	9,345	73.8
Total	40,051	68,418	70.8
Total Services			
Attica	10,115	19,130	89.1
Auburn	8,415	10,970	30.4
Bedford Hills	5,693	10,300	80.9
Clinton	10,815	15,641	44.6
Elmira	14,629[b]	27,392[b]	87.2
Fishkill	7,621	8,732	14.6
Green Haven	10,714	20,609	92.4
Total	68,002	112,774	65.8

[a] Excluding interfacility transfers the total is 6,001.
[b] Includes administration of medications.

Source: LCER staff from OMH "Report on Service Information for Forensic Outpatient Units."

category reflects improved accounting in the 1979-80 year. While total services advanced by almost 66 percent, this reflects the inclusion of partial visits (inmates served in a group program) during the 1979-80 year.

Comparable data were not available for OMH nonsatellite units at Eastern, Coxsackie, Great Meadows, Mt. McGregor, New York City, Ossining and Wallkill. However, OMH staff reported that a new information system to be implemented during 1981 is intended to provide data for these units.

Merle Cooper Program. Inmates with personality disorders (not psychotic), mentally retarded or disciplinary problems are referred to the Merle Cooper program at Clinton. A therapeutic setting is provided which gives inmates group and individual counseling, work therapy, educational training and psychiatric/psychological services. Participants who exhibit psychotic symptoms are treated by the satellite unit at Clinton on an out patient basis or for short term (ten days) hospitalization. Between July 1977 and February 1979, Merle Cooper accepted 411 of 540 referred--an average of 206 inmates per year with an average stay of 11.2 months.

RAP Program. The Resident Activity Program (RAP) in Attica was established in 1979 to serve inmates identified as having mental and emotional personality disorders. Inmate counselors and counselor aides assist the program participants to handle their personal problems and daily correctional life. Activities, include daily living skills, remedial education and group and work therapy. Supportive services are provided by the satellite centers. The program served 48 inmates in 1980 with an additional 20 more to be assigned in 1981.

Inpatient Care. Some inmates' psychiatric problems are so severe that they require transfer to CNYPC. As discussed in Chapter I, Section 401 of the Correction Law provides due process and emergency procedures for the transfer of inmates from DOCS to OMH jurisdiction. The number of CNYPC admissions from DOCS doubled since 1977; during 1979-80 about 37 percent of the DOCS admissions were readmissions.

Year	DOCS Admissions	Average Length of Stay (days)
1977-78	219	71
1978-79	345	76
1979-80	448	78

Specialty Clinics

An outside consultant interviews and treats inmates in need of specialty care during a clinic held in a correctional facility. The DOCS Division of Health Services did not maintain information on the number and type of specialty clinics held at the various correctional facilities. With the exception of the reconstructive surgery program, there is little centralized management and coordination of this function; each facility made its own arrangements with consulting specialists.

The availability of specialty health clinics at the correctional facility varied among the 13 correctional facilities. No clinics were held at Coxsackie, Camp Adirondack, Lincoln and Mt. McGregor. An inmate in need of specialty care at one of these facilities might be transferred to an institution where care was available or be seen by a physician

practicing the specialty in the community. Inmates at Lincoln most likely would use the clinics available in the New York City area.

Clinton, Fishkill, Attica, Arthur Kill, and Auburn correctional facilities had the most extensive range of clinics available. During the period under review, 2,456 inmates at Clinton were seen at nine different types of clinics. Of these, almost 50 percent made use of the ophthalmology/optometry clinics; another 17.3 percent used the reconstructive surgery clinic. At Attica, of the 1,772 inmates who used a clinic, 90.5 percent went to the ophthamology/optometry clinic. The largest proportion of visits at Arthur Kill, 30 percent, were to the podiatry clinic.

At six facilities--Attica, Clinton, Coxsackie, Elmira, Fishkill and Queensboro--medical service providers mentioned that additional clinics would be helpful. An increase in the availability of clinics was suggested to reduce the costs of inpatient and ambulatory care as well as the attendant costs for security.

Medical Fee Schedule. Several Facility Health Service Directors and nurse administrators told LCER staff that the medical fee schedule was an obstacle to arranging for additional clinics. Health unit personnel at Attica, Coxsackie and Elmira said that physicians in their communities were reluctant to conduct on-site clinics because the reimbursement was considered inadequate. As currently structured, the fee schedule permits greater reimbursement for physicians who see inmates in their own offices than for those conducting on-site clinics.

Physicians often prefer to schedule clients at their professional offices. This may be more convenient, allows more productive use of their time and make available their own support staff. Conversely, consultations at the correctional facility involve time to commute and to clear security. Physicians also may be reluctant to come because of concerns about (1) the potential for unpleasant situations in dealing with inmates and (2) delayed payment for services.

The State Medical Fee Schedule was developed in 1975, and has not been revised since. Table 7 compares State medical fee schedule reimbursements for certain selected specialties to 1980 median fees for the eastern region of the United States. It shows large discrepancies between the survey data and the State medical fee schedule allowances, indicating that reimbursements have not kept pace with inflationary increases in fees.

The outdated medical fee schedule means that specialist and consulting physicians have little incentive to attend clinics in correctional facilities. Such clinics save the State considerable expense compared to transporting and escorting inmates to the specialist's office. Generally such escorts require two security guards and involve overtime expense, driving up the indirect cost of providing medical care. Further, scheduling problems and unavailability of escorts may result in delay of treatment, with potential for complications, complaints or lawsuits. For financial implications see Chapter IV.

Reconstructive Surgery Program. Since the early 1950's, DOCS has operated a reconstructive surgery program. In addition to elective surgery, inmates sometimes need surgery to remove functional defects or deformities, scars, congenital impairments, tattoos, etc. This program addresses such needs at two correctional facilities, Clinton and Fishkill. The Clinton component is supervised by an Albany Medical Center Hospital attending surgeon and surgical procedures are performed by resident physicians from the hospital without compensation. The Fishkill program is managed pursuant to contract with Montefiore Hospital. Surgical procedures are performed under local anesthesia, in

Table 7

Comparison of State Medical Fee Schedule
to Median Fees (East Region) by Specialty

	NYS Medical Fee Schedule	Median Fee East Region
Internist		
Initial Visit	$20.00	$35.00
Subsequent	15.00	21.00
Neurologist		
Initial Visit	20.00	73.00
Subsequent	15.00	30.00
Orthopedist		
Initial Visit	20.00	35.00
Subsequent	15.00	20.00
Obstetrician/Gynecologist		
Initial Visit	20.00	35.00
Subsequent	15.00	21.00
General Surgeon		
Initial Visit	20.00	25.00
Subsequent	15.00	16.00
Urologist		
Initial Visit	20.00	31.00
Subsequent	15.00	20.00
All Surgical Specialists		
Initial Visit	20.00	31.00
Subsequent	15.00	20.00

Source: LCER staff from NYS Department of Health, Medical Fee Schedule, (Albany: the Department, July 1, 1975) and Merian Kirchner, "Fees, Where They Stand in 11 Specialties," Medical Economics, October 13, 1980, pp. 210-213.

well equipped operating rooms. If need for more sophisticated medical support facilities is indicated, the inmate would be admitted to an outside hospital.

In 1979 the program provided 841 inmates with consultation services and 274 inmates with surgery as shown on Table 8. Consultant interview were held at Clinton, Great Meadows, Auburn and Fishkill, and inmates from 20 of the 33 correctional facilities were served. For each inmate, the reconstructive surgery program may involve extensive screening, consultation, one or more surgical procedure(s), and post-operative check ups. The program's 1979-80 costs were $13,782 for Fishkill and $13,850 for Clinton.

Referral to Outside Health Providers

Health services not available within the correctional system must be furnished outside the system at significantly higher costs because of transportation and security

Table 8

Reconstructive Surgery Program Workload
1979

Workload	Clinton	Fishkill
Consultation with Surgeon	554	287
Inmates Receiving Surgery		
In Facility	142	132
At Outside Hospital	123	127
Waiting List	19	5
	106	N/A
Type of Surgical Procedures Performed in Facility		
Scar Removal	16	37
Excision of Mass or Lesion	18	14
Tattoos Removed	6	13
Dermabrasion	6	6
Septoplasty	49	15
Rhinoplasty	--	44
Other Plastic Repairs	24	21
SMR	6	33
Other	7	--
Total	132	183

Source: DOCS, Division of Health Services.

escort considerations. Over the period 1977 through 1979, outside referrals of inmates for ambulatory health care increased from 13,792 to 16,463--by 19.4 percent. During the same period the inmate population increased from 15,829 to 19,754; a 25 percent growth. Table 9 shows outside ambulatory health care referrals by type over the three years.

Significant increases are noted in radiology and laboratory tests. The increase in use of outside dental providers is striking in view of shortages of DOCS dental staff noted by the Department of Audit and Control. Similarly, increases in outside provider reconstructive surgery raises a question as to the potential for expansion of the "in-house" reconstructive surgery program.

Inpatient Care at Community Hospitals

Community hospitals in proximity to the correctional facility render most of the needed inpatient hospital care. When an emergency arises, an inmate may be transported by ambulance or by security personnel to the hospital emergency room. Depending upon the severity of the injury, this may occur with or without physician approval.

It is the Facility Health Service Director's responsibility to identify inmates who warrant admission to an outside hospital for a planned medical or surgical procedure (elective surgery). As will be discussed in Chapter III, the inmate's condition is classified

Table 9

Outside Health Referrals for
State Prison Inmates

	1977	1978	1979
Diagnostic Tests			
X-Ray	609	1,452	2,310
Gastrointestinal	105	211	a
EEG	90	266	206
EKG	108	197	100
IVP (Kidney X-ray)	277	70	a
Lab	256	720	1,009
Gall Bladder	12	54	a
Brain Scan	7	68	a
Other	164	405	--
Subtotal	1,628	3,443	3,625
Ophthalmology	1,126	1,356	877
Ear, Nose, Throat	686	629	658
Dental	919	1,107	1,599
Surgical Consults			
General	2,431	3,334	1,063[b]
Reconstructive	113	66	110[c]
Orthopedic	1,772	1,386	1,322[d]
Renal Dialysis	666	719	1,123[e]
Dermatology	351	360	527[f]
Physical Therapy	2,037	1,455	932
Other	2,063	596	4,251
Total	13,792	14,451	16,087

[a]Included in X-ray category.
[b]Includes 496 Diagnosis/Evaluations, 151 Treatments, 416 Followups.
[c]Of the 110, 46 are classified as Diagnosis/Evaluations, 4 Treatments, and 60 Followups.
[d]Includes 576 Diagnosis/Evaluations, 60 Treatments, 478 Followups, 60 Prosthetics, 26 Appliances, 37 Shoes, 82 Hand Clinic and 3 Outpatient Surgery cases.
[e]All nephrology referrals including renal dialyses.
[f]Includes allergy.

Source: DOCS, Division of Health Services.

as to priority, and a request for a examination or surgical procedure (HS-19 form) is sent to the DOCS Physican's Review Committee for approval or denial.

Results of DOCS Approvals. LCER staff reviewed planned surgery requests for the 13 facilities, which were approved by DOCS during January through March 1980. As of December 31, 1980, 60 of the 100 approved surgeries were completed. The number of months required to complete and the reasons/factors for noncompletion follows:

Completed		Not Completed	
Months to Admit	Number of Inmates	Reason	Number of Inmates
1	23	No Record	4
2	10	Inmate Refused	5
3	8	Inmate Paroled/ Released	6
4	4	Inmate Transferred	15
5	1	No Reason	8
6	1	Other Treatment Elected	2
7	--		
8	2		
11	1		
Unknown	10		
Total	60	Total	40

Many inmates who received approval for medical surgical procedures at outside hospitals never received them. Others, whose procedures were approved, waited as long as 11 months.

The Division of Health Services has instituted a "medical hold" procedure for priority cases approved for elective surgery. Basically, inmates scheduled for surgery are retained at the correctional facility until that surgery is performed. The effectiveness of this procedure in assuring that inmates receive scheduled elective surgery, however, remains to be demonstrated.

Inpatient Utilization Data. Table 10 presents the number of outside hospital admissions, discharges, patient days and the average length of stay for State prison inmates, from 1975 through 1979. Overall admission/discharges and patient days increased by two-thirds during this period.

Table 10

State Inmate Inpatient Care at Community Hospitals
1975-1979

	Patients		Patient Days	Average Length of Stay[a]
	Admitted	Discharged		
1975	885	880	8,462	9.6
1976	1,067	1,043	10,418	10.0
1977	1,318	1,294	12,864	9.9
1978	1,261	1,260	12,652	10.0
1979	1,474	1,465	14,067	9.6
Percent Increase[b]	66.6	66.5	66.2	--

[a]Based upon discharges.
[b]Compares to a 28.3 percent increase in inmate population.

Source: DOCS, Division of Health Services.

Type of Inpatient Care. Table 11 shows the patient days used during January through June 1980 by type of health problem or disease. Over half of patient days are covered in the first six categories. Removal of tumors, stomach surgery, orthopedics, heart and kidney problems and neurological problems are among the most prevalent reasons for inpatient admission.

Table 11

State Inmate Patient Days in Community Hospitals by Type of Disease/Problem
January through June 1980*

Problem/Disease	Patient Days	Percent of Total
Abdominal Surgery	615	10.2
Orthopedic	595	9.8
Neurology	563	9.3
General Medical	546	9.0
Neoplasm	476	7.9
Cardiac	475	7.9
GU/Renal/Kidney	466	7.7
Thoracic Nonsurgery	322	5.3
Minor Surgery	270	4.5
Hernia	258	4.3
Gastrointestinal	214	3.5
Rectal/Anal	198	3.3
Ear, Nose, Throat	153	2.5
Eye	140	2.3
Dental	96	1.6
Deceased	82	1.4
Gynecology/Obstetrics	73	1.2
Stabbing	71	1.2
Plastic Surgery	65	1.1
Metabolic	55	.9
Neurosurgery	45	.7
Psychiatry	29	.5
Thoracic Surgery	26	.4
Incomplete Information	213	3.5
Total	6,046	100.0

*Includes inmates either admitted or discharged during this period.

Source: Compiled by LCER staff from DOCS, Division of Health Services, "Community Hospital Report" data, January through June 1980.

Interfacility Variation in Inpatient Care. The 33 correctional facilities vary in the extent to which inpatient hospital care is used. The following presentation characterizes 1979 utilization of inpatient hospital care, by security level and by male and female inpatient use.

Number of:	Security Level - Male Maximum	Medium	Minimum	Female
Facilities	9	9	13	2
Discharges	852	464	52	97
Patient Days	7,840	5,104	356	767
Inmates	12,002	5,309	1,969	530
Length of Stay (Days):				
Minimum	1.40	5.70	1.00	7.80
Average	9.20	11.00	6.80	7.90
Maximum	13.20	18.30	9.00	8.80
Patient Day/Inmate	0.65	0.96	0.18	1.45
Discharge/Inmate	0.07	0.09	0.03	0.18

Source: DOCS, Division of Health Services.

Maximum security facilities use the most inpatient care, because they hold 61 percent of the inmates in the system. However, proportionally more inpatient care is rendered to medium security and female inmates as reflected by the percent of patient days to inmate population (.96 and 1.45 respectively). Minimum security inmates use the least amount of inpatient care; part of this is due to the selection of healthy inmates as campmen.

The reasons for the variations in inpatient utilization among the facilities are not clear. Of the larger facilities, Attica, Fishkill, Ossining and Queensboro report long 1979 average lengths of stay for inpatient care (13.2, 14.2, 13.5, and 18.3 days respectively), while Elmira and Coxsackie report very low 1979 average lengths of stay (1.4 and 2.4 days, respectively). Elmira, to prevent unnecessary hospitalization, brings patients to the facility infirmary for recuperation. This minimizes costs of outside hospitalization, (See Chapter IV), but places an additional burden on a sometimes overcrowded and understaffed infirmary.

DOCS has pointed out in its initial response to this audit that medium security facilities (particularly Fishkill and Queensboro) have some chronic and disabled inmate who required a disproportionately high number of inpatient care days. DOCS states: "Disregarding the increased length of stay generated by the Unit for Physically Disabled patients, the elimination of 400 days attributable to the two Fishkill and Queensboro cases, the length of stay for all medium security facilities drops from 11.0 to 10.2 days."

DOCS explains further:

> The variations in lengths of stay depend on diagnoses, available resources at the facility level, availability for follow-up, care and treatment and trust in the facilities health care staff by the community provider. Due to the litigiousness nature of our clients, the outside practitioners are reluctant to discharge to the facility in which they have no direct supervision or control.

The utilization review program discussed in Chapter III deals with DOCS efforts to reduce unnecessary hospitalization of inmates.

Secure Wards. A secure hospital ward allows the grouping of inmate inpatients in a special section of a hospital. The advantage is savings in security coverage due to the consolidation of bed and hospital space. The disadvantages are hospital staff resistance to giving special treatment to inmate clients and the difficulty of serving inmates in one place when hospital units and specialties are decentralized.

DOCS provide security at four secure wards:

--A six bed unit at Erie County Medical Center serving Western New York,

--A four bed unit at Glens Falls Hospital serving Great Meadow,

--Up to eight beds at Champlain Valley Physicians Hospital serving Clinton, and

--A 15 bed unit at Westchester County Medical Center serving the downstate area.

The number and proportion of inmate patient days provided in the secure wards has grown. In 1976, 5,172 of 8,462 inmate patient days (61 percent) were furnished by secure wards. In 1979, 9,302 of 14,067 inmate patient days (66 percent) were provided by secure wards. However, over half of the 1979 secure ward patient days were provided by Westchester County Medical Center's secure unit, where the 15 beds are guaranteed by the State; the other three hospital secure wards divided the remaining patient days. Westchester County is the only one of the secure ward hospitals with a full-time nurse coordinator who plans and oversees workload and monitors bed utilization.

Because 4,765 patient days were furnished in nonsecure ward hospitals during 1979, further development and more careful monitoring of the secure ward program may be beneficial. This could reduce or even eliminate the State expenditure for security coverage in nonsecure ward programs.

Allocation of Inmate Health Resources

This section reviews the distribution of inmate health service resources at the facilities visited by LCER staff. A comparison of the number of health related positions, staffing patterns and the available health facilities is presented.

This analysis is based on the number of hours health providers were available at the time of LCER staff's visit at the correctional facility. It assumes a 35 hour work week for physicians and dentists and a 40 hour work week for all other personnel.

Significant variation in the number of filled full-time equivalent (FTE) health positions was apparent among the 13 correctional facilities. The staffing differences were not necessarily related to the size or security classification of the facility.

A summary of the numbers of health service staff and their availability, for each facility is provided in Table 12. Persons on leave of absence or vacant positions were not counted on the table. Persons on vacation or short-term leave were included in the count.

Table 12

Allocation of Inmate Health Resources Health Service Positions
August/September 1980

Health Services Position	Maximum Security					Medium Security				Minimum Security			
	Attica	Auburn	Clinton	Coxsackie	Elmira	Arthur Kill	Fishkill	Queensboro	Woodbourne	Bayview	Camp Adirondack	Lincoln	Mt. McGregor
Physicians													
Number (FTE)	.43	1.14	2.00	.57	1.57	1.60	1.00	1.14	.93	.69	.09	.31	--
Total Hours/Week	15	40	70	20	55	56	35	40	33	24	3	11	--
Dentists													
Number (FTE)	2.29	2.50	4.57	1.00	1.00	1.00	2.28	.57	.57	--	.46	--	.57
Total Hours/Week	80	87.5	160	35	35	35	80	20	20	--	Up to 16	--	20
Dental Hygienists													
Number (FTE)	1.0	--	--	--	--	--	--	--	--	--	.5	--	--
Total Hours/Week	40	--	--	--	--	--	--	--	--	--	20	--	--
Dental Assistant													
Number (FTE)	--	--	--	--	--	2.0	2.0	1.0	1.0	--	--	--	--
Total Hours/Week	--	--	--	--	--	80	80	40	40	--	--	--	--
Physician's Assistant													
Number (FTE)	2	--	3	--	--	--	--	--	--	--	--	--	--
Total Hours/Week	80	--	120	--	--	--	--	--	--	--	--	--	--
Nurses													
Number (FTE)	9	8	17.5	6.8	9	7	20	6	6.8	7	0.5	2	1
Total Hours/Week	24 Hours/7 Days a Week										20	80	40
Pharmacists													
Number (FTE)	1.0	1.0[a]	1.0	--	1.0	.5	1.0	--	.5	--	--	--	--
Total Hours/Week	40	40	40	--	40	20	40	--	20	--	--	--	--
Radiology Technicians													
Number (FTE)	1.0	1.0	1.0	0.05	1.0	1.0	1.0	--	0.05	--	--	--	--
Total Hours/Week	40	40	40	2	40	40	40	--	2	--	--	--	--
Medical Lab Technician													
Number (FTE)	1.0	--	1.0	--	--	--	1.0	--	--	--	--	--	--
Total Hours/Week	40	--	40	--	--	--	40	--	--	--	--	--	--
Medical Records Clerk													
Number (FTE)	1.0	1.0	1.0	1.0	1.0	1.0	1.0	--	1.0	--	--	--	--
Total Hours/Week	40	40	40	40	40	40	40	--	40	--	--	--	--
Clerical/Steno													
Number (FTE)	2.0	1.0	4.0	1.0	1.0	1.0	1.0	1.0	1.0	--	--	--	--
Total Hours/Week	80	40	160	40	40	40	40	40	40	--	--	--	--
Inmate Census on Day of LCER Visit	1,701	1,565	2,456	700[b]	1,526	785	1,198	300	697	127	207	140	124

[a] There is also a full-time pharmacy aide employed at Auburn.
[b] Approximately.

Source: LCER Staff Visits at Sample Correctional Facilities.

Physicians

The number and availability of physicians varied greatly. This was especially noticeable in the maximum security facilities. For example, Attica which had the second largest inmate census, had a physician at the facility 15 hours per week. In comparison, Elmira which had almost 200 fewer inmates than Attica, had a physician at the facility 55 hours per week. Auburn, with an inmate population almost identical to Elmira, had a physician available 40 hours per week.

The variation in the availability of physicians and its possible effect on inmate health care is highlighted when maximum and medium security facilities are compared. For example, Queensboro with an inmate population of 300, and Auburn with 1,565 inmates, both had physicians available 40 hours per week. As a second example, Arthur Kill with an inmate census of 785, had a physician available 56 hours per week; Elmira, as pointed out above, with more than twice the number of inmates, had a physician available for 55 hours per week. The relationship between the number of inmates at a facility and physician availability may significantly affect access to health care.

Except for Bayview, a facility for females, physician availability at minimum security facilities was limited. This is attributable to the relatively small number of inmates and also to the supposition that these inmates have fewer medical problems, a prerequisite for transfer to some minimum security facilities.

An analysis of the difference in physician availability at the institutions must consider the variation in the hours of coverage for clinical physician positions. As shown in Table 13, there was significant variation in the number of hours full-time physicians were actually available at the institutions.

In several instances the variation in hours available was not related to the salary paid. For example, full-time physicians at Attica, Auburn, Coxsackie and Elmira were available at the facilities for only 20 hours or less per week. Yet they were being paid more than other physicians at Clinton, Fishkill and Elmira who worked a 35 hour week. Ad hoc arrangements were being made to provide a minimum level of physician coverage at certain correctional facilities with salary disparities resulting. See Chapter III for more on the physician salary issue.

Note that these physician allocation data relate to physician service patterns identified previously on Table 4. For example, Auburn and Elmira, with physicians available 40 and 55 hours per week respectively, also have high percentages of inmate encounters, 33.5 and 32.3 respectively provided by physicians. Similarly medium security facilities show high inmate access to physicians.

Other Health Service Personnel

There was also variation in the number and availability of dentists in the facilities. For example, at Elmira and Auburn, which have similar inmate populations, dentists were available respectively, 35 hours and 87 hours per week. Bayview and Lincoln did not have dentists on the premises and inmates in need of dental care were taken to other State correctional facilities in the City.

Nursing coverage was available 24 hours a day/seven days a week at all of the facilities except Camp Adirondack, Lincoln and Mt. McGregor.

Table 13

DOCS Physician Grades Hours and Salaries
August/September 1980

Institution	Clinical Physician[a]	Number of Physician Hours Per Week[b]
Attica	II	15
Auburn	II	20
	I	20
Clinton	II	35
	I	35
	PT	8
Coxsackie	I	20
Elmira	II[c]	20
	I	35
Arthur Kill	PT	20
	PT	20
	PT	16
Fishkill	II	35
Queensboro	I	20
	I	20
Woodbourne	I	15
	PT	18
Bayview	I	35
Lincoln		
Camp Adirondack	--	--

[a]Key: I= Clinical Physician I, II = Clinical Physician II, PT = part time Clinical Physician.
[b]As of LCER staff visit to the facility during August and September 1980.
[c]This physician also serves as a part-time Regional Health Services Director.

Source: LCER staff Visits at Sample Correctional Facilities.

Staffing Standards

Health service staffs at the facilities reviewed are inadequate when compared with generally accepted staffing patterns. The ACA has provided a guideline or suggested staffing pattern for health service positions at correctional facilities. Based on a 500 inmate facility, the ACA recommends:

--One physician or physician's assistant,

--Seven nurses and/or physician's assistants,

--Three paraprofessionals,

--One dentist,

--One dental assistant and one dental hygienist, and

--Three clerical support positions.[19]

As shown in Table 14, none of the facilities completely met the guidelines. Attica, Auburn, Coxsackie, Elmira and Woodbourne were below each of the staffing guidelines. Queensboro, on the other hand, met the guidelines for physicians, dentists and nurses.

Physicians. Clinton, Arthur Kill, Queensboro, Bayview and Lincoln met the guidelines for physicians. Auburn and Elmira, on the other hand, fell short of the ACA standard; while both facilities should have had at least three physicians and/or physician's assistants, they had 1.1 and 1.7 FTE's in these positions respectively.

Dental. Fishkill, Queensboro, Camp Adirondack and Mt. McGregor were the only facilities that met the guidelines for dentists. Camp Adirondack was the only facility which met the dental hygienist standard. In fact, Attica was the only other facility that employed a dental hygienist. Though Arthur Kill, Fishkill, and Woodbourne employed dental assistants, only Arthur Kill met the ACA guidelines for this position.

Nursing. Although understaffing was common in all medical provider positions, nursing was the greatest shortage area. For example, based on the ACA standard, Attica should have at least 23 nurses, Auburn 21, Clinton 35, Coxsackie 10, and Elmira 21. But except for Clinton which had 17.5 FTE nursing positions, none of the facilities had more than nine positions filled. Only Fishkill, Queensboro, Bayview and Lincoln met the standard for nurses.

Table 14

Correctional Facilities
Compliance to LCER Sample ACA Health Staff Guidelines

Correctional Facility	Physician or Physician Assistant	Dentist	Dental Assistant	Dental Hygienist	Nurse	Clerical Support
Maximum Security						
Attica	No	No	No	No	No	No
Auburn	No	No	No	No	No	No
Clinton	Yes	No	No	No	No	No
Coxsackie	No	No	No	No	No	No
Elmira	No	No	No	No	No	No
Medium Security						
Arthur Kill	Yes	No	Yes	No	No	No
Fishkill	No	Yes	No	No	Yes	No
Queensboro	Yes	Yes	No	No	Yes	No
Woodbourne	No	No	No	No	No	No
Minimum Security						
Bayview	Yes	No	No	No	Yes	No
Camp Adirondack	No	Yes	No	Yes	No	No
Lincoln	Yes	No	No	No	Yes	No
Mt. McGregor	No	Yes	No	No	No	No

Source: LCER staff from ACA 4257.04.

Clerical Support. None of the facilities met the guidelines established by ACA for clerical support positions. The shortage of clerical staff resulted in medical personnel, especially nurses, doing non-medical jobs. An example of this was the use of nurses to verify the services of outside providers.

In addition to the apparent staff shortages at the sampled facilities when compared with the ACA standards, the need for increased medical providers was stated by medical staff and inmates.

Vacancy Rates. As discussed in the next chapter, there is a significant number of vacancies among the various health services positions. For example, at least 55 percent of the dental hygienists and health care manager positions were vacant as of October 1980. Also, at least 25 percent of the physicians, pharmacist, radiology technician and clerical positions were vacant.

Of the facilities included in the LCER study, only Coxsackie, Arthur Kill and Queensboro did not have any health staff vacancies as of October 1980.

Inmate Health Providers

One result of the understaffing in the health service areas is the use of inmates in the delivery of health care. In five of the facilities included in the study--Auburn, Clinton, Coxsackie, Elmira and Camp Adirondack--inmates had access to health records and were involved in providing health care. This is contrary to standards set forth by the AMA and the ACA which recommend that inmates not be involved in the delivery of health care.[20] DOCS promulgated a policy in 1974 prohibiting inmate access to health records; this policy has been abandoned.

The capacity in which inmates were used at the five facilities varied. At Clinton and Elmira the nurse was aided at sick call by an inmate health assistant. At Clinton, inmates transferred and filed medical records, served as orderlies in the infirmary and as operating room technicians, and even as helpers in the pharmacy. Approximately 15 inmates were used at Elmira to file medical records, as orderlies and to change or dress wounds. At Coxsackie, inmates filed dental records and provided such medical care as enemas and baths. Inmates at Auburn took the vital signs of sick inmates during afternoon and evening hours.

None of the four medium security facilities used inmates to handle records or deliver health services. Of the minimum security facilities, only Camp Adirondack used inmates in the job of dental assistants.

Emergency Response

In case of an emergency or accident, a correctional officer (CO) would most likely be the first individual on the scene. All COs receive instruction in basic first aid as part of their initial training. There are, however, no departmental requirements for training as an emergency medical technician (EMT) or in cardio-pulmonary resuscitation (CPR). This training is left to the discretion of the individual CO or facility superintendent. Consequently, there was variation in the number of COs at an institution who had received advanced emergency training. For example, at Arthur Kill, Fishkill, Camp Adirondack and Mt. McGregor all COs had received instruction in CPR, while at Bayview none of the COs had. At the other facilities at least some of the COs had received advanced emergency training.

Health Service Facilities

At each of the institutions visited, LCER staff toured the health service facilities. LCER staff reviewed the physical layout of the medical areas and their maintenance, the extent and condition of medical equipment, and the security coverage provided to health personnel. There were differences among the institutions in the size and care of the health service facilities. Generally, the areas were found to be adequate with the basic equipment needed to provide routine and emergency care. However, most were not as clean or as well equipped as a community hospital should be. This section will highlight some of the more serious problems observed during the LCER visits.

The most serious deficiencies were at Fishkill. The central clinic, where sick call and physical examinations were held, was in a basement. The quarters were cramped and poorly lit. It was dirty, with flaking paint, roaches and a history of rat infestation. A second area--the elderly and handicapped unit--was also poorly lit, dirty and dingy. The CO on duty warned LCER staff not to enter a particular area because of "rats."

The security protection for medical staff at Fishkill was poor. For example, the nurse dispensing medication on one of the hospital floors was without CO protection except when medications were scheduled to be dispensed. The nearest CO was a distance away, and through a locked door. The nurse did not have a radio or "security" phone. The nurse and controlled medications and syringes were vulnerable.

The infirmary area at Bayview was inadequate and it was used for storage and as the clerk's working area. Since it was located near the nursing station where daily sick call was held, it would be a difficult place to rest. A second problem was that the keys for the narcotics cabinet were kept in a drawer in the pharmacy area. This was against regulations and could pose a problem because inmates cleaned the area and could get access to the keys and drugs.

The infirmary at Arthur Kill was also inadequate. It had several ceiling tiles missing and was cluttered with excess or discarded equipment.

At Attica the major problem was the pharmacy as previously discussed. It was dirty and disorganized. Contrary to statute, there was no perpetual inventory of controlled drugs. Medications were being dispensed by COs in the cell blocks. They told LCER staff that an increasing number of drugs have been found missing from dispensary boxes in the cell blocks.

Woodbourne is at the other end of the spectrum since the physical plant was comparatively new. More than adequate space was available, and the medical areas were clean with appropriate security precautions.

Management of Inmate Health Resources

This section assesses the adequacy of facility management of inmate health services. Management practices and resources of the facilities are compared to generally accepted health administration standards.

According to ACA, AMA and USDJ standards, the management of inmate health services should rest with a designated facility health authority.[21] This individual should have responsibility for health care services pursuant to a written agreement, contract or

job description. The AMA has defined health care to include, among other things medical and dental services, personal hygiene, dietary and food services, and environmental conditions.

The management practices in the health services area varied among the institutions visited by LCER. It was apparent that none of the facilities had complied completely with the preceding health administration standards.

Clinton Correctional Facility came closest to meeting the suggested standard for a health care facility manager. At Clinton, an individual, with a written job description, had been designated manager. The person's responsibilities included managing the dental, pharmacy, nursing, medical and medical support areas. Attica also has a health care facility manager position but it was not filled. Both the superintendent and nurse administrator at Attica, in interviews with LCER staff, mentioned that a health service manager was needed.

Facility Health Services Director

In most of the other facilities, health management is the responsibility of a physician who has been designated "Facility Health Services Director." In actuality the designation in many cases appeared to be pro forma with the physician's time at the facility limited and actual management roles minimal. Health services management was often undertaken by nurse administrators who had other duties and administrative and management tasks were not done. Consequently, LCER staff found that there is often inadequate management of the health care delivery system at the facility level.

Attica, Coxsackie, Elmira, Arthur Kill, Queensboro, Woodbourne, Bayview and Lincoln each had a Facility Health Services Director. The physicians' actual role in the management of the health care system varied among the institutions. For example, at Elmira the physician was clearly in charge of inmate health services. As director he was responsible for the management of medical, dental, pharmacy, laboratory, nursing and other health services. At Attica, on the other hand, the designated facility health director did not directly supervise health care. The nurse administrator provided some management but only as time permitted.

Although the Superintendent at Arthur Kill identified one of the physicians as Facility Health Services Director, the physician disagreed and said he was a part-time physician only. An unusual management situation was noted at Woodbourne: while responsibility for health services management had been assigned to the Facility Health Services Director, a Regional Health Service Director and the facility's Deputy Superintendent for Administration shared management of the system.

Camp Adirondack and Mt. McGregor did not have Facility Health Services Directors. At Camp Adirondack the institutional steward reported to the Superintendent who made the decisions.

According to the standards and DOCS' job description for Facility Health Services Director, the physical environment and general sanitation of the facility come under the purview of the health services director. But at the facilities in this study, environmental matters were the responsibility of the deputy superintendent for administration or the housekeeping and fire and safety committees which were usually headed by a CO. (At the time of the LCER visit, neither the housekeeping nor the fire and safety committees were operating at Attica or Bayview.)

Facility Level Evaluation of Health Services

The AMA and APHA recommend that individual correctional facilities monitor and evaluate health care services as part of effective management practices.[22] It is suggested that there be both independent, i.e., medical school audit teams, local medical society review teams and PSRO participation, and internal, i.e., peer review, audits of health care services. There were no mechanisms to review the health services delivery system in any of the facilities visited by LCER staff.

Health Records Management

The management of medical records, considered by inmate health care authorities to be crucial as a base line indicator of health care, was found inadequate in some facilities. For example, at Attica the medical records did not include information on medication prescribed by the psychiatrist. In addition, many medical codes were missing or improperly filled out. At Auburn, Clinton and Arthur Kill records were found to be incomplete, with items missing and improperly filed. The records at several other institutions were illegible. Finally, inmates had access to medical records at three facilities. This is contrary to generally accepted standards.

A subsequent section of this chapter reviews the adequacy of the medical records system, based on LCER's random sample of inmate records.

Quality of Service

This section presents several perspectives on how well the inmate health delivery system is working, and the extent to which it serves the inmate population.

Employees

Facility administrators and health service personnel in the institutions told LCER staff that inmates were receiving better medical care in prison than they did when they were on the outside. They maintained that since many of the inmates have backgrounds of poverty, under-education, and alcohol and drug addiction, they had little exposure to proper medical care. Several health providers said that the care received by inmates was better than the average individual could expect; they cited 24 hour nursing coverage, free medical care and access to specialty physicians to back up their statements.

Although generally satisfied that inmates were being provided adequate health care, health service personnel did not view the delivery system as without shortcomings. Most needed were more on-site clinics and an increase in medical and support personnel and supplies. Several persons also noted that problems sometimes arise because of a conflict between medical and security considerations.

Inmates

Not unexpectedly, inmates did not perceive the health services as favorably. At each of the facilities, LCER staff interviewed members of the Inmate Grievance Committee and Facility Liaison Committee. Although there were unique problems and concerns voiced at each of the institutions, certain common problems were identified.

Inmates at several institutions told LCER staff that there was little, if any, orientation with regard to the available medical services. Consequently, new inmates lack an awareness of the medical services and only become fully aware of the services through their peers. The inmates at one facility said that they were aware of the services available but not of their rights with regard to such services. A second problem mentioned by inmates at several of the facilities was the difficulty they had in gaining access to the facility's physician. Long waiting periods to see the dentist were also indicated as a problem.

Inmates voiced concerns about the quality of the medical services available. Most often mentioned was that after sick call hours it was very difficult to get medical care unless there was an emergency with symptoms recognizable by COs. A second complaint dealt with the biennial physical examination. Inmates interviewed at several institutions maintained that often they were not given or administered late. LCER's record search verified this.

Finally, inmates brought to the attention of LCER staff conditions within the facility that they believed were dirty, unsanitary or unhealthy. Following their suggestions, LCER staff inspected the areas and some were found to be unsanitary. (See the preceding section on facilities and Chapter III sections on "DOCS Environmental Health and Department of Health--Inspection Findings.")

Licensure and Identification of Health Personnel

According to State regulations all professional health personnel are required to be licensed. LCER verified that all the medical staffs were licensed at the facilities under review.

State regulation requires health professionals practicing in a hospital, clinic, group practice or multiprofessional facility to wear identification badges. Rarely did health personnel wear badges indicating the practitioner's name and professional title. Inmates especially at the larger facilities, were unable to tell who was furnishing health service.

Adequacy of Records

The base line indicator of the health care received by inmates is the health record. The importance of the record being complete, legible and properly filled out is a generally accepted standard of the medical profession. This criterion is critical when the medical care of an individual is not necessarily the responsibility of one health provider; this is what often occurs in prisons. An inmate, especially at larger facilities, is not likely to be seen by the same health care provider on different sick call visits. Thus, the health professional delivering the care is dependent upon the information contained in the records for previous problems, diagnoses and treatments.

According to departmental directives all inmates are to have an active health record which is to contain the following information:

--Problem list--stapled to the inside left side of the folder;

--AHR--in chronological order;

--Physical examination--stapled to the inside right side of the folder, over the medical history; and

--Medical history--stapled to the inside right side of the folder, under the physical examination.

Most of the records reviewed in the LCER sample had the problem list and ambulatory health records in their proper places, as shown:

	Percent		
	Missing from Record	Filed in Wrong Place	In Proper Place
Problem list	2.4	0.3	97.4
AHR	1.6	1.8	96.6
Physical	4.2	14.0	81.8
History	4.0	14.2	81.8

There were greater problems with the physical examination and the medical history forms. Both the physical examination and medical history forms were missing in four percent of the records and misfiled in another 14 percent of the folders.

Even when the required forms were in the folders, they were not always filled out completely or correctly. For example, as part of the physical examination there is a 21 item general information section which includes such data as pulse rate, temperature, weight and blood pressure. Overall, 9.5 percent of the general items were missing from the record. In nine of these institutions at least 11 percent of the general items had not been completed. The largest proportions of items missing were in the records of minimum security facilities; 22.6 percent at Mt. McGregor, 15.9 percent at Bayview and 14.3 percent at Lincoln. Records at Attica, Auburn, Clinton, Queensboro, Woodbourne and Camp Adirondack had some 12 percent of these items missing. On the other hand, less than one percent of these general items were missing from the records at Coxsackie and 3.3 percent from Elmira's records.

For each entry on the AHR, there is to be an indication of who provided the primary health care, i.e., physician, nurse, physician's assistant, etc. This information was not indicated on seven percent of the encounters reviewed. In another one percent of the encounters this information was illegible. Similar to other indicators of record adequacy, there was variation among the individual institutions.

At Clinton, information on the health service provider was not indicated in 15.8 percent of the encounters reviewed. The respective proportions at Arthur Kill and Coxsackie were 11.7 percent and 9.4 percent. All of the encounters at Queensboro, Lincoln and Bayview had this information indicated.

Each problem addressed during a health service encounter is to be coded on the ambulatory health record using the "International Classification of Health Problems in Primary Care" (ICHPPC) code. Of the encounters reviewed, 37.3 percent were not properly coded. Less than 50 percent of the encounters at Clinton and Mt. McGregor had been properly coded. Camp Adirondack and Woodbourne had the highest proportions of properly coded encounters 88.9 percent and 85.1 percent respectively. This information is presented for all facilities:

Institution	Percent Properly Coded
Attica	57.0
Clinton	47.5
Auburn	67.0
Elmira	74.2
Coxsackie	77.4
Arthur Kill	72.7
Fishkill	53.6
Queensboro	52.4
Woodbourne	85.1
Bayview	57.9
Camp Adirondack	88.9
Lincoln	75.0
Mt. McGregor	48.3

Adequacy of Physical Examinations

LCER's sample of health records was used to assess the completeness of the physical examinations administered at the correctional institution.

Part of an inmate's active health record is the physical examination form. It includes a listing of the areas to be examined during the physical. The individual conducting the physical is to indicate if the area was examined and if it was normal or abnormal.

Overall, almost seven percent of the required examinations had not been checked off. The largest proportion of items missing, i.e., the least complete was at Coxsackie, where 14.3 percent of the items were not included in the examinations. The respective proportions at Elmira, Fishkill and Arthur Kill were 9.5 percent, 7.6 percent and 7.3 percent. Only at Bayview were all areas included in the physical examinations.

A second indicator of the completeness of the physical examinations is the number of laboratory tests given. Depending on the age, race and sex of the individual, departmental rules require between five and ten tests as part of the physical examination.

Almost one fifth of the required lab tests were not given. Except for Coxsackie and Fishkill, at least ten percent of the required lab tests at each institution had not been administered. At Camp Adirondack, Mt. McGregor and Woodbourne over one-third of the tests had not been administered.

Inmates are to receive physical examinations annually if they are over 40 years of age and biennially if under 40. In the LCER sample, 24 percent of the inmates were overdue in receiving their physicals. Of these 47 percent were more than one year late while another ten percent were four or more years overdue.

Chapter Summary

Contrary to the intent of Correction Law, Section 137(1), DOCS did not have a program and classification procedure to evaluate the physical, mental and emotional

conditions of each inmate entering the system. Such uniform procedures had been discontinued by DOCS. In 1980, LCER staff found the process designed primarily to serve the security program, with most emphasis on cell availability.

Ⓝ Orientation of inmates to available health services was minimal. AMA and ACA recommend that such orientations be both oral and in writing so that the inmate can act in his own best health interest.

Ⓟ Attica and Elmira, of the 13 sample correctional facilities, did not meet the ACA and AMA minimum standards for inmate access to sick call.

Ⓠ Health records were not being maintained properly nor were they always consulted. Many health encounters were never recorded. Good medical practice dictates that all health encounters be recorded in the health record and that the record be available during the health encounter. Given the increasing number of health-related inmate lawsuits being brought, complete record keeping is essential.

Ⓞ Emergency equipment was not properly maintained, in some instances, or was impractical for the setting in which it would have to be used.

Ⓞ DOH noted the absence of a systemwide pharmacy policy and procedure manual. The pharmacy operation at Attica, in particular, was found to be deficient.

Ⓞ At Auburn and Attica, correction officers were administering controlled substances. AMA and ACA recommend that medications only be administered by medical personnel. At Attica there was poor accountability for controlled substances.

Inmate Use of Health Services

Ⓞ The LCER survey shows that about two-thirds of the inmates made minimal use of health services--i.e., no visits or two or fewer visits--during the three month study period. Conversely, about 18 percent of the inmates drew heavily on the system--five or more visits during the study period--accounting for 55 percent of the total health encounters. These and other LCER survey results suggest a review of DOCS policies: (1) of minimal emphasis given to inmate health in classification and placement decisions, and (2) of allocation of health resources within the correctional facilities system.

Ⓟ Inmates in maximum security facilities used considerably less health care than did those at minimum or medium security facilities. Similarly, physicians handled proportionately fewer of the inmate cases in maximum than in medium and minimum security facilities. These variations suggest that security considerations may inhibit inmate access to health care.

Ⓠ The LCER survey highlights the extensive use of mental health care in prisons, with one-third of the inmate sample requiring mental health services. This proportion would seem understated, however, in view of the limited or unavailable mental health personnel at several of the LCER visited facilities.

Ⓡ Having outside medical specialists come to a correctional facility saves the State money by reducing security and escort costs. Correctional facilities varied in the extent to which they provided specialty clinics. Most health services personnel interviewed agreed that such clinics were desirable from both medical and efficiency viewpoints. The major obstacle to providing more specialty clinics was an out-of-date fee

schedule, which provided little incentive for specialists to come to the correctional facility.

Ⓢ The in-facility reconstructive surgery program provided 274 inmates with surgical procedures in 1979. Program expansion may be beneficial if reconstructive surgery inpatient days at community hospitals thereby would be reduced.

Ⓣ While inpatient days at community hospitals were increasing (at a slower rate than inmate population growth), DOCS was attempting to shift this care to secure ward settings. Secure wards facilitate the consolidation of security staffing, effecting reductions in the indirect (security) costs of inpatient care.

Ⓤ Another cost-effective technique to lower inpatient care costs was increased use of infirmaries for inmate convalescence from surgery. This approach, however, is contingent upon the adequacy of medical support and nursing coverage at the facility's infirmary. Many of the infirmaries may not be suitable for this function.

Ⓥ Variations in use and length of inpatient care were widespread among the correctional facilities. Significantly more inpatient care was rendered at female and medium security facilities than at maximum facilities.

Allocation of Resources

Ⓞ No correlation existed between the number of inmates at a facility and physician availability.

Ⓞ The number of hours physicians classified as full-time were available varied among the institutions. For example, at Attica, Auburn, Coxsackie, and Elmira, physicians classified as full-time were available at the facilities for 20 hours or less per week.

Ⓦ Nursing coverage was available 24 hours a day/seven days a week at all of the facilities except Camp Adirondack, Lincoln and Mt. McGregor.

Ⓧ The ACA's suggested staffing patterns for health service positions were not being met. Attica, Auburn, Coxsackie, Elmira and Woodbourne did not meet any of the staffing guidelines. Queensboro met the most standards, three out of seven.

Ⓞ Contrary to AMA and ACA standards, inmates were involved in the delivery of health care at Auburn, Clinton, Coxsackie, Elmira and Camp Adirondack.

Management of Facility Health Resources

Ⓨ Facility inmate health services management should rest with a designated facility health authority according to standards set by the ACA, AMA and USDJ. None of the facilities completely met the standards.

Ⓩ Management of the health care delivery system at the facility level was often inadequate.

Ⓐ Standards and DOCS' job description for facility health director stipulate that the physical environment of the facility be the responsibility of the Facility Health

Service Director. But at the facilities visited it was the responsibility of the deputy superintendent for administration or a committee headed by a CO.

⊛ The AMA and APHA standards recommend that there be internal and external evaluation of the health care services. There are no mechanisms at any of the facilities to review inmate health services.

Quality

⊛ All health providers at the LCER sample facilities were licensed or registered, as required by law.

⊛ Medical records, a base line indicator of health care, were sometimes found to be inadequate, incomplete or illegible. Missing were four percent of the medical histories and physical examinations, seven percent of the required examination points, almost 10 percent of the general information items, and 20 percent of the laboratory tests. Moreover 37 percent of the health encounters were improperly coded on the AHR.

○ In the LCER sample, 24 percent of the inmates had not received their physicals when due. Some physical examinations were more than four years overdue.

III STATE ADMINISTRATION OF PRISON INMATE HEALTH CARE

Management and oversight of health care in State correctional facilities is divided among five State agencies: Department of Correctional Services, Office of Mental Health, Commission of Correction, Department of Health, and Department of Education. A sixth agency, the Health Planning Commission (HPC), could exercise a planning role, but it does not.

This chapter discusses the roles, responsibilities and effectiveness of this fragmented administrative system and shows that the system itself is an impediment to effective oversight. Implicit in the findings are considerable staff time spent in interagency coordination, duplicate management, budgeting, oversight and information system functions.

DOCS Division of Health Services

The Commissioner of DOCS established the Division of Health Services (DHS) in 1973 to develop and manage the department's inmate health care system. DHS's mission is to "deliver quality health care to our target population as effectively and economically as possible."[1] Health care includes ambulatory care, hospital outpatient and inpatient care, non-psychiatric mental health care and certain aspects of facility environmental health.[2]

Background

The priority accorded to inmate health care varied during the 1970's. At the time of the Attica uprising (1971), DOCS employed a single inmate health administrator, stationed at Dannemora. Due partially to impetus provided by the Legislature's Joint Select Committee on Correctional Institutions and Programs, the Commissioner created the position of Assistant Commissioner for Health Services and hired a physician to fill it on June 13, 1973.[3]

A plan was formulated to address inmate health care needs through base line and follow-up evaluations of facility inmate health care; the development of health service job descriptions, standards of care, staffing patterns, a management information system, and system policies and procedures; and the establishment of a health services advisory group. Federal funding was secured to finance this program.[4]

By December 1977 these priorities had been or were being achieved. Other components of an inmate health service delivery system were operating:

--Regional management of facility health services,

--An elective surgery program with improved inmate access to community hospitals,

--A central pharmacy, and

--A DHS central staff.

The DHS staff of 15 included nine health service professionals and six support personnel. Thirteen of the positions were federally funded; only the Assistant Commissioner and his secretary were State supported positions.

The federal grants expired March 31, 1978. DHS funding was reduced, resulting in the release or transfer of four of the DHS health service professionals. Central office program management was deemphasized; program evaluation, standards development, employee training and development, the health services advisory committee and information system maintenance and operation, among other management functions, were either curtailed or discontinued. In January 1978 the first Assistant Commissioner for Health Services was replaced by an administrator who was not a physician.

Tables C-1 and C-2 (Appendix C) show that DHS expenditures and staffing dropped significantly during the 1977-78 through 1979-80 period. As federal monies tapered off, State support grew from $63,132 in 1975-76 to $249,445 in 1977-78 and to $285,755 in 1980-81 with the staff again reaching 15--the 1975-76 DHS staffing level. DHS has requested further augmentation of staff resources for the 1981-82 year.

Personnel Administration

The Commissioner has delegated appointing authority to the Assistant Commissioner for Health Services.[5] The Assistant Commissioner, through Regional Directors, evaluates and approves all physician and dentist appointments. Facility Nurse Administrators select and recommend qualified nurses and physician assistants to DHS. The endorsement of the Facility Health Services Director and the Superintendent are required for all health services hirings, prior to submission to DHS for final decision by the Assistant Commissioner.

Vacancies in Health Service Positions. The recruitment of qualified health services personnel has been a problem. Pursuant to the Division of the Budget (DOB) directives, the department operates at approximately 90 percent of its authorized administrative support services positions including those in health services. In 1976, the Director of the Budget viewed the "medical and other health services positions in the Department" as "critical" and "exempt from the hiring freeze."[6] This, however, was not the State's policy during 1979 and 1980. Table 15 shows vacancy rates by type of health service position as of April and October 1980.

High vacancy rates are reflected for most health service positions. There are shortages of physicians (28.6 percent), pharmacists (27.8 percent), pharmacy aides (25.0 percent), dental hygienists (53.8 percent), radiology technicians (28.6 percent), and health services support and management personnel (25.5 percent). The vacancy problem recently has become more acute advancing from the 11.1 percent level in April 1980 to 16.2 percent in October 1980, partially because of an increase in the number of positions. Priorities have been established to fill nurse positions first, physician positions second, and laboratory and radiology positions third.[7]

Recruiting and Retaining Physicians. According to DHS and HPC, it is difficult to recruit and retain qualified physicians for inmate health services. An October 1980 Health Manpower Advisory Council report cited obstacles to recruiting and retaining DOCS physicians:

--Physician salaries too low;

--A lack of flexibility in developing financial packages;

--The department's physician's work week is too rigid, e.g., forty hours a week of on-site coverage plus every other evening and every other weekend on call;

Table 15

Correctional Facility Health Service
Staff Vacancy Rates
April 1 and October 6, 1980

Position Title	April 1, 1980 Number of Positions	April 1, 1980 Number of Vacancies	April 1, 1980 Vacancy Rate	October 6, 1980 Number of Positions	October 6, 1980 Number of Vacancies	October 6, 1980 Vacancy Rate
Physicians	34	10	29.4	28	8	28.6
Physicians (Part-time)	7	3	42.9	16	--	--
Dentists	38	3	7.9	30	4	13.3
Dentists (Part-time)	4	1	25.0	13	--	--
Physician Assistants	15	2	13.3	16	3	18.8
Nurse Administrators	23	--	--	23	--	--
Nurses	150	6	4.0	168	16	9.5
Dental Hygienists	11	2	18.2	13	7	53.8
Dental Assistants	16	3	18.8	14	2	14.2
Pharmacists	16	1	6.3	18	5	27.8
Pharmacists (Part-time)	--	--	--	3	--	--
Pharmacy Aides	5	1	20.0	4	1	25.0
Radiology Technicians	14	1	7.1	14	4	28.6
Medical Lab Technicians	7	1	14.3	7	1	14.3
Medical Records Clerks	14	2	14.3	16	4	25.0
Clerical/Steno/DMT/Typists	30	6	20.0	31	8	25.8
Health Care Managers	3	1	33.3	4	2	50.0
Licensed Practical Nurses	8	1	12.5	7	4	57.1
Other	1	--	--	--	--	--
Total	396	44	11.1	425	69	16.2

Source: LCER staff from data furnished by DOCS.

--A lack of physician peer support;

--Remote geographic location of most facilities;

--The prison physician is often regarded with low status and esteem in the community at large;

--Insufficient resources within the health unit;

--Unattractive prison environment where inmates are often abusive, and frequent threats of practitioners with legal suits.[8]

These problems were repeatedly mentioned to LCER staff members during field work at the correctional facilities. However, it is extremely difficult to find physicians who will work a 35 hour week at many upstate correctional facilities for the available compensation. State physician salaries are:

Title	Salary
Clinical Physician I	$38,035-42,900
Clincial Physician II	$42,050-47,445

Adding fringe benefits at 30.26 percent, the highest salary, $47,455, converts to $61,800. This is less than the comparable 1980 median net salary for general practitioners in the mideastern states--$71,840.[9]

The Health Manpower Advisory Committee of HPC provides another perspective:

> Continued inflation and a sharp drop in the supply of foreign medical graduates have combined to diminish the State's ability to compete in an increasingly competitive market with a smaller personnel pool. In an effort to meet serious physician short-falls, a number of ad hoc arrangements and novel administrative procedures have been instituted by agencies to increase physician salaries.[10]

Such ad hoc arrangements were apparent at several correctional facilities. LCER staff found that physicians were paid full-time salaries for 20 hours or less per week spent at the correctional facility. LCER staff were informed that the remainder of the physicians' work week was provided on an "on call" basis. As discussed in Chapter II, this practice was observed at: Attica, Auburn, Coxsackie, and Elmira.

Such salary arrangements make it feasible to have physician coverage at some correctional facilities. However, there is high potential for abuse in hours of work and inequality in the compensation of physicians throughout the system.

Budgeting

DHS does not have a program budget for inmate health services. Each correctional facility prepares the health services component as a part of the facility support services budget. DHS reviews and adjusts facility health staff and equipment requests but the inmate health services component remains a part of the facility administrative support services budget. This means that facility superintendents make budget decisions which weigh inmate health service needs against those of facility plant maintenance, facility administrative and fiscal operations, and food services. Thus the superintendent has maximum budget discretion and flexibility, at the facility level.

Because of this decentralized budget system, there is no integrated statewide financial plan for inmate health service. DHS is inhibited in its ability to plan, justify, allocate, monitor and control resources to meet inmate health needs. DHS goals and objectives cannot be related to a financial plan, nor can DHS be held accountable for the effective expenditure of State funds. No budget document is available to provide the basis for this accountability.

The lack of an integrated health services budget makes it difficult for the Governor and the Legislature to focus attention on inmate health needs and priorities. Authorities in the management of prison health services believe that it is desirable to present an integrated inmate health services budget to the executive and the Legislature.

> The Governor's budgetary agency, the Governor, the state legislative committees, and the legislators can thus give correctional health care the attention it deserves. If the health care budget is cut at any level, the cut is fully visible--not disguised as a cut in "repairs and maintenance" or in some other nonmedical function. Budget reviewers and legislators can see precisely where to intervene.[11]

Monitoring Inmate Health Services

The supervision and oversight of inmate health services takes place at facility and central office levels. Inmates can directly impact monitoring through a grievance procedure.

Facility Level. The Facility Health Services Director (a physician) "supervises all health personnel within the Correctional Facility and all health staff report directly to him." The director is responsible for the review of "health program standards, objectives, policies and procedures together with evaluating their appropriateness. The director may submit recommendations to the Regional Health Services Director."[12]

The Regional Director. The DHS regional director has the responsibility to monitor all aspects of inmate health care within the region. This includes participation in recruitment and advancement of health services personnel, reviewing facility budget requests, performing health services needs assessment, reviewing inmate complaints and evaluating health service delivery. The regional directors perform these tasks on a part-time basis, because each of the five incumbents has other central office or field roles.

Inmate Grievance Procedure. Correction Law, Section 139 requires the Commissioner to provide a "fair, simple and expeditious resolution of grievances." Pursuant to DOCS directive,[13] Inmate Grievance Resolution Committees have been established at each correctional facility; inmates may file health service complaints or grievances and seek their resolution or appeal through an established grievance procedure. If an aggrieved inmate is not satisfied with the results of the procedure, further appeal can be made to the Commission of Correction. (The commission's role is discussed in a subsequent section of this chapter.)

As shown below medical or health services grievances constitute about 9.5 percent of those filed.

	Grievances		Percent
	Total	Medical	Medical
1978	8,376	792	9.5
1979	8,776	780	8.9
1980 (through August)	4,085	397	9.7

The majority of the medical complaints relate to alleged delays in the provision of medical/dental services or the lack of access to or availability of such services.

Utilization Review

In 1979, 1,465 inmates needed 14,067 days of inpatient care at 44 community hospitals. The average length of hospital stay was 9.6 days. As discussed in Chapter IV, this inpatient hospital care cost $1.9 million in 1979-80, excluding the indirect cost of security coverage and escort. The extent and costs of this inpatient hospital care and its associated security means utilization review must be a critical central office function.

Utilization review is designed to eliminate unnecessary hospital admissions and to reduce unduly long hospital stays, thus saving money without lowering service levels. First suggested in 1975, as a federal grant proposal by the then Assistant Commissioner, inmate hospital inpatient utilization review was rejected by the department's administration. DHS, however, continued collecting information on inpatient admissions, discharges, length of stay by hospital and by type of procedure performed. This information was the basis for a limited hospital utilization review system but was not used in this way.

Regional directors had to approve all requests for hospital admission and surgery. However, according to DHS staff this permission was not always requested, and when it was, it was generally given, unless the request form (HS-19) was incomplete. No physician review of the HS-19 was required. Facility Health Directors were held responsible for the clustering of inpatient admissions--i.e., two or more inmates in order to reduce security coverage.[14]

In July 1980, DHS initiated a more rigorous request and review procedure.[15] The purposes were to:

--Assure that each planned admission was warranted,

--Curtail excessive inmate hospital stays, and

--Determine retrospectively whether such hospital stays were appropriate to the surgical procedures performed.

A Utilization Review Coordinator (URC) confirms the appropriate documentation for each inmate elective surgery request. (Two physicians must certify this need.) Documented requests are referred to a member of the department's Physician's Review Committee (PRC) for approval or rejection. If rejected, the request is referred to review of the whole committee. Upon approval, PRC assigns priority to the surgery according to seriousness of problem or need for hospitalization.

Category A - A progressively disabling and/or deteriorating condition, endeavor to admit within 120 days of approval;

Category B - A condition which can be indefinitely stabilized within the correctional facility, endeavor to admit within 180 days of approval;

Category C - A stable condition with a negligible impact on the patient's ability to function within the correctional facility, without time limit.[16]

To prevent unnecessarily long hospital stays, URC monitors stays in excess of nine days. This is intended to detect lapses in concurrent review activity at the hospital level. When a stay occurs in excess of nine days, URC initiates a reappraisal of patient progress by requesting concurrent utilization review by the hospital.

URC also examines each case to assure that procedures and length of stay were in accord with hospital stay experience and standards. The objective is to reduce average length of stay from the current 9.6 days.

Management Information System

DHS's initial priority (1973) was to build a health service management information system. In the mid 1970's a three part system was implemented which included data on

inmate use of ambulatory care in and outside the correctional facility and inmate inpatient hospital care.

Inside Ambulatory Care. A problem oriented uniform record, including a specification of each encounter with a health provider, was the basis for this information system. The Ambulatory Health Record (AHR) is illustrated by Exhibit I in Chapter II. Coded information is entered into the DOCS computer. The computerized data base is capable of displaying: number of inmate health encounters by type of health problem, by type or individual provider, by inmate and by facility. The analysis and presentation of these data make it possible to determine demand for and characteristics of inmate health service use and thus to document inmate health care needs. This system operated from April 1975 until fall 1977.

With the transfer of information system personnel out of DHS, the ability to manage the system was lost or deemphasized. No capability remained to assure correct coding, data entry and/or verification; to analyze statistics; and to prepare meaningful reports.

LCER staff found that correctional facility personnel still coded and entered AHR data into the computer during summer 1980. The management information system, however, was of little use because of:

--Incorrect coding of inmate health problems,

--Failure to complete AHR for all health encounters,

--Limited monitoring of AHR reports by some Facility Health Services Directors,

--No verification of data entry accuracy,

--No feedback of data entered to the person entering the records,

--No systematic monitoring of data collected and reported.

Though data were continuously being entered and the system was operating, they were of little value due to lack of information system management.

Outside Ambulatory Care. This manual system records the inmate name, type of outside outpatient or ambulatory care consultation, and the health provider. A yearly manual tabulation is kept of outside health care visits. The information could be reported on the computerized AHR, if that system were managed and further developed.

Inpatient Hospital Care. This manual information system is maintained by DHS. Though hospital utilization data have been maintained since 1975, analyses have been limited, with little comparative study of inpatient stay by hospital and by type of procedure. Beginning in 1980 these data were being analyzed for purposes of hospital utilization review.

Standards Development

DHS has developed a Policies, Procedures and Guidelines Manual (PPGM) to guide and provide minimum standards of care throughout the inmate health care delivery system. The PPGM was first established in 1975 and has been partially updated as new medical care policies were formulated by DHS. Efforts to revise the manual were underway in early 1980, at the inception of the LCER audit. At that time DHS had the

temporary services of a lawyer; however, this staff person left DHS during the summer, and efforts to update the manual had stalled, as of November 1980.

The major need is to bring the DHS inmate health services policies and procedures into conformance to standards recommended by the American Medical Association (AMA). A DHS survey of PPGM coverage (Table 16) shows conformance to 42 of 69 AMA standards. Compliance can be improved by devising and implementing new policies to cover requirements not now included in the PPGM.

Table 16

DHS Policy and Procedural Manual
Conformance to American Medical Association Standards

Type of Standard	Number of Standards: PPGM Sheet	AMA Requests	DHS Score
Administration	14	21	66.6
Personnel	9	11	81.8
Care and Treatment	19	28	67.8
Pharmaceutical	--	1	--
Health Records	--	6	--
Medical-Legal Issues	--	2	--
Total	42	69	60.9

Source: DHS.

Litigation

Inmate suits alleging improper or inadequate health care are on the increase in New York. The result is a growing demand on DHS staff time to provide information, to answer interrogatories, to prepare for court testimony or to spend time in court. In 1980 an estimated $23,000 in salaries (excluding fringe benefits) of DHS central office staff resources was spent for this task. To this must be added an estimated 1.5 lawyer positions in DOCS Counsel's office plus an undetermined amount of staff time from other DOCS central office units and from correctional facilities. Improved DHS management and oversight might avoid some litigation and its attendant costs in future years.

DOCS Environmental Health Functions

Unhealthy conditions such as overcrowding, inadequate or non-nutritious food, unsanitary conditions, vermin and unsafe or hazardous facilities or equipment increase the need for and use of health and mental health resources. Generally accepted standards of prison health care suggest that responsibility for monitoring and assuring adequate environmental conditions be placed in the "responsible health authority."[17]

Though DOCS is required to provide "for the health and safety of every person" in its custody,[18] the responsibility for overseeing and managing environmental health has not been delegated to DHS or to Facility Health Service Directors. At the facility level,

Deputy Superintendents for Administration generally have charge of environmental matters. At the central office environmental health responsibility is divided between the Division of Support Operations (DSO) under the Deputy Commissioner for Administration and the Correctional Emergency Response Team (CERT) under the Deputy Commissioner for Correctional Facilities. This fragmented responsibility has resulted in ineffective planning, monitoring and management of environmental health.

Division of Support Operations

Responsible for meeting the prison system's administrative needs, the division oversees facility administrative and financial support services, plant maintenance, farms and grounds, and food services. Division personnel include food service management and laundry and housekeeping specialists. Each year 3.2 professional and 0.6 support person years are allocated to the monitoring of environmental health matters. This amounted to about $83,680 in expenditures during the 1979-80 fiscal year.

Nutrition. Pursuant to DSO directive 3003, each correctional facility must meet daily food and nutrition requirements recommended by the National Academy of Science. Each facility food manager must keep detailed daily records of food consumption and cost experience. Monthly reports of food consumption and costs (form 1500) are to be sent to the DOCS Office of the Director of Nutritional Services who summarizes data and monitors conformance to departmental food and nutrition standards.

LCER staff reviewed the monthly food consumption and cost summaries (form 1500) on file for the months of January to October 1980. Sixty-nine reports were missing out of the 260--a 27 percent failure to comply with directive 3003. Five facilities do not file form 1500--Rochester, Lincoln, Edgecomb, Bayview and Fulton--because they are work release and have other systems to derive food costs.

Although the correctional facilities file advance copies of their planned weekly menus with the Office of Nutritional Services, the office did not have a dietitian on its staff. Thus the menus were not evaluated from a nutritional standpoint. Moreover, without a professional dietitian the office was unable to develop nutritional policies, standards and training programs for institutional food service personnel. The lack of monitoring special diets was a case in point.

Department policy provides that a special diet may be furnished to inmates if an institutional physician so prescribes.[19] LCER staff interviews with prison inmates and facility physicians, as well, indicated that this policy was neither well understood nor widely implemented. Special dietary arrangements were not easily made; and some correctional facilities made no special diets available or, if available, restricted them to the infirmary.

Food Service Sanitation. According to DOCS directive 3002, the facility food service manager is to complete a weekly food service sanitation inspection. A detailed checkoff list (form 1530) is used to indicate problems and improvements; the form is signed by the facility superintendent and returned to the Office of Nutritional Services. According to division staff, the form was of limited evaluative use to the central office, but it did force a regular tour of facilities by the facility food service manager and highlight needs for the superintendent.

LCER staff reviewed the central office files for the months of June and July 1980 and found almost total noncompliance to directive 3002. Only one facility regularly filed form 1530 while four others sent in occasional reports during the period.

As discussed in a subsequent section of this chapter, the State Department of Health (DOH) Bureau of Food Protection performs yearly food service sanitation inspection at State correctional facilities. Draft copies of the DOH inspection report are left with the appropriate facility official at the conclusion of the inspection. Subsequently, typed final reports are sent to DOCS for follow-up and comment. These reports, however, are not immediately referred to the DSO Office of Nutritional Services but are referred to the Deputy Commissioner for Correctional Facilities for his follow-up with the institutional superintendent. The department's follow-up on DOH food service inspections may bypass DSO personnel even during facility level implementation of DOH recommendations.

This shortcoming became evident from an LCER staff review of DOH reports available to the Office of Nutritional Services. Of 27 DOH food service inspection reports made available to DOCS during January to July 1980 only 16 had been referred to the office. However, all 27 had been logged in the office of Deputy Commissioner for Correctional Facilities. Part of the problem seems to be unclear lines of authority and responsibility with regard to environmental health.

Another aspect of the dilemma is the lag in time from the date of the actual DOH inspection to the time the report is received by DOCS. Immediate implementation of environmental health improvements is most appropriate, therefore it would be beneficial for DOCS to require each facility to file with central office a draft copy of the DOH inspection at the time the inspection is made, thus expediting follow-up and implementation of DOH recommendations.

Housekeeping. Pursuant to departmental directives 3090-3096, each correctional facility superintendent is to establish a housekeeping committee. Including the Deputy Superintendent for Administration as Chairperson, the committee is charged to completely inspect the facility each month and to report the results of each inspection (form 1641) to the Laundry and Housekeeping Supervisor in DSO. During the period January to October 1980, only 27 of 320 required reports (8.4 percent) were filed--four of these were available in the CERT office, but not in the housekeeping file.

CERT

Placed under the Director of CERT (position vacant as of November 1980), four facility operations specialists have responsibility for liaison between facility staffs and the Deputy Commissioner for Correctional Facilities. Assigned on a geographic basis to specific facilities, each is responsible for developing and monitoring facility compliance to cell, personal property, housekeeping, fire and safety standards and procedures. The specialists also handle complaint and accident investigations. Approximately 25 percent of each specialist's time is allocated to environmental health or safety matters--the equivalent of one full-time staff person with an additional allocation of 0.4 of a support person. This amounted to $30,714 in expenditures in the 1979-80 year.

Facility Fire and Safety Committee. Directive 4003 requires each facility to have an active fire and safety monitoring system. A fire and safety committee, appointed by the superintendent and chaired by his designee, is to be operational at each facility. The fire and safety committee is to inspect the environment, locate hazards and insure their removal. Only 13 of 33 correctional facilities reported to DOCS that they had established fire and safety committees as of December 1980.[20] The committee is to hold monthly meetings and the minutes of these meetings are to be filed with the Director of CERT.

LCER staff reviewed the CERT Office files for the period January through October 1980. The fire and safety committees were not functioning in accordance with Directive 4003. For the ten-month period, 320 sets of minutes of fire and safety committee meetings should have been filed. There were 277 missing or 87 percent. Moreover, 22 of 33 facilities failed to file a single set of minutes. These data raise questions as to whether or not fire and safety committees exist at the facility level.

Health and Safety Audit. Directive 4066 requires that each correctional facility forward to the Deputy Commissioner for Correctional Facilities an Annual Health and Safety Audit by May 31 of each year. Included is to be information on how the audit was conducted, deficiencies noted, actions taken and to be taken and other documentation. As of December 4, 1980 only 11 of 33 facilities had complied with this directive.[21]

Inspections. The facility operations specialists complete at least an annual health and safety inspection at each correctional facility. The inspection is detailed and may last two or more days. All parts of the correctional facility are to be inspected including administration, housing, kitchen and food storage, health services, shops, schools and recreational facilities. Each of the 33 facilities had been inspected at least once during 1979-80.

Bureau of Forensic Services

The OMH Bureau of Forensic Services provides mental health services to inmates of State correctional facilities and local jails, persons found mentally incompetent to stand trial or acquitted by reason of mental disease or defect, and those experiencing violent or aggressive behavior that cannot be handled in a psychiatric center.

Background

Before 1977, the bureau administered part-time clinical services at the correctional facilities. Enactment of Chapter 766, Laws of 1976 transferred DOCS' responsibility for the care of mentally ill inmates to OMH and authorized establishment of OMH programs to treat mentally ill at correctional facilities.

Since 1977 OMH satellite units have operated at seven correctional facilities, and two more units are anticipated to start during 1981, one at Downstate and one at Ossining. Severely mentally ill inmates in need of inpatient care are transferred to OMH custody and are treated at Central New York Psychiatric Center (CNYPC).

The bureau's program is divided into two regions for management purposes, each headed by an administrator who reports to the bureau's assistant director. Psychiatric center directors report directly to the bureau director.

Table C-3 in Appendix C shows bureau administrative expenditures from 1977-78 through 1980-81. In 1979-80 the administrative expense was $44,105.

The bureau director recommends to the Commissioner of Mental Health persons to be appointed directors of the psychiatric centers and satellite unit chiefs. Unit and center directors or chiefs recruit, hire and direct their respective staffs.

Table 17 shows total bureau full- and part-time positions for services to DOCS for April 1, 1980 and for November 5, 1980. Included are the staffs of the seven satellite centers, OMH staff at six other correctional facilities and bureau administrative staff.

Over the seven-month period total positions increased from 115 to 134 with the vacancy rate advancing from 14 percent to 24 percent. The highest vacancy rate is for unfilled new positions in the occupational and recreational therapy areas.

Like DOCS, the bureau experiences difficulty in filling psychiatrist and psychologist positions. The remote location of some of the correctional facilities, their maximum security atmosphere and unfavorable salaries and working conditions are major difficulties inhibiting the filling of professional positions. To meet professional staffing needs, the satellite centers have drawn on the part-time extra service of psychiatrists and psychologists who are employed full-time at other State OMH institutions.

Budgeting and Financial Reporting

Annual budget requests of the seven satellites and the six other prison psychiatric units are merged with OMH services to the Division of Parole--i.e., pre-parole psychiatric

Table 17

OMH Satellite Centers
Authorized Positions and Vacancies

Position Title	April 1, 1980 Positions	Vacancies	Vacancy Rate	November 5, 1980 Positions	Vacancies	Vacancy Rate
Psychiatrists	16	3	18.8%	13	2	15.4%
Psychologists	35	4	11.4	37	7	18.9
Psychology Assistant	5	2	40.0	4	1	25.0
Nurse	14	--	--	13	1	7.7
Psychiatric Nurse	3	--	--	4	1	25.0
PSW	7	3	42.8	7	2	28.6
PSW Assistant	1	--	--	1	--	--
Licensed Practical Nurse	6	--	--	7	--	--
Community Mental Health Nurse	1	--	--	1	1	100.0
Occupational Therapist	2	2	100.0	2	2	100.0
Occupational Therapy Assistant	--	--	--	1	1	100.0
Recreational Therapist	4	1	25.0	7	5	71.4
Recreational Therapy Assistant	--	--	--	2	1	50.0
Recreational Worker/Assistant	1	--	--	1	1	100.0
Community Client Service Assistant	--	--	--	1	1	100.0
Clerical (Typist, Clerk, Steno, Medical Records, DMT)	16	1	6.3	25	6	24.0
Director of Bureau	1	--	--	1	--	--
Assistant Director of Bureau	1	--	--	1	--	--
Chief, Forensic Unit	--	--	--	2	--	--
Forensic Unit Program Administrator	2	--	--	2	--	--
Administrative Aide	--	--	--	1	--	--
Research Scientist	--	--	--	1	--	--
Total	115	16	13.9%	134	32	23.9%

Source: LCER staff from data provided by OMH.

exams. This lump sum for "Services to Corrections and Parole" is presented as one component of the Forensic Services executive budget proposal. The CNYPC budget is a separate component for executive budget purposes.

The OMH budget process does not identify individual satellite center staffing, finances, needs and priorities. It excludes the Bureau of Forensic Services central office entirely and does not allocate CNYPC costs for State inmate inpatients.

Because the OMH accounting procedure is compatible with this budget approach, expenditure data are not available to segregate costs (1) for central office management, (2) by satellite center or other unit and (3) for CNYPC services to inmates. End of fiscal year data were not easily matched with units of services or numbers of clientele served; so that measures of efficiency were not available. Moreover, personnel and payroll data were not readily available by satellite center; thus the bureau Assistant Director had to poll each of the satellite and other units to determine current numbers of filled and unfilled positions.

Operating Standards

A recurring criticism of the Commission of Correction mortality reviews has focused on the lack of a Bureau of Forensic Services manual of field operations. Standard procedures are essential to assure a minimum level of service and uniformity of performance among the different satellite and psychiatric unit programs. Such a guide also is a useful training device.

Although several satellite centers visited by LCER staff had developed their own operating manuals, there was no consistency with regard to medical staff access to psychiatric information, staff duties and responsibilities, administration and recording of psychotropic medication, allocation of staff resources and 24-hour coverage, and documentation and reporting of patients served and workload data.

A draft OMH Forensic Services "Policy and Procedure Manual" was available March 1980. The document covered a variety of policies and procedures that had been developed by the bureau. As of November 30, 1980 the manual had not been formally adopted.

Monitoring Inmate Mental Health Services

The Assistant Director and the two Program Administrators are responsible for monitoring of overall program performance. Each Forensic Unit Chief is responsible for review, evaluation and consultation on individual patient treatment plans and for monitoring the distribution of psychotropic medication.

There is no formal procedure for regular review or evaluation of satellite center services, facilities, procedures, and staff competence. Such a procedure, recommended by the American Association of Correctional Psychologists, would be conducted yearly by headquarters personnel or by an outside group:

> The program review should follow a structural outline and should include (but not be limited to) an assessment of effectiveness (what the service accomplished), efficiency (cost of services), continuity (linkages

to other human services, both inside and outside the facility) availability (staff inmate ratio), accessibility (days and hours of work schedule) and adequacy (ability to meet identified needs).[22]

During the LCER audit, a team of DOCS and OMH staff were participating in a joint program audit of the satellite center program with a report planned for early 1981.

Another avenue to monitor program effectiveness is the Inmate Grievance Procedure, discussed previously. Because OMH programs are independent of DOCS, and the grievance procedure is an internal complaint resolution and appeal process within DOCS, the procedure may not serve as an adequate monitoring device for OMH satellite center services. However, all OMH complaints are subject to review by Mental Health Information Services.

Management Information System

The bureau draws on two management information systems: the Department of Mental Hygiene Information System (DMHIS) and its own monthly reporting from satellite centers and from OMH staff at other facilities. Neither system is activated until an inmate receives mental health services. The systems do not provide data on the overall need for mental health services due to the lack of psychiatric screening at reception and classification.

DMHIS provides extensive information on each inmate admitted to a satellite center or to CNYPC. Included are data on the inmate's personal background, education level, prior mental health history, admission diagnosis, and mental health service records. Reports on clients served, type and length of service received, and personal characteristics of the inmate client population are available.

The system, however, does not provide timely and useful information for managing OMH services to prison inmates. First, not included in the reporting are several nonsatellite OMH units (Eastern, Mt. McGregor, Wallkill, Coxsackie and New York City Parole Office); thus the DMHIS reports are incomplete. Second, OMH staff report that processing is delayed by a two-to-three-month backlog. Third, information useful to bureau management is not included: e.g., time distribution of staff, type of satellite center housing used, services performed at the request of corrections or parole.

Bureau Monthly Report. The bureau requires each OMH satellite and correctional facility unit to submit a monthly report which summarizes workload and problems encountered. Reports include active cases, clinical contacts, ward admissions and CNYPC admissions and discharges. According to bureau staff, there is no standardized reporting format and facility level documentation of statistics reported is inadequate.

The bureau is developing a revised report system which will provide basic documentation and more useful management information. Included in the revised system will be data on type and quantity of services rendered to DOCS and parole, substantiation of how the service was delivered, and detail of the type of confinement and service setting.

Coordination With DOCS

Because they operate within DOCS correctional facilities, the satellite centers must conform to correctional facility policies, procedures and practices. For example,

inmate access to the satellite center is contingent upon availability of facility level security resources.

Another condition which affects satellite center operation is its staff's proximity to and relationship with the facility health services staff. Coordination and interchange of nursing or support staff resources, joint staff meetings, mutually agreed upon sharing of responsibilities, access to and exchange of patient information and other cooperative ventures may translate into improved health services for inmates at lower overall costs.

At the central office level, coordinative mechanisms have been established to facilitate OMH-DOCS communication and cooperation. Regular weekly meetings are held between the OMH Assistant Director of Forensic Services and the DHS Director of Mental Health Programs. For the 1981-82 budget, DOCS and OMH cooperated in planning programs and budget proposals, and during summer and fall 1980 DOCS and OMH staffs participated in a joint review of the satellite center program. As of December 1980, the two staffs were collaborating on the development of a protocol on the exchange of medical/psychiatric information.

Notwithstanding these efforts to coordinate two distinct programs and approaches, several problems were apparent at the time of LCER field visitations to correctional facilities.

Lack of Access to Medical/Psychiatric Records. Because there are two separate sets of inmate health records, psychiatric information is not generally available to a physician when diagnosing a patient's problem, nor is medical information available to the psychiatrist or the psychologist when making a clinical analysis of a patient. Generally this information can be requested, but incompatible hours between the two programs may mean delay in or lack of access to such records. This is particularly a problem when extra service psychiatrists work in evening hours and the medical records office is closed. Another problem documented in LCER's review of inmates health service records was the lack of complete medication information in either medical or psychiatric record files.

Transfer of Inmate Clients Without Prior Notification to the Satellite Center. A major criticism documented in LCER staff interviews and found in Commission of Correction mortality reviews, was the lack of pre-notice of transfer for inmates who were active users of satellite center services. This resulted in gaps in care and delayed follow-up of psychiatric treatment and medication with these patients. Lack of continuity of mental health care had been a contributing factor to inmate deaths resulting from suicide.[23]

Closing of Satellite Ward Without Prior Approval of OMH. At one facility visited by LCER staff, the superintendent closed the satellite ward to reduce the expense of security. Patients were moved to observation cells in a different building. Satellite center personnel told LCER staff that the result has been increased difficulty in observing patients, loss of trained COs to observe patients, loss of satellite inpatient capacity, and a decrease in the level of inpatient housing sanitation. According to bureau staff this closing has resulted in increased admissions to CNYPC, decreased client discharges to the general population of the facility and overloading of satellite centers at other correctional facilities.

Commission of Correction

The commission was established to monitor and oversee the effective operation and performance of State and local correctional facilities. The commission has statutory authority to:

--Visit, inspect and review correctional facility management and programs;

--Promulgate minimum standards for inmate care, custody, correction treatment, supervision, etc.;

--Close, after showing cause and hearing, any correctional facility found unsafe, insanitary or inadequate;

--Collect and disseminate information and undertake research on the administration, programs, effectiveness or coordination of correctional facilities; and

--Review inmate grievances referred by the Commissioner of Correctional Services.[24]

To carry out its responsibilities, the commission may "advise and assist the Governor" and "make recommendations to the administrators of correctional facilities."[25] While lacking statutory enforcement authority, the commission may close a correctional facility, although it has not yet done so, or issue public statements of its findings. The commission's role is primarily advisory to the Governor.

Organization

Three commission units have direct responsibility for oversight of State inmate health.

Medical Review Board. MRB consists of a forensic pathologist, a forensic psychologist, an attorney and one other member. The Governor designates one of the Commissioners of Correction as MRB chairperson. The board investigates:

--All inmate deaths and reports its findings to the commission;

--The condition of systems for the delivery of medical care to inmates and recommends improvements in the quality and availability of such care.[26]

Health Systems Unit (HSU). Operating under the direction of the Chairman of MRB, HSU provides staff support to MRB. It determines the circumstances surrounding inmate deaths, evaluates the inmate health care delivery system and assists in the development of plans and projects to improve correctional health care.[27] For the commission as a whole, the HSU investigates and resolves inmate health complaints and grievances. The unit has four personnel: three health service evaluators and one technical assistance coordinator.

Bureau of State Correctional Facility Review (BSCFR).[28] This bureau oversees the management and administration of all State correctional facilities and DOCS' central

office. Within its responsibility are environmental health concerns (i.e., sanitation, food service, housekeeping, safety, fire prevention, etc.) but not medical, dental, psychiatric or pharmacy matters which fall under the jurisdiction of MRB and HSU. The bureau responds to inmate complaints, investigates grievances, exercises general correctional facility oversight, and undertakes special assignments. Bureau facility review often focuses upon the extent to which DOCS directives, policies and procedures are carried out. As of December 8, 1980 the bureau had six filled positions: a Director, four Facility Review Specialists and one stenographer.

Each Facility Review Specialist is assigned to a specific group of State correctional facilities for operational oversight, grievance coverage, and complaint investigation. Unannounced inspections are conducted to maximize impact. According to the commission chairman, "No one knows which facility we will visit next."[29] Review of environmental health usually is included in each facility inspection. No allocation of staff and workload to the environmental health function was available.

Finance, Staffing

Commission expenditures and staffing for the three units responsible for overseeing State and local inmate health are presented in Appendix C, Table C-4. The commission was unable to furnish a cost/staffing breakdown for State inmate health oversight alone.

Workload

Several indicators of the workloads of the three units are shown on Table 18. These data include MRB and HSU local correctional facility activities and BSCFR's non-environmental health oversight. While some fluctuation is evident in BSCFR workload, the table shows relative stability in MRB and HSU workload.

An allocation of MRB and HSU 1979 workload between State and local correctional facilities was developed by LCER staff from commission data:

	State		Local		Total
	Number	Percent	Number	Percent	Number
MRB-Mortality Reviews Initiated	31	38	50	62	81
HSU-					
Complaints Closed	175	51	165	49	340
Grievances Closed	29	100	--	--	29
Subtotal	204	55	165	45	369

As shown, in 1979 State inmate deaths constituted 38 percent of the MRB workload. Similiarly, State inmate matters constituted 51 percent of HSU complaints closed, and all grievances were filed by State inmates.

Table 18

Commission of Correction
Health Systems Unit and Bureau
of State Facilities Workload
1976-1980

Type of Workload	Calendar Year 1976	1977	1978	1979	1980
Medical Review Board Mortality Review[a]	--	177	165	177	N/A
Health System Unit:					
Grievances	--	27	26	29	N/A
Complaints	--	377	335	355	N/A
Total	--	404	361	384	N/A
State Facility Visits	--	16	19[b]	18[b]	N/A
Bureau of State Facilities:[a]					
Grievances	500	341	411	352	208[c]
Complaints	1,970	1,100	1,994	2,574	1,623[c]
Total	2,470	1,441	2,405	2,926	1,831[c]
State Facility Visits	N/A	N/A	394	459	328[c]

N/A=Not Available
[a]Cases initiated, closed and continuing.
[b]About 35 percent of the visits represent technical assistance which may include investigation and mortality review follow-up.
[c]Through October 1980.

Source: LCER staff from data furnished by the Commission of Correction.

Mortality Review

MRB determines the circumstances of each inmate's death. HSU collects relevant background investigations and performs fact-finding. MRB reviews the collected data, and, if the data are complete, finds that the circumstances of the death are either "natural" or "unnatural." A report is issued on each closed case. Where problems are observed in correctional facility procedures or in the conduct of personnel, MRB issues findings and recommendations. These are forwarded to the Commissioner of DOCS, the Director of OMH Forensic Services, facility superintendents or other appropriate persons, with a request for response within a specified time.

Table 19 shows State inmate mortality by type of death between 1973 and 1980. Over three-fourths of the deaths were from natural causes. Approximately 15 percent were suicides and seven percent were homicides.

MRB Findings and Recommendations. LCER staff reviewed 1979 through August 1980 mortality findings and recommendations. About 28 percent of inmate deaths

Table 19

Inmate Mortality by Type of Death*
1973-1980

Year	Natural Number	Natural Percent	Suicides Number	Suicides Percent	Homicides Number	Homicides Percent	Total Number
1973	30	81.0	7	19.0	--	--	37
1974	25	78.1	5	15.6	2	6.3	32
1975	27	81.8	4	12.1	2	6.1	33
1976	21	80.8	2	7.7	3	11.5	26
1977	20	71.4	5	17.9	3	10.7	28
1978	21	75.0	5	17.8	2	7.1	28
1979	22	71.0	6	19.4	3	9.6	31
1980	33	82.5	4	10.0	3	7.5	40
Total	199	78.0	38	14.9	18	7.1	255

*Excludes extrinsic deaths--those which occur outside a facility but are related to incarceration, e.g., while on work or temporary release, escapee status.

Source: DOCS; Commission of Correction for 1980.

stemming from natural causes reviewed by LCER staff included findings of inadequate medical treatment, patient neglect or inattention, inappropriate delay or failure to properly follow up on the case. Such adverse findings were included in seven of 21 closed 1978 natural deaths, and five of 22 natural deaths closed in 1977. MRB recommended improved procedures:

--For transfer of essential inmate mental health information to DOCS (one report);

--To determine the level of care to be provided within and outside of the correctional facility (one report);

--To ensure complete physical examination at reception and classification (one report);

--To provide effective case management and follow up to treatment (seven reports); and

--To clarify policy on the care and treatment of inmates who need medical intervention, but who refuse same (one report).

DOCS responded to ten of the 12 MRB mortality review recommendations, while OMH replied to one of two. The responses were received by the Commission from one to eight months from the date of case closing, with an average of four-and-one-half months.

In eight of the reviews, DOCS took issue with MRB findings (five) or stated that MRB recommendations were already or soon to be implemented (three). In three instances DOCS agreed with MRB recommendations but was precluded from implementing them due to shortage of facility health service staff. One OMH response indicated that the problem identified by MRB would be studied; however, the file contained no

subsequent information on the results of the study over one year after the OMH response was written.

LCER staff's review of 16 unnatural inmate deaths during 1978 and 1979 indicated a pattern of recurring MRB recommendations:

--Improve satellite center management, functions and procedures (six reports);

--Increase accountability of medicine dispensing system (three reports);

--Initiate weekly pharmacy review of each inmate's medicine (one report); and

--Transfer medical/psychiatric information with inmates (four reports).

Eight of the 16 case files were reviewed in detail by LCER staff. DOCS replied to six of seven MRB reports for which replies were requested, while OMH replied to three of eight. Time required to reply ranged from two to 18 months; DOCS averaging nine months and OMH eight months.

Agency replies related steps taken to implement recommendations or answered questions posed by MRB. Three replies acknowledged the problems identified by MRB but included reasons for noncompliance:

--Lack of health service personnel and security requirements which together preclude elimination of CO administration of medication and

--OMH confidentiality requirements which inhibit transmittal of inmate mental health summaries.

On the latter point, it is elsewhere noted that DOCS and OMH are negotiating a "letter of agreement" to resolve procedures which prevent the exchange of inmate mental health information.

Timeliness. The time required by MRB to close an inmate mortality is important because:

--The longer the investigation, the more likely the loss of physical evidence, expert testimony, or witnesses and

--MRB findings and recommendations may encourage the improvement of the inmate health system.

A 1978 report of the New York State Department of Audit and Control suggested that the commission ensure prompt investigation of inmate deaths.[30] That report found that the 82 mortality cases during the two years ending December 31, 1977 averaged 285 days to close.

LCER staff examined cases closed over the 1978 through October 1980 period. The time required to investigate and close cases had not decreased since 1977. Yet, during the 1978 to 1980 period, the backlog of cases was reduced by 35 or by over one-third since 1977. Moreover, fewer cases were open for longer than 181 days in 1980 than in 1977. MRB's timeliness in investigating and closing inmate death cases had improved.

Inmate Medical Grievances

As the final appeals mechanism for all DOCS inmate grievances, the commission refers inmate medical/psychiatric care grievances to the HSU. Inmate health grievances represent about seven percent of the total grievances:

	Inmate Health		Other Matters		Total	
1976	27		473		500	
1977	27		314		341	
1978	26		385		411	
1979	29		323		352	
1980*	14		194		208	
Total	123	(6.8%)	1,689	(93.2%)	1,812	(100.0%)

*Through October 1980.

Each health grievance is investigated and if appropriate, field interviews are conducted. Written findings and recommendations may be sent to the Commissioner of DOCS, the correctional facility superintendent, the grievant, and/or other concerned parties. Pursuant to Section 139 of the Correction Law, if the Commissioner of DOCS rejects the commission's recommendation on a grievance, he must write his reasons; and both the recommendation and the Commissioner's reasons for rejection are made public.

A Comptroller's 1978 audit cited untimely delays in the commission's response to health grievances. To process 19 cases, an average 258 days (8.6 months) was required.[31]

LCER staff reviewed 28 inmate health grievances processed during 1979. The type of grievance and its disposition were:

Type of Health Grievance	Commission Finding: Valid	Invalid	Total
Service Not Provided	7	7	14
Delay in Service	6	1	7
Dissatisfaction With Quality of Service	2	5	7
Total	15	13	28

Table 20 shows the calendar days required to resolve health related grievances initiated during 1978. The first two columns indicate processing time within DOCS while the last two indicate processing time within the commission (HSU). According to DOCS policy, the grievance procedure should be completed within the department in 43 working days, or 60 calendar days. As shown, 77 percent of the health grievanees filed exceeded this time limit within DOCS. The commission, however, was able to complete approximately one-half of the grievances within two months.

On average DOCS took 97 days to process each health service grievance, while the commission took 85 days. The 85 days represent a substantial improvement over the 258 day average recorded in the Comptroller's audit.

Table 20

Time to Process Inmate Health Service Grievances
1979

Calendar Days	From Filing Grievance to Referral to Commission of Correction		From Commission of Correction Receipt of Grievance to Letter to Commissioner of DOCS	
	Number	Percent	Number	Percent
30 or Under	--	--	10	41.7
31-60	5	22.7	2	8.3
61-90	9	40.9	3	12.5
91-120	3	13.6	3	12.5
121-150	3	13.6	2	8.3
151-180	--	--	1	4.2
181-365	2	9.1	2	8.3
Over 365	--	--	1	4.2
Subtotal	22	99.9	24	100.0
Unknown	6		4	
Total	28		28	

Source: LCER file search of 1978 grievances.

Complaint Processing

Complaint investigation is a commission activity which facilitates the monitoring of inmate health and psychiatric care. According to the MRB Chairman, response to inmate health complaints keeps the commission informed as to quality of and obstacles to inmate health care.[32] Resolution of complaints may avert subsequent grievance proceedings or lawsuits.

Of 355 State and local inmate health complaints processed by HSU during 1979, 184 (52 percent) were filed by or for State inmates.

Upon receipt, each complaint is logged in and assigned to an HSU evaluator. Notice of complaint investigation initiation is sent to the complainant, the Commissioner of DOCS, and the facility superintendent. The evaluator may request institutional records, correspondence, or other documentation or may interview inmates or facility personnel. Complaint investigation is conducted by correspondence or phone; however, on-site follow-up is undertaken when the evaluator visits a correctional facility. Each open complaint is to be reviewed monthly.

Type of Complaint. LCER staff reviewed a random sample (ten percent) of the 435 inmate health complaints HSU processed during 1979 and 1980 (to November 20). The type and disposition of the 45 complaints are:

Type of Complaint	Disposition		Total
	Closed	Open	
Delay in Service	4	2	6
Dissatisfaction with Quality of Service	22	3	25
Absence of Service	6	1	7
Lack of Dentures, Glasses, Prosthetics, etc.	3	0	3
Subtotal	35	6	41
No Information	2	2	4
Total	37	8	45

Most complaints represented dissatisfaction with the quality of health services. Inmates may lack confidence in health staff judgments; sometimes they disagree with diagnosis, treatment and/or prognosis and initiate a complaint to secure an outside professional's opinion.

Of the 35 closed complaints in the LCER sample, 29 resulted in the inmates being treated by the health staff. This may have occurred without commission intervention. In nine of the 35 cases, inmates were uncooperative with prison health staff or would not follow prescribed regimens (four cases); inmate allegations were refuted by the investigation (four cases) or inmate did not respond to the commission's request for further detail (one case).

Timeliness of Commission Response. In its 1978 audit of the commission, the Office of the Comptroller found that an average of eight months (230 days) was required to close a sample of 19 complaints (including health matters).[33] Improvements were recommended to speed complaint closings.

Table 21 shows the months required to close inmate health complaints in the two years since the Comptroller's study. Almost two-thirds of the inmate health service complaints were closed within four months of initiation. An average 109 days was required to close an inmate health complaint during the period.

There is no question as to the desirability of prompt response to inmate complaints. The time required to close a case, however, is not the best effectiveness measure; rather an adequate response to the complaint is more relevant. For example, the HSU may keep a complaint case open several months, even after "adequate response" to assure that the inmate receives follow-up care. An "adequate response" might be time required to fully investigate the case and to report findings. HSU does not compile this information.

Inmate Health Standards

The commission is required by statute to promulgate minimum standards for "the care, custody, correction, treatment, supervision" of State prison inmates.[34] Under a federal grant, draft standards were developed for State facilities during 1978. Particularly relevant were proposed standards on: environmental health and safety, prisoner personal hygiene, fire safety, food service, sanitation and health care. The commission, however, chose not to promulgate the standards.[35]

Table 21

Months to Close State Inmate
Health Care Complaints
1979 through November 20, 1980

Months Required to Close Case	Number of Complaints	Percent of Subtotal
1	31	11.0
2	70	24.7
3	46	16.3
4	35	12.3
5	30	10.6
6	23	8.1
7	17	6.0
8	8	2.8
9	7	2.5
10	3	1.1
11	5	1.8
12	8	2.8
Subtotal	283	100.0
Missing Data	73	
Total	356	

Source: LCER Review of Commission of Correction files.

With regard to the minimum health standard, MRB decided not to recommend its adoption to the commission:

> The Board feels that prior to implementing enforcement of these minimum standards, which might bring about catastrophic exodus of the personnel now performing health care services in the local county facilities and state correctional facilities, or severely limit the number of medical personnel, the health care administrative officers should be involved in order to anticipate and plan for this future continuance and emergency situation.
>
> The above by no means should lead one to believe that the current health services within the state for the incarcerated person is adequate, but to underscore the increasing demands on facility administrators with limited resources.[36]

In 1980, the commission initiated a second federally funded project "to identify and address special correctional needs throughout the state." Commission officials indicated to LCER staff that the development of State standards was one of those priority needs.[37]

The Comptroller has recommended that the commission evaluate DOCS' existing minimum standards "to determine whether they are pertinent to the various programs

administered by the Department. The commission should, where needed revise and create minimum standards."[38]

The commission's BSCFR reviews facility conformance to DOCS directives and policies as a part of its overall inspection role. However, no commission unit has reviewed the adequacy of DOCS' standards as recommended. According to the MRB Chairman, MRB and HSU lack the staff resources to carry out this recommendation.[39]

LCER staff review of DOCS' DHS policy and procedure manual indicates that some of the provisions are outdated or no longer carried out. As mentioned previously, many national standards have not been incorporated in the procedural manual. Thus, the evaluation of DOCS standards is as relevant today as it was when recommended in 1978.

Inspection, Review and Management Analysis

The commission is responsible for visiting and inspecting facilities and appraising management with respect to matters such as safety, health of inmates, and sanitary conditions. The State Comptroller found that the commission:

> had not developed annual work plans to identify such tasks as the type of inspection to be performed for each institution or the time estimated for completing various aspects of facility inspections. Such plans, when developed in concert with stated performance goals, would provide the Commission with a means to measure its accomplishments. By periodically evaluating its programs, the Commission could determine the degree of adherence to work plans and help guide future productivity as well as identify areas that need modification to improve each program.[40]

The commission has not yet complied with this 1978 audit recommendation.

Rather than an inspection schedule or program, the commission's BSCFR chooses a "random" unannounced inspection technique which, according to the chairman, keeps the next State facility inspection a secret. Most of the BSCFR follow-up to inspections, complaint handling and the grievance procedure is accomplished by correspondence with facility superintendents.

The MRB Chairman asserts that the reason for MRB's lack of work plans is lack of staff and money.[41] When an HSU evaluator visits an institution, he checks on all pending grievances and complaints, as well as inspecting the health service program.

MRB has developed a survey method which provides the basis for comprehensive assessment of inmate health care. Because an inmate health services evaluation at a large State correctional facility requires about 30 staff days, the chairman of MRB indicated to LCER staff that the additional staff needed to conduct such studies is not available.[42]

MRB has conducted several evaluations of inmate medical care as required by Correction Law, Section 47(1)(e). However, only one such evaluation has been completed for a State correctional facility--Ossining in 1979.

The Ossining evaluation, performed in September 1979 and updated January 1980, found shortcomings in:

--Physician coverage, responsibilities and supervision of health personnel;

--Nursing coverage;

--Inmate health assistant roles and selection;

--Sick call procedure;

--Mental health services.

A large population of newly incarcerated inmates had not received medical evaluations.[43] As a result of the evaluation, DOCS' DHS requested in March 1980, that Ossining health staff be increased and that vacant positions be filled.[44] As of October 1980, two of three vacant positions had been filled; while 4.7 new positions had been requested, three had been established but none were filled.

Department of Health

DOH monitors public environmental health in State prisons. The Public Health Law[45] establishes the general statutory authority and the sanitary code[46] provides the standards of measurement and specifics about methods of implementation.

DOH is required by law[47] to supervise and regulate narcotics (manufacture, distribution and use), food handling, facility sanitation, water sanitation and the use of radiation equipment. Narcotics, food, water and radiation control are carried out as part of the department's overall statewide regulatory responsibilities. Facility sanitation oversight is to be carried out as part of the Commissioner of Health's duty to perform periodic inspections of each State institution.

Office of Health Systems Management

The DOH Office of Health Systems Management (OHSM), as regulatory arm of the Department of Health, links with DOCS in several ways:

1. It seeks the advice of and informs DHS on matters concerning the Medical Fee Schedule and Medicaid rates.

2. It oversees the hospital based concurrent review progress pursuant to Section 405.24 of the State Hospital Code.

3. DHS is represented on Statewide Planning and Research Cooperative System (SPARCS) Technical Advisory Committee dealing with hospital billing.

4. It is anticipated that the SPARCS Bureau will shortly begin forwarding to DHS retrospective utilization review reports comparing inmate inpatient stays with the stays of Medicaid recipients.

Narcotic Control

The licensure, supervision and regulation of narcotic manufacture, distribution and use is carried out by the Bureau of Narcotic Enforcement (BNE). BNE inspectors from

DOH regional offices visit correctional facilities to establish standards for inventory control and for the physical security of controlled substances. Visits are not regularly scheduled.[48]

In fiscal 1979-80 BNE investigators inspected one DOCS facility. Each correctional facility survey requires two Senior Investigator days at a cost of $412. During 1980-81 BNE undertook a more extensive survey, involving 35 visits to 32 correctional facilities at an estimated $14,435.

Environmental Inspections

Environmental health inspections by State investigators have been limited to food service areas. Because the Public Health Law mandates that DOH make "inspections of sanitary conditions of each State institution," inmate living areas should be included.[49]

During the 33 months from October 1977 through June 1980, eight environmental sanitation inspections at New York State prisons were reported. One upstate facility (Camp Adirondack) was inspected by State sanitarians for use as State employee housing during the 1980 Winter Olympics. New York City Department of Health sanitary inspectors performed seven inspections of State facilities located in New York City.

Food Handling

DOH's Division of Food and Drug Protection is responsible for enforcing Sections 1350-1352 of the Public Health Law and the provisions of the State Sanitary Code (10 NYCRR Part 14) relating to food handling. It inspects food preparation and handling areas including kitchens, dining rooms, service and storage areas.

During 1979-80, 29 correctional facilities were visited. One prison had not been inspected in more than three years--Attica Correctional Facility--last visited in October of 1977.

DOH estimated its costs for food, water and sanitation inspections in 1979-80 at $15,154.

Inspection Findings

Food Service. Inspections of facility food service areas noted "deficiencies" which ranged from shortcomings in structure and equipment, to roaches, rodent droppings and dead rodents found in food service areas. Arthur Kill, Camp Adirondack, Coxsackie, Downstate, Mt. McGregor, Bayview, Fulton and Parkside had a few minor violations.

At Bedford Hills, Eastern, Fishkill, Mid-Orange, Ossining/Tappan, Otisville, Wallkill, Woodbourne, Queensboro, Camp Summit, Hudson, Camp Pharsalia and Camp Georgetown numerous violations were found including improper food handling and/or presence of vermin.

Eight facilities showed overall deterioration indicative of the lack of a regular maintenance and replacement program, in addition to the problems listed above. The food service facility at the Clinton farm was "sub-standard and inadequate."[50] At Auburn much of the equipment was unclean and uncleanable. At Green Haven dead rodents were

found in the food service area. Attica, Great Meadow, Albion and Rochester had numerous violations especially in food handling techniques.*

In general the inspections indicate that equipment and facilities are not maintained, replaced or repaired. Though DOH states that standards applied to DOCS' facilities are equal to those applied commercially (see Agency Response), correctional facility compliance was not required. Moreover, revisits to find out if conditions had improved were not made.

While DOH asserts that conditions in correctional facility kitchens may not be worse than those at some commercial establishments, persons living in State institutions, unlike commercial patrons, cannot choose to go someplace else for their meals. Therefore, comparison with commercial establishment standards seems inappropriate.

Facility Sanitation.** During the time period for which data were available, October 1977 through June 1980, an inspection of correctional facility sanitation was conducted for one upstate prison. Camp Adirondack was inspected on November 21 and 27, 1979 in preparation for its use as housing for staff of the 1980 Winter Olympics.

NYCDOH sanitarians inspected facility sanitary conditions at seven State prisons located in New York City. The violations noted were indicative of the lack of a maintenance, upkeep and replacement program. Among the problems cited: cracked or missing glass, many ceiling tiles broken or missing, light shields missing, exposed wiring, open toilet waste line where there was a missing toilet fixture, defective plumbing and peeling wall and ceiling paint. The deterioration was pervasive.

Water Purity. The only water sanitation inspection performed was at Coxsackie entailing three visits to take samples in December 1979 and January 1980. There was no continuous monitoring program carried out by DOH. The department's role was reactive rather than that of initiator.

X-Ray Monitoring

DOH's Division of Radiologic Health conducts radiological facility inspections at two- and three-year intervals. During fiscal year 1979-80 inspection of x-ray installation's in State correctional facilities utilized 12 inspector-days at $125 per day for a total cost of $1,500.

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*At Elmira LCER staff observed cockroaches, rodent droppings, pots of food on the floor and a foul, offensive odor.

**LCER staff, in field visits at State correctional facilities encountered several examples of unhealthy environmental health conditions:

--Attica, Observation Cells and Cell Block B--dirty, food out and pots uncovered;

--Fishkill, Elderly and Handicapped Company--rats in closet, roaches in health area.

--Elmira--women employees walk through inmate living areas to daily jobs; blankets hung across cells to give inmates privacy; food and garbage in corridor for several days.

The State Health Planning Commission

Although the Health Planning Commission (HPC) is required to review the plans of State agencies relating to the provision of health and mental health services, DOCS has been excused from submitting a service plan for the 13 years during which HPC has been planning for the health needs of the residents of the State. The commission was designated the single State agency to supervise the administration of State comprehensive health planning functions, implementing the Federal Comprehensive Health Planning and Public Health Services Amendments of 1966. HPC was to (1) receive and disburse federal funds for comprehensive planning; (2) be responsible for the coordination and review of all health planning efforts in the State including services, facilities and manpower; and (3) create and maintain a comprehensive State health plan. The planning mandate is specific with reference to State agencies.

> The Commission shall review all the plans of State agencies relating to the provision of health and mental health services to assure that such plans are in accordance with the comprehensive State health plan.[51]

The vice-chairman of HPC told LCER staff that the commission has no role in health planning for correctional institutions. DOCS has never been required to submit its plans for provision of health and mental health services to HPC.

Approximately 22,000 users of health resources are not included in regional or statewide planning. In some prisons the population approaches the size of a small town. State prison inmates are residents of the State and make use of shared community resources: physicians, laboratories, pharmacies, support specialists, highly specialized equipment, e.g., dialysis machines and hospital beds. In planning manpower and facility usage, the impact of 22,000 persons, many located in already medically deprived areas, must be considered. By omitting DOCS facilities HPC is helping to perpetuate the isolation of areas which need to be drawn into the main stream of health care planning.

State Education Department
Board of Pharmacy

Inspectors employed by the Board of Pharmacy in the State Education Department periodically visit and inspect prison pharmacies. The inspections are carried out as part of the board's overall responsibility to "regulate the practice of pharmacy . . . [as well as] the sale, distribution, character and standard of drugs . . ." and "to investigate alleged violations of the provisions of [Article 137 of the Education Law] . . . ."[52] All pharmacies, including those at State correctional facilities, must be registered with the Board of Pharmacy.

Inspection findings are recorded on a pre-printed report form. Possible avenues for dealing with violations are instruction by inspector (IBI), administrative warning letter (AWL), informal hearing with possible fine and formal disciplinary hearing.

Sixteen correctional facilities had pharmacies staffed by 13 full-time and four part-time pharmacists. An additional five facilities had positions authorized for part-time pharmacists which were unfilled as of November 30, 1980.

During fiscal year 1979-80 Board of Pharmacy staff inspected ten DOCS pharmacies. The visits involved ten inspectors and took a total of 25 person hours at a cost of $2,000.

Inspections have not been carried out on a regular basis. Auburn, Elmira and Ossining correctional facilities have been inspected every two years. Five years lapsed between inspections of Attica prison's pharmacy and three years lapsed between inspections at Eastern and Fishkill facilities. The pharmacies at Clinton and Great Meadow prisons were last inspected in 1975 and the Bedford Hills pharmacy was inspected in 1976.

Of the 12 instances where violations were found, two resulted in an administrative warning letter being sent, and in ten cases the pharmacist was instructed by the inspector about proper practice. Woodbourne had a full-time pharmacist operating a pharmacy which is not registered with the Board of Pharmacy. On June 11, 1980, the Commissioner of Corrections was notified by letter that this is illegal practice. As of November 30, 1980 the Board of Pharmacy had still not received a reply from DOCS.

Chapter Summary

Department of Correctional Services

The priority DOCS has accorded to inmate health care varied during the decade of the 1970's. Through federal funding, a 1973 plan to develop an inmate health care delivery system was implemented. Expiration of federal funding, however, led the department to deemphasize central leadership and oversight of inmate health care between 1977 and 1979. In 1980, DOCS again developed its central office capacity to plan, monitor and control inmate health service delivered at the facility level.

Contrasting with a 1976 DOB policy of considering inmate health service positions "critical," vacancy control requirements imposed during 1979 and 1980 necessitated that inmate health service positions operate at about a 90 percent fill rate. As of October 6, 1980, 16 percent of the authorized health service positions were vacant.

Physician recruitment and retention was a major problem. Noncompetitive State salaries, shortage of physicians in certain geographic areas, and inflexibility in physician coverage arrangements were obstacles to filling DOCS facility health service physician vacant positions.

There was no integrated inmate health services budget within DOCS. This made it difficult for the Governor and the Legislature to focus attention on inmate health needs and priorities.

The ability of DHS to assure quality inmate health services depended upon adequate facility level management and follow-up of inmate health care problems, monitored by a regional oversight case review system. It is questionable whether such supervision and oversight can be properly provided on a part-time basis, either at the facility or regional direction levels.

DHS utilization review, instituted in summer 1980, may lead to prevention of unnecessary inmate hospitalization and reduction in the average inmate's length of stay at community hospitals.

The DHS managment information system has been neglected since 1977. Though it has potential to provide useful management, planning and utilization data, the system is currently not providing such information. Effective DHS management and oversight would improve the systems usefulness.

The department did not effectively plan, monitor and manage environmental health. Contrary to the generally accepted standards, environmental health was not the mission of the "responsible health authority," nor did any DOCS major official have this mission. Environmental health functions were fragmented within DOCS. The result was widespread correctional facility noncompliance to environmental health directives.

Mental Health Services for Inmates

As of November 5, 1980, OMH Satellite and other services units at State correctional facilities operated at 24 percent below authorized staffing.

OMH budget and financial reporting procedures did not facilitate effective management of the Bureau of Forensic Services program.

Though under development during the last year, operating guidelines and standard procedures for the satellite center programs had not been promulgated. The result was a lack of uniformity in the access to and availability of inmate mental health services among the centers. There was unevenness in performance and management among the programs.

There was no formal documented annual review of the satellite and other psychiatric unit programs. The American Association of Correctional Psychologists considers such a review essential.

Bureau management information systems were inadequate. A new record keeping and reporting format is under development.

Improved coordination of OMH/DOCS health programs was needed. While both agencies were working to resolve existing deficiencies, potential exists for further cooperation, interchange of staffs and joint use of facilities.

Commission of Correction

The Commission of Correction's responsibility for monitoring and oversight of State inmate health services was divided--medical and psychiatric services under the MRB and HSU and environmental health under BSCFR.

The commission's approach to oversight of State inmate health care was primarily reactive. Commission involvement and investigations were initiated by inmate deaths, grievances or complaints. Commission officials perceived this approach as most effective, given the limited size of the HSU and BSCFR staffs.

LCER staff analyses of commission State inmate health services workload indicate that since December 1977: (1) the inmate mortality investigation backlog has been reduced and (2) response time on inmate grievances and complaints has been shortened.

Agency responsiveness to commission mortality review recommendations was often slow and occasionally defensive. Commission findings identified repeated shortcomings, which sometimes were ignored or rationalized in agency response letters. Resolution of the problems was slow.

Though authorized by statute to promulgate standards of State inmate health care, the commission has not done so. Such standards would provide a solid basis for assessment of the quality of inmate health care and that of prison environmental health.

◉ MRB has evaluated the medical care at one State correctional facility. This evaluation effort was comprehensive, consumed over 30 staff days and resulted in specific recommendations made to DOCS. MRB does not view State correctional facility health system evaluation as a priority, due to the heavy emphasis on and allocation of staff resources to mortality review, grievance and complaint investigation.

Department of Health

◉ DOH views its role as monitor of the health environment at DOCS facilities as purely advisory with no powers of enforcement. However, the DOH commissioner was mandated to enforce the Public Health Law and the Sanitary Code under Public Health Law Section 206 (1) (f).

◉ State sanitarians limited their inspections to food service areas excluding, except in two instances, water and general facility sanitation.

◉ Attica Correctional Facility has not had any kind of sanitation inspection in more than three years -- since October 18, 1977.

Health Planning Commission

◉ Although HPC was required to review the plans of State agencies relating to the provision of health and mental health services, no State inmate health plan has been required of DOCS. By omitting State prison inmate health needs, HPC was not taking into account the drain on community health resources by inmate health care.

IV FINANCING INMATE HEALTH SERVICES

During 1979-80, the State spent more than $42.4 million or $2,079 per inmate to provide health services to inmates of the 33 State correctional facilities. This includes identifiable expenditures for medical, dental, psychiatric, psychological and environmental health services as well as the indirect cost of inmate security necessitated by such health services. Not included are undetermined costs to the State which result from inmate health care litigation. Table 22 shows the components of this expenditure.

Health services to inmates constitute 50.4 percent of total, security costs 26.8 percent, fringe benefits 20.9 percent, and administrative and equipment costs 1.9 percent. Inmate health services provided by DOCS amounted to $13.4 million ($658.30 per inmate), significantly higher than $10.4 million ($508.61 per inmate) reported in the DHS 1981-82 budget request. LCER's higher amount reflects admission/classification, central pharmacy, Westchester County Medical Center and other inmate health service outlays which are not normally recorded by DOCS as direct health costs.

Table 22

Estimated Expenditures for State Inmate Health Services
1979-80

Type of Expense	Total	Per Inmate[a]
Inmate Health Services		
Department of Correctional Services	$ 13,431,268	$ 658.30
Office of Mental Health	7,906,426	387.51
Office of Mental Retardation and Developmental Disabilities	60,000	2.94
Subtotal	$ 21,397,694	$1,048.75
Security (DOCS)	$ 11,347,742[b]	$ 556.18
Fringe Benefits	$ 8,880,389	$ 435.25
Administration/Oversight		
Department of Correctional Services	$ 410,636	$ 20.13
Office of Mental Health	44,105	2.16
Commission of Correction	140,767[b]	6.90
Other	19,066	0.93
Subtotal	$ 614,574	$ 30.12
Equipment	176,514	8.65
Total	$ 42,416,913	$2,078.95

[a] Based on average inmate population of 20,403.
[b] LCER staff estimate.

Source: LCER staff from Tables 23, 24 and 25, ff.

CONTINUED

1 OF 2

OMH direct health service expenditures, including satellite center, non-satellite unit and Central New York Psychiatric Center (CNYPC), amounted to $7.9 million or $387.51 per inmate.

In addition to detailing inmate health care expenditures, this chapter also discusses the State's financial management of inmate health care and options available to improve system management and efficiency.

Expenditure Trends 1975-76 through 1979-80

Table 23 presents the inmate health services expenditures of four agencies between 1975-76 and 1979-80. These data were developed by LCER staff from review of State accounts and agency documents. Excluded from this table are inmate health services expenditures for which a five year data base was not available (e.g., DOCS environmental health, DOH inspections, SED pharmacy inspection and Commission of Correction oversight activities); these will be presented for a single year in a subsequent discussion.

Table 23

State Inmate Health Service Expenditures As Reported 1975-1980
(Excluding Fringe Benefits)

Department of Correctional Services	1975-76	1976-77	1977-78	1978-79	1979-80	1975-76 - 1979-80 Total Expenditures	Percent Change
Division of Health Services	$ 476,264	$ 737,496	$ 498,791	$ 301,778	$ 244,242	$ 2,258,571	-49
New York City Central Administration	--	--	74,971	177,895	112,716	365,582	--
Direct Inmate Health	7,116,937	8,207,539	9,300,388	9,719,287	11,225,892	46,070,043	+57
Admission/Classification Health Services	126,922	252,918	278,789	313,509	333,981	1,306,119	+163
Admission/Classification Psychiatric/Psychological Services	128,253	132,964	83,778	87,834	92,623	525,452	-28
Psychiatric, Psychological or Geriatric Health Programs	1,106,579	814,397	381,509	479,750	661,651	3,443,886	-40
Westchester County Medical Center	--	--	--	543,034	1,004,405	1,547,439	--
Medical Equipment	611	71,173	23,035	111,624	176,514	382,957	--
Satellite Center Facilities	--	--	349,418	--	--	349,418	--
Subtotal	$ 8,955,566	$10,216,487	$11,490,679	$11,734,711	$13,852,024	$56,249,467	+54
Office of Mental Health							
Bureau of Forensic Services	--	--	$ 44,408	$ 22,006	$ 44,105	$ 110,519	--
Direct Psychiatric/ Psychological Service Including Satellite Centers	$ 1,036,984	$ 1,045,329	1,735,064	2,103,890	2,306,106	8,227,373	+122
Central New York Psychiatric Center	--	--	4,406,151	4,925,204	5,582,203	14,913,558	--
Outside Health Providers -Central Psychiatric	--	--	279	37,341	18,117	55,737	--
Subtotal	$ 1,036,984	$ 1,045,329	$ 6,185,902	$ 7,088,441	$ 7,950,531	$23,307,187	+666
State Education Department Office of Vocational Rehabilitation							
Central Administration	$ 15,000	$ 15,000	$ 15,000	--	--	$ 45,000	--
Direct Services to Inmates	20,793	14,605	10,010	--	--	45,408	--
Subtotal	$ 35,793	$ 29,605	$ 25,010	--	--	$ 90,408	--
Office of Mental Retardation and Developmental Disabilities							
Technical Assistance to DOCS for Extended Classification of Retarded Inmates	--	--	--	--	$ 60,000	$ 60,000	--
Total	$10,028,343	$11,291,421	$17,701,591	$18,823,152	$21,862,555	$79,707,062	+118

Note: Reported expenditures include carry-over funds from one fiscal year to another.

Source: LCER staff from NYS Department of Audit and Control, State Accounts, R-6 and R-6C Reports and Data furnished by DOCS, OMH, SED, and Facilities Development Corporation, Central Administration.

The table shows that inmate health services expenditures of the four agencies increased by $11,854,212 or 118 percent between 1975-76 and 1979-80. The largest increments were for (1) OMH psychiatric services (666 percent), reflecting startup of satellite centers and CNYPC programs and (2) DOCS services (54 percent). The latter stems from initiation of the secure ward program at Westchester County Medical Center in 1978-79, the establishment of the central pharmacy program at New York City Central Office in 1977-78, and significant increases in medical equipment, admission/classification health services and direct inmate services expenditure categories. Offsetting these DOCS increases were declines in admission/classification psychiatric/psychological services (-28 percent), DHS administrative expenses (-49 percent) and psychiatric, psychological and geriatric programs (-40 percent).

To report inmate health services expenditures, DOCS includes only DHS and direct inmate health services expenditures. LCER staff has included other DOCS inmate health outlays for a more accurate estimate of inmate health care costs. Because DOCS does not associate these with inmate health care, the department's expenditure data usually have understated program costs.

Similarly OMH satellite center and CNYPC expenditures are not specifically identified as State inmate health care related expenditures, nor are OMH, Bureau of Forensic Services administrative costs.

Segmented administration and accountability for the inmate health care program likely will continue, unless steps are taken to develop central budgeting and accounting procedures to consolidate program finances and reporting.

1979-80 State Expenditures for Program Administration

Table 24 estimates State Inmate Health Services program administration expenditures and FTE staffing. Chapter III has presented the bases for these estimates.

Since the Commission of Correction was unable to furnish its 1979-80 expenditures for State inmate health oversight, LCER staff estimated them based upon workload experience presented in Chapter III and the financial data in Appendix C. The estimate was derived:

Commissioner ($40,350 x .33)	$ 13,316
Other Than Personal Service ($13,316 x .15)	1,997
Medical Review Board ($14,527 x .38)	5,520
Health Systems Unit ($111,325 x .55)	61,229
Bureau of State Correctional Facility Review ($234,027 x .25)	58,705
	$140,767

These four agencies spent $614,574 to manage and oversee inmate health in 1979-80. Of the total estimated expenditure, 67 percent was incurred by DOCS, 23 percent by the Commission of Correction and seven percent by the OMH, Bureau of Forensic Services. Also, note that $288,347 of the total has been included in Table 23, leaving a $326,227, not previously shown.

Table 24

Staff and Expenditure Allocation
to Central Administration of State Inmate Health Services
(Excluding Fringe Benefits)
Estimated 1979-80

Agency/Unit	1979-80 Estimated FTE Staff Allocation	1979-80 Estimated Expenditures
Department of Correctional Services		
Division of Health Services	11.0	$244,242[a]
Counsel's Office	1.5	52,000[b]
Division of Support Operation	3.8	83,680[b]
Correctional Emergency Response Team	1.4	30,714[b]
Subtotal	17.7	$410,636
Office of Mental Health-Bureau of Forensic Services	1.5	$ 44,105[a]
Commission of Correction	5.8	$140,767
Department of Health		
Bureau of Narcotic Enforcement	0.3[c]	412
Division of Food and Drug Protection	0.5[c]	15,154
Bureau of Local Health Management	d	1,500
Subtotal	0.9[c]	$ 17,066
State Education Department		
Board of Pharmacy	d	2,000
Total	25.9	$614,574

[a]Included in Table 23 Central Administration.
[b]Estimated by DOCS based upon staff FTE x salary grade and adding 15 percent for other than personal services.
[c]Estimated based upon 230 day work year.
[d]Less than 0.1 FTE

Source: LCER staff from Appendix C, Tables C-1, C-2, C-3, C-4.

Indirect Costs - Security and Escort

As mentioned previously, security considerations add substantially to the costs of inmate health care. Facility health and mental health units must be staffed with COs to oversee inmates and assure safety of health service personnel. Particularly in maximum and medium security facilities COs must escort inmates to and from health service encounters, whether within or out of the facility. When inmates are admitted to outside hospitals for inpatient care, 24 hour security coverage is required.

Table 25 shows the 1979-80 direct and indirect expenditures for inmate health care at the 13 correctional facilities in the LCER sample and the 20 other correctional facilities. Direct health care includes DOCS and OMH health unit operating expenditures at the facilities, while indirect expenditures are regular and overtime security costs associated with those health units' operating expenditure. Excluded from these operating costs are the direct and indirect expenditure for the Merle Cooper program at Clinton and

Table 25

Total Estimated Direct/Indirect Health Care Expenditures in 1979-80
LCER Sample and Other 20 Facilities
(Excluding Fringe Benefits)

Security Level	Direct-Health: DOCS Health	Direct-Health: OMH Satellite & MH Unit	Direct-Health: Subtotal	Indirect-Security: Regular	Indirect-Security: Overtime	Indirect-Security: Subtotal	Total Health Care Including Security	Security as a Percent of Total	Per Inmate Cost: Direct Health	Per Inmate Cost: Indirect Security	Per Inmate Cost: Total
Maximum											
Attica	$ 1,240,885	$ 212,583	$ 1,453,468	$1,715,677	$ 135,017	$ 1,850,694	$ 3,304,162	56.0	$ 813.81	$1,036.22	$1,850.03
Auburn	598,322	183,208	781,530	440,147	124,387	584,534	1,346,064	41.9	493.70	356.62	850.32
Clinton	1,193,861	221,173	1,415,034	1,407,274	48,742	1,456,016	2,871,050	50.7	569.66	586.16	1,155.82
Coxsackie	244,773	61,048	305,821	181,149	32,985	214,134	519,955	41.2	439.40	307.66	747.06
Elmira	502,039	256,820	758,859	327,865	15,995	343,860	1,102,719	31.2	498.92	226.07	724.99
Subtotal	$ 3,779,880	$ 934,832	$ 4,714,712	$4,072,112	$ 357,126	$ 4,429,238	$ 9,143,950	48.4	$ 584.23	$ 548.85	$1,113.08
Medium											
Arthur Kill	508,554	--	508,554	152,704	177,884	330,588	839,142	39.4	695.70	452.24	1,147.94
Fishkill	1,047,056	229,977	1,277,033	428,171	4,883	433,054	1,710,087	25.3	1,087.76	368.87	1,456.63
Queensboro	251,683	--	251,683	101,803	86,787	188,590	440,273	42.8	853.16	639.29	1,492.45
Woodbourne	309,511	12,606	322,117	404,217	46,991	451,208	773,325	58.3	484.39	678.51	1,162.90
Subtotal	$ 2,116,804	$ 242,583	$ 2,359,387	$1,086,895	$ 316,545	$ 1,403,440	$ 3,762,827	37.3	$ 823.52	$ 489.86	$1,313.38
Minimum											
Adirondack	65,237	--	65,237	14,971	139	15,110	80,347	18.8	501.82	116.23	618.05
Mt. McGregor	60,457	--	60,457	7,485	7,363	14,848	75,305	19.7	431.84	106.06	537.90
Lincoln	54,683	--	54,683	--	2,682	2,682	57,365	4.7	569.61	27.94	597.55
Bayview	152,547	--	152,547	14,971	12,217	27,188	179,735	15.1	1,386.79	247.16	1,633.95
Subtotal	$ 332,924	--	$ 332,924	$ 37,427	$ 22,401	$ 59,828	$ 392,752	15.2	$ 699.40	$ 125.69	$ 825.11
LCER Sample	$ 6,229,608	$1,177,415	$ 7,407,023	$5,196,434	$ 696,072	$ 5,892,506	$13,299,529	44.3	$ 649.11	$ 516.39	$1,165.50
20 Other Facilities	4,996,284	1,128,691	6,124,975	3,225,981*	1,030,632	4,256,613*	10,381,588	41.0	681.16	473.38*	1,154.54
33 Facility Total	$11,225,892	$2,306,106	$13,531,998	$8,422,415*	$1,726,704	$10,149,119*	$23,681,117	42.9	$ 663.24	$ 497.43*	$1,160.67

*LCER estimate based upon LCER sample FTE security coverage; estimated unit costs were developed for health unit, satellite unit (where appropriate) and other health related security coverages for each sample facility; these were averaged by level of security and applied to the remaining 20 correctional facilities. Since these estimates were based upon the minimum security guard salary base ($14,972), they are conservative.

Source: LCER staff from Tables 26, 27 and Appendix C-5.

the Westchester County Medical Center secure ward. Also presented are per inmate costs for direct, indirect and total health care.

The table illustrates the high cost of security at correctional facilities. Almost $5.9 million of the $13.3 million or 44 percent of total health care represented health related security for the LCER sample of 13 facilities. In maximum security facilities, the percentage that security comprised of health care costs, ranged from 31.2 percent at Elmira to 56 percent at Attica. On a per inmate basis, Attica's health related security was over four-and-one-half times higher than Elmira's. This variation is partially attributable to Elmira's policy of providing "in facility" recuperative care of inmates having outside surgery. This lowers length of stay and the attendant cost of security at outside hospitals. Attica's (and Clinton's) relatively high per inmate security costs in part are attributable to secure ward coverage provided at outside hospitals (See Table C-5).

Costs of security coverage represent a smaller percentage of total inmate health care expenditures at medium and minimum security facilities than at maximum security facilities. Similarly, per inmate security costs parallel degree of security, with maximum facilities most costly and minimum facilities least costly. The relatively high security costs at Woodbourne stem from the intensive security staffing of that health unit. As indicated on Appendix C, Table C-5, Woodbourne's health unit had three times more CO coverage than either Arthur Kill or Queenboro and almost two-thirds more than Fishkill. Of the minimum security facilities, Bayview, the only female facility in the LCER sample, stands out as having relatively high security cost on a per inmate basis.

As noted on Table 25, LCER staff extrapolated the indirect costs of security for the remaining correctional facilities. This estimated amount, $3,225,981, was added to actual overtime of $1,030,632 for a total estimate of $4,256,613.

This estimated security expenditure for the 20 facilities is lower than the $5,892,506 for the LCER 13 facilities sample; this stems from the sample's inclusion of large maximum facilities, with satellite centers and heavy outpatient hospital usage. Conversely, ten of the 20 non sample facilities are minimum security with limited health security requirements. Only two of the other non sample facilities have satellite centers.

Excluded from Table 25 were direct and indirect health care costs for Clinton's Merle Cooper Program and the Westchester County Medical Center secure ward. Both programs were separately funded. Table 26 shows total security costs of $11,347,742, adding $1,198,623 to the $10,149,119 previously shown on Table 25.

Almost 60 percent of the regular security outlays occur at maximum security facilities, where 62 percent of the inmates reside. This also is attributed to (1) stringent security requirements of those facilities, (2) operation of secure wards and heavy use of community hospital care, and (3) operation of five satellite units.

Fringe Benefits

LCER staff calculated the fringe benefit costs associated with the 1979-80 Expenditures for Inmate Health Services, Security, Administration and Oversight. Personal Services for these expenditures totalled $27,290,684. This figure was multiplied by the Department of Audit and Control 1979-80 fringe benefit rate of .3254. The result, $8,880,389 is reported on Table 22.

Table 26

1979-80 Inmate Medical Security Costs
(Excluding Fringe Benefits)

Type of Facility	Number of Facilities	Number of Inmates[a]	Average Cost Per Inmate LCER Sample	Aggregate Cost
Regular Security				
Maximum	9	12,643	$ 485	$ 6,134,646
Medium	10	6,112	353	2,158,188
Minimum	14	1,648	79	129,581
Subtotal	33	20,403	$ 413	$ 8,422,415
Overtime at 33 Facilities	--	--	85	1,726,704
Merle Cooper Program	--	--	51	1,032,999[b]
Weschester County Medical Center Secure Ward	--	--	8	165,624
Total	33	20,403	$ 557	$11,347,742

[a]Excludes "out to court" inmates, who for various reasons have been remanded to municipal county and local jails.
[b]Estimated by LCER staff, 69 correction officers (per Table C-5) x $14,971 per year = $1,032,999.

Source: LCER staff.

Interfacility Expenditures Comparison

Table 27 compares DOCS 1979-80 total and per inmate expenditures for direct inmate health care among the 33 facilities. The amounts shown correspond to the category "Direct Inmate Health Services," as reported on Tables 23 and 25.

DOCS spent $11.2 million to provide direct inmate health care services at the 33 correctional facilities in 1979-80. About 68 percent of this amount was for personal services, almost 19 percent for miscellaneous contractual services (e.g., outside hospital, physician, ambulance, laboratory services), while the remaining 13 percent was for equipment, supplies, and other.

The medium security facilities as a group spent the highest amount for direct health care -- $763 per inmate. Maximum security facilities spent the least --$458 per inmate. This variation is explained partially by a much larger per inmate expenditure for personal services in medium security facilities -- an average $544 per inmate compared to $299 per inmate in maximum security facilities. As pointed out in Chapter II, the medium security facilities in the LCER sample had more physician coverage and used proportionately more inpatient hospital care than the sample maximum security facilities.

Table 27

DOCS Direct Inmate Health Care Expenditures for 1979-80
Total and Per Inmate
(Excluding Fringe Benefits)

Facilities by Type of Security	Inmate Population	1979-80 Expenditures: Personal Services	Miscellaneous Contractual Services	Other	Total	1979-80 Expenditure Per Inmate: Personal Services	Miscellaneous Contractual Services	Other	Total
Maximum									
Downstate	406	$ 221,745	$ 11,798	$ 55,839	$ 289,382	$ 546	$ 29	$138	$ 713
Attica	1,786	596,639	535,607	108,639	1,240,885	334	300	61	695
Eastern	845	334,391	52,352	31,048	417,791	394	62	37	493
Clinton	2,484	755,015	271,054	167,792	1,193,861	304	109	68	481
Great Meadow	1,452	410,469	186,866	82,327	679,662	283	129	57	468
Auburn	1,583	406,798	96,900	94,624	598,322	257	61	60	338
Coxsackie	696	201,727	25,698	17,348	244,773	290	37	25	352
Green Haven	1,867	469,699	43,007	112,687	625,388	252	23	60	335
Elmira	1,521	377,854	46,302	77,883	502,039	248	30	51	330
Subtotal	12,643	$3,774,337	$1,269,584	$ 748,187	$ 5,792,103	$ 299	$100	$ 59	$ 458
Medium									
Bedford Hills	405	$ 484,677	$ 65,607	$ 81,690	$ 631,974	$1,197	$162	$202	$1,560
Albion	305	229,249	71,160	26,953	327,362	752	233	88	1,073
Fishkill	1,174	775,698	160,364	110,994	1,047,056	661	137	95	892
Queensboro	295	202,415	22,560	26,708	251,683	686	76	91	853
Arthur Kill	731	326,158	130,029	52,367	508,554	446	178	72	696
Ossining	1,142	440,070	208,959	116,362	765,386	385	183	102	670
Mid Orange	425	203,064	36,173	34,802	274,033	478	85	87	645
Otisville	471	208,570	40,174	46,625	295,369	443	85	99	627
Wallkill	499	199,222	10,109	45,412	254,743	399	20	91	511
Woodbourne	665	253,922	29,579	26,010	309,511	382	44	39	465
Subtotal	6,112	$3,323,045	$ 774,714	$ 567,923	$ 4,665,671	$ 544	$127	$ 93	$ 763
Minimum									
Edgecombe	90	$ 127,272	$ 2,853	$ 55,106	$ 185,231	$1,414	$ 32	$612	$2,058
Bayview	110	139,569	8,149	4,829	152,547	1,269	74	44	1,387
Fulton	81	56,231	1,568	2,720	60,519	694	19	34	747
Lincoln	96	55,345	7,335	2,557	65,237	557	76	27	680
Mt. McGregor	140	32,156	22,888	5,492	60,547	230	163	39	432
Adirondack	130	39,364	4,069	11,250	54,683	303	31	87	421
Hudson	183	56,302	9,261	10,406	75,969	308	51	57	415
Rochester	37	79	4,910	522	5,511	2	133	14	149
Georgetown	112	3,706	3,564	2,081	9,351	33	32	19	83
Taconic	304	1,817	3,712	17,343	22,872	6	12	57	75
Pharsalia	111	1,254	3,966	2,665	7,885	11	36	24	71
Summit	130	5,192	360	1,966	7,518	40	3	15	58
Monterey	109	93	130	629	852	1	1	6	8
Parkside	6	--	663	746	1,409	--	111	124	235
Other	9	--	2,442	55,540	57,987	--	NA	NA	NA
Subtotal	1,648	$ 518,380	$ 75,870	$ 173,852	$ 768,118	$ 315	$ 46	$105	$ 466
Total	20,403	$7,615,762	$2,120,168	$1,489,962	$11,225,892	$ 373	$104	$ 73	$ 550

Source: LCER staff from NYS Department of Audit and Control, State accounts, R-6 and R6-C reports.

The table shows wide variation in expenditure effort. Noticeable are the high per inmate costs generated at female facilities, Bedford Hills ($1,560) and Bayview ($1,387). The high Bedford Hills per inmate cost largely stems from the seven-and-one-half health staff positions added due to the Todaro v. Ward decision.[1] The high costs at Edgecombe ($2,058) are attributable to a relatively large number of filled health services positions (seven) for a small population (90) facility and unusually high outlays for equipment, supplies, etc. Edgecombe health providers also serve other New York City facilities.

The table reflects wide variations in per inmate direct health care costs, even within the different security levels. For example, Attica at $695 per inmate spent more than twice Elmira at $330 per inmate. This variation largely is explained by Attica's

miscellaneous contractual service amount ($300 per inmate) -- attributable to inmate hospitalization at the secure ward. Moreover, Attica's personal services costs are higher per inmate reflecting a larger health service staff. Similiar variations are apparent for the medium and minimum security facilities.

Miscellaneous Contractual Services

The costs associated with inpatient care at community hospitals, outpatient ambulatory care, use of consultants and specialists, and laboratory and ambulance services are classified as Miscellaneous Contractual Services Expenditures. Unlike Personal Services expenditures which are fixed by staffing requirements, Miscellaneous Contractual Services are more susceptible to management and control. For example, careful monitoring of inmate inpatient days through DHS utilization review can lead to more efficient use of hospital care. Similarly, augmented infirmary facilities and personnel might make possible greater utilization of facility infirmaries for recuperation of surgical cases, again diminishing the number of hospital inpatient care days. Another example, could be lowering the cost of specialty care and consultant services per inmate served through improved management and greater use of in-facility specialty clinics.

Table 28 shows DOCS' direct inmate health care expenditures for miscellaneous contractual services. These data exclude journal transfers and, for that reason, do not fully agree with data presented in preceding tables.

Of the total $2,196,860 in Miscellaneous Contractual Expenditures $1,922,425 (87.5 percent) was for inmate hospitalization. While most hospitalization occurred at the maximum security facilities, the medium security facilities spent more per inmate ($109) than the maximum facilities ($96).

Total Miscellaneous Contractual Services costs per inmate are highest in the medium facilities ($126) and lowest in the maximum security units ($106). However, the table shows relatively high costs in three of nine maximum, five of 10 medium and two of 14 minimum security facilities. It is at these high cost facilities that the greatest potential for cost-effective innovation exists.

The $27,918 for Medical Groups may understate physician specialists and consultant costs. These costs were not always identifiable from the payee data provided, and therefore also may be included in the Other Services category.

Financial Management

Several State agencies provide health services to inmates of State correctional facilities. Each employs its own budgeting and accounting procedures to record inmate health service expenditures; however, no common purpose or subpurpose category facilitates aggregation of such expenditures or designates such services as rendered by one agency for another. Because inmate health expenditures are not consolidated by the budgeting and accounting process, the Legislature, the Governor and the public do not have complete financial and performance data on the inmate health service program.

Policy and Procedure

DOCS does not have a financial management policy and procedure manual for inmate health service expenditures and payments. Correctional facilities generally

Table 28

DOCS Direct Inmate Health Care Miscellaneous Contractual Expenditures[a]
1979-80

Facilities by Type of Security	Inmate Population	Hospitalization	Medical Groups	Other Services	Total	Expenditure Per Inmate
Maximum						
Attica	1,786	$ 517,907	$ 1,158	$ 21,118	$ 540,183	$302
Clinton	2,484	288,252	30	24,197	312,479	126
Great Meadow	1,452	177,419	7,639	691	185,749	128
Elmira	1,521	78,468	--	3,438	81,906	54
Auburn	1,583	58,183	4,551	27,357	90,091	57
Eastern	848	37,345	30	15,135	52,510	62
Coxsackie	696	24,564	154	1,866	26,584	38
Green Haven	1,867	21,688	517	20,803	43,008	23
Downstate	406	4,186	--	7,541	11,727	29
Subtotal	12,643	$1,208,012	$14,079	$122,146	$1,344,237	$106
Medium						
Ossining	1,142	$ 202,284	$ 100	$ 6,571	$ 208,955	$183
Fishkill	1,174	147,244	279	15,285	162,808	139
Arthur Kill	731	130,023	--	516	130,539	179
Albion	305	60,846	249	9,609	70,704	232
Bedford Hills	405	34,278	2,055	29,175	65,508	162
Otisville	471	27,729	--	10,622	38,351	81
Mid Orange	425	26,606	--	6,358	32,964	78
Woodbourne	665	22,717	70	6,992	29,779	45
Queensboro	295	8,242	--	14,215	22,457	76
Wallkill	499	6,851	--	3,277	10,108	20
Subtotal	6,112	$ 666,800	$ 2,753	$102,620	$ 772,173	$126
Minimum						
Mt. McGregor	140	$ 17,249	$ 3,211	$ 2,405	$ 22,865	$163
Hudson	183	8,164	709	388	9,261	51
Adirondack	130	4,069	--	--	4,069	31
Taconic	304	3,697	8	--	3,705	12
Georgetown	112	3,152	--	412	3,564	32
Pharsalia	111	2,171	30	2,508	4,709	42
Rochester	37	982	3,928	--	4,910	133
Summit	130	360	--	--	360	3
Bayview	110	140	25	485	650	6
Monterey	109	130	--	--	130	1
Lincoln	96	--	75	369	444	5
Edgecombe	90	--	45	32	77	b
Fulton	81	--	--	48	48	b
Other[c]	15	7,499	3,055	15,104	25,658	N/A
Subtotal	1,648	$ 47,613	$11,086	$ 21,751	$ 80,450	$ 49
Total	20,403	$1,922,425	$27,918	$246,517	$2,196,860	$108

[a]Excludes journal transfers, thus does not agree with preceding tables.
[b]Less than $1.
[c]New York City, Iroquois

Source: LCER staff from data provided by NYS Department of Audit and Control October 28, 1980.

operate as separate fiscal entities. As such they are governed by the provisions of the State Finance Law, the Medical Fee Schedule and OGS purchasing policies.

DOCS central office does not audit health service vouchers or monitor health service expenditures; these roles are viewed as facility responsibilities. Central office will provide financial management assistance, upon request of the facility personnel.[2]

In conversations with finance officers at the 13 facilities, LCER staff found some dissatisfaction with and confusion about DOCS financial management and policies. Specifically indicated were needs for clarification of DOCS budgeting and accounting policies and for inservice training of facility finance management personnel.

A DOCS central administrative fiscal review team, operating under an LEAA grant, was organized during August and September of 1980 to assist correctional facilities: reduce financial work backlog, assess and correct facility financial procedures, recommend changes in procedures, and determine if recommended changes were made by the facility during a follow up visit.[3]

Financial Control

Though institutional stewards were responsible for correctional facility financial management, they were unable to effectively monitor and control health service outlays at the facilities LCER staff visited. Generally, outside health service expenditures were authorized by the head nurse, nurse administrator or Facility Health Services Director. Purchases were made or monies committed without involvement of the institutional steward or his staff. The stewards were unable to account for health service supplies and equipment on hand, and could not effectively manage purchases, due to lack of inventory control. As a result, the finance office was unable to monitor or control cash flow until after the payee vouchers were received.

After receipt of the voucher, the nurse administrator or other person in charge of the health service unit was required to review the expense for authenticity and accuracy. Due to unavailability of trained clerical help in the health unit, professional health providers' time was spent checking vouchers.

Alternative Inmate Health Care Delivery Approaches

There are three basic models of prisoner health care:

--The custodial agency, i.e., department of corrections provides health services;

--A health agency, i.e., department of health or other state agency is charged with the responsibility, or

--A community provider of health services, such as a hospital or medical center or a private medical services management company, enters into a contractual agreement to care for a prisoner population.

In most state correctional systems, including New York State, the agency responsible for the custody of the prisoner also provides the health services. Several problems, however, are almost always inherent in the custodial model approach:

--Fundamentally conflicting objective between furnishing health care and security may result in curtailed access to health care or extra demands upon the security system.

--Resource allocations are controlled by non-medical staff and requests for augmented health resources must be balanced against other correctional priorities and needs.

--Health professionals working in a prison may be asked to perform custodial or non health tasks. This blurring of the health and custodial functions creates a professional identity problem for the health professional.[4]

Recently several county correctional systems have switched from the custodial to the health agency model. Advantages cited are: expertise in health delivery, unrestricted health identification, enhanced recruiting ability and a better bargaining position with funding agencies. The major disadvantage is that differing priorities of health and correctional administrators occasionally remain a source of conflict.

In the third alterative--the contractual model--the agency responsible for prison health care arranges for a community provider of health services or a medical management firm to supply care to a prison population. One example is the agreement between the NYC Departments of Health and Corrections and Montefiore Hospital to provide medical services on Rikers Island.

Another is the State of Illinois contract with a private medical management firm for health services to the Pontiac, Dwight, and Centralia correctional facilities.[5]

Advantages include:

--Health providers, in the business of rendering health care, can be expected to provide quality services efficiently;

--Recruitment of health services staff is facilitated;

--Relatively few lawsuits against the prison health care system.

Again a disadvantage may be friction between health service and custodial program needs and approaches.

Improving Inmate Health Care at Reduced Cost

This program audit shows the high and growing costs of providing health care to prison inmates and highlights problems in the health care delivery system. Several alternatives exist to reduce these costs and/or improve the health care system.

The orientation of inmates to the range and type of inmate health services available was found to be minimal (See pp. 17-18). The promulgation of a patient's bill of rights might be an easy way to alleviate this shortcoming. South Carolina has done this.

During the reception/classification process inmates should be informed orally and in writing of the range and scope of health services available and their rights to health care during incarceration. In addition, each correctional facility should provide inmates with a explanation of the health services available and how to gain access to them.

Careful review and evaluation of each newly admitted inmate's physical and mental health would help to identify inmates in need of specialty or supportive health services.

These health findings should be fully considered in placement and transfer decisions. LCER staff were informed in a phone interview that the Michigan Department of Corrections does this.[6]

The inmate health care utilization analyses presented in Chapter II indicate that a few inmates draw heavily on correctional health services while most inmates seldom or only occasionally use health services. Inmates with chronic, acute or recurring problems might be placed at specifically designated correctional facilities, equipped and staffed to provide more intensive or specialty health care services. This technique might allow better distribution and more efficient use of health staff and equipment resources.

Again, Michigan has taken steps in this direction. Inmates with chronic illnesses (e.g., arthritis, asthma, etc.) are housed at designated facilities.

Because the indirect cost of security accounts for 44 percent of inmate health care costs, improved planning and management of the security component has potential for reducing the costs of care. Several alternatives are available:

--Increasing the use of on-site specialty clinics, (this will require an updating of the medical fee schedule);

--Adding secure ward beds at community hospitals;

--Improving utilization of existing secure ward facilities;

--After surgery, limiting the number of hospital days with greater utilization of the facilities' infirmaries for recovery, (this will probably require the upgrading of some infirmary facilities and staffing);

--Expanding the reconstructive surgery program into other minor surgery (local anesthesia) areas; and

--Continuing to develop and improve inmate hospital service capability.

During field visits to the correctional facilities, LCER staff were told of difficulty in recruiting and retaining qualified health professionals, especially physicians (See pp. 49-50). Although several impediments were repeatedly mentioned, the problem boils down to extreme difficulty in finding physicians to work a 35 hour week for the available compensation. The situation calls for the exploration of innovative methods of staffing.

One way to improve the availability of physician manpower might be the development of individualized contracts with physicians [as permitted by Correction Law, Section 70(8)]. Such arrangements could be based on the total State resources available (salary and fringe benefit costs) to compensate a physician. Moreover, such negotiated physician agreements could include cost-effective documentation and take into account the maldistribution of physician manpower, the unique time availability of some practitioners and varying physician compensation levels throughout the State.

A second approach might be more coordination with area medical schools/teaching hospitals. Residents could spend part of their time practicing at correctional facilities. DOCS already does this on a limited scale in the reconstructive surgery program (See pp. 25-26).

The expansion of the "physician shortage area" designation to include State correctional facilities is a third option. This could make tuition support available to medical students in exhange for their commitment to work in State correctional facilities for a prearranged period of time after graduation.

LCER found that because of DOCS decentralized budget system there is no integrated statewide financial plan for inmate health services (See pp. 50-51). From the State perspective, it is difficult to plan, to set objectives and priorities, and monitor their achievements, without an appropriate financial and program plan. The development of a DOCS integrated inmate health services budget, the use of computerized financial classification and accounting techniques to track inmate health service costs and the implementation of a single inmate health service management information system would be steps in that direction. Such management tools facilitate accountability to the Legislature, the Governor and the public as well as provide a basis for measurement of program accomplishment. South Carolina and Michigan have established centralized inmate health service budgets.

Environmental health considerations, LCER staff discovered, have been neglected in the State's oversight of correctional facilities (See pp. 54-57, 73-74). The roles and responsibilities of the Commission of Correction, DOH and DOCS divisions charged with environmental health oversight need redefinition to eliminate overlap, gaps in supervision and to improve environmental management and planning.

Finally, although HPC is required to review the plans of State agencies relating to the provision of health and mental health services, no State inmate health plan has been required from DOCS (See p. 75). HPC's exclusion of correctional facilities from the planning process should be reevaluated. Without question, correctional facilities impact the community health care resources in their localities. There is need to bring such health resources into prison health care, both to provide outside scrutiny of inmate health care and to expand health care services at correctional institutions.

Chapter Summary

○ In 1979-80, New York State spent $42.4 million to provide health care to an average prison inmate population of 20,403 inmates--$2,079 per inmate. Each 1979-80 dollar spent by the State for inmate health care was distributed: 50 cents for direct inmate health service, 27 cents for security coverage, 21 cents for fringe benefits and two cents for administration and oversight.

○ Improved management of the inmate health care system could result in reduced security costs and associated for fringe benefits. Having a high potential for improving the efficiency of security officer coverage are such techniques as: (1) increased utilization of secure wards, (2) upgrading infirmary staff and facilities so that inmates can be transferred from community hospitals to infirmaries for recuperation, and (3) increased use of "in facility" specialty clinics and reconstructive surgery programs, (4) central staff utilization review of inpatient hospital care.

◎ Accurate and complete inmate health care financial and performance information was not available. Although several agencies were involved in providing direct health service or program oversight, no common purpose or subpurpose account code was used to facilitate the aggregation of inmate health service information.

○ The absence of definitive DOCS financial management policy and procedure for health service outlays, contributed to inappropriate financial practices in the correctional facilities. Finance offices did not give prior approval for health service outlays, and therefore were unable to properly control such expenditures. Health providers were reviewing vouchers for authenticity and accuracy, a job that could be handled by clerical personnel familiar with the health services component.

FOOTNOTES

I Introduction

1. Newman v. Alabama, 349 F. Supp. 278 (1972), 503 F. 2d 1320 (1975), 559 F. 2d 283 (1977), 564 F. 2d 97 (1977) and subsequent decisions.
2. Battle v. Anderson, 376 F. Supp. 402 and subsequent decisions, (Oklahoma),
   Holt v. Sarver, 300 F. Supp. 825 (1969), 309 F. Supp. 362 (1970), and 442 F. 2d 304 (1971), (Arkansas),
   Finney v. Arkansas Bd. of Corrections, 505 F. 2d 194 (1974), 410 F. Supp. 251, and 548 F. 2d 740, and Hutto v. Finney, 437 U. S. 678.
   Laaman v. Helgemoe, 437 F. Supp. 269 (1977) (New Hampshire),
   Newman, op. cit., see also Pugh v. Locke, 406 F. Supp. 318 (1976),
   Palmigiano v. Garrahy, 443 F. Supp. 956 (1977) (Rhode Island),
   Ramos v. Lamm, 485 F. Supp. 122 (1980) (Colorado),
   Trigg v. Blanton, Davidson County (Tennessee) Chancery Court, Vol. No. A-6047 (1978).
3. Todaro v. Ward, 565 F. 2d 48 (1977), and subsequent decisions.
4. Spicer v. Williamson, 132 S.E. 291 (1926).
5. McCrossen v. State, 101 NYS 2d 591 (1950),
   Nettles v. Rundle, 453 F. 2d 889 (3d Cir. 1971),
   Robinson v. Jordan, 494 F. 2d 793 (5th Cir. 1974),
   Campbell v. Beto, 460 F. 2d 765 (5th Cir. 1973),
   Martinez v. Mancusi, 443 F. 2d 921 (2d Cir. 1970),
   Williams v. Vincent, 508 F. 2d 541 (2d Cir. 1974),
   Hight v. State, 231 NYS 2d 361 (1962),
   Fitzke v. Shappel, 467 F. 2d 1072 (6th Cir. 1972),
   Pisacano v. State, 8 App. Div. 2d 335 (1959).
6. Wolff v. McDonnell, 94 S. Ct. 2963 (1974).
7. Estelle v. Gamble, 429 U.S. 97 (1976) and Trop v. Dulles, 356 U.S. at 101 (1958).
8. "The Difficulty in Defining Constitutional Standards of State Prisoners' Claims of Inadequate Medical Treatment," in Duquesne Law Review, Vol. 17, No. 3-4, pp. 687-710.
9. Colman v. Johnson, 247 F. 2d 273 (7th Cir. 1957).
10. Flint v. Wainwright, 433 F. 2d 961 (5th Cir. 1970).
    Freeman v. Lockhart, 503 F. 2d 1016, 1017 (8th Cir. 1974).
    see also: The Rights of Prisoners to Medical Care and the Implications for Drug Dependent Prisoners and Pre-Trial Detainees, 42 U. Chicago Law Review, 705 (1975).
11. Coffin v. Reichard, 143 F. 2d 443 (6th Cir. 1944).
12. 551 F 2d 44 (4th Cir. 1977).
13. N. 2 and Newman v. Alabama, 349 F. Supp. 278 (1972),
    Todaro v. Ward, 565 F. 2d 48 (1977) (New York) and subsequent decisions.
    Gates v. Collier, 349 F. Supp. 881 (N.D. Miss. 1972).
14. N. 1 and Holt v. Sarver, 309 F. Supp. 362 (E.D. Ark. 1970) and subsequent decisions.
15. For a complete listing see Palmigiano, supra N. 2 at 990.
16. N. 13.
17. Correction Law, Section 70(2).
18. Ibid.
19. Ibid., Sections 7(1), 70(3), 112.
20. Lloyd F. Novick, M.D., and Mohamed S. Al-Ibrahim, M.D., Health Problems in the Prison Setting: A Clinical and Administrative Approach, (Springfield: Charles C. Thomas, Publishers, 1977), p. 185; hereafter cited Novick.
21. Ibid., Sections 7(2), 112(1).

22. Ibid., Section 70(8).
23. Ibid., Section 23(2).
24. Ibid., Sections 23(1), 73(5), 84.
25. Ibid., Section 70(5-6), 7 NYCRR 100.
26. Ibid., Section 401.
27. Ibid., Section 430(1-2).
28. Ibid., Section 141.
29. Ibid., Section 137.
30. Ibid., Section 18(3).
31. Ibid., Section 137(3,4).
32. Ibid., Section 137(6c).
33. Ibid., Section 137(6d).
34. Ibid., Section 137 (6b).
35. Correction Law, Section 430(1-2).
36. Ibid., Section 137; letter to LCER staff from DOCS Assistant Commissioner for Health Services, December 1980. (Hereafter cited Letter from Assistant Commissioner.)
37. Ibid., Section 439 (a,c).
38. Letter from Assistant Commissioner.
39. Correction Law, Section 401 ff.
40. McKinney's Session Laws, 1975 Legislative Memoranda pp. 1703-1705; Governor's Memoranda pp. 1781-1782.
41. Correction Law, Section 45; Chapter 865, Laws of 1975.
42. Ibid., Section 47.
43. Ibid., Section 43.
44. Public Health Law, Section 206(1f).
45. Ibid., Sections 1350-1352.
46. Ibid., Section 206 (1g-h).
47. Ibid., Section 201(1j).
48. Ibid., Section 201(1r), 10 NCYRR 16.10(a)(i)(i).
49. Chapter 769, Laws of 1977, Section 1.
50. Novick, p.5.
51. Ibid., pp. 5-28 and Lambert King and Steven Whitman, "Morbidity and Mortality Among Prisoners: An Epidemiologic Review," (unpublished research paper).
52. King and Whitman, p. 12.
53. King and Whitman, p. 18.
54. Ibid., p. 22.
55. Ibid., 19-20.
56. Ibid.

II Inmate Health Services Delivery System

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4. Ibid., pp. 3-12.
5. LCER staff interview with DOCS Director, Division of Classification and Movement.
6. ACA, 4379.01.
7. LCER staff interviews with medical/psychiatric staff, Clinton Correctional Facility, August 19-21, 1980, see also N. 5.
8. AMA 137, ACA 4262.01.
9. AMA 146, ACA 4262.02, USDJ 016.

10. Novick, p. 37, and Edward Brecker and Richard Della Penna, M.D., Prescriptive Package: Health Care in Correctional Institutions, (Washington, D.C.: National Institute of Law Enforcement and Criminal Justice, September 1975). p. 11. Hereafter cited as Prescriptive Package.
11. ACA 4262.02, AMA 146.
12. USDJ 016.
13. Novick, p. 37, Prescriptive Package, p. 11.
14. ACA 4262.02, AMA 146.
15. AMA 154, APHA I.F., ACA 4257.02.
16. PPGM, Pharmacy, 27 Guidelines for Pharmaceutical Services, p. 4, 10/21/74.
17. ACA 4279.03, AMA 127.
18. LCER staff interview with correctional officers at Attica, September 12, 1980.
19. ACA 4257.04.
20. ACA 4258.13, AMA 133.
21. ACA 4253.01, AMA 101, USDJ 001.
22. APHA, pp. 107-108, AMA 110.

III State Administration of Prison Inmate Health Services

1. DOCS, "Department of Correctional Services, Health Services," PPGM-26, April 17, 1974.
2. DOCS, "Department of Correctional Services Division of Health Services, Health Program Standards," PPGM-25, August 1974, pp. 14-15.
3. NYS Legislature, Select Committee on Correctional Institutions and Programs, Report #4, September 15, 1972, pp. 43-44; Report #5, May 24, 1973, pp. 22-24.
4. LEAA, Inmate Health Services Grants I, II, and III, September 21, 1973 through March 31, 1977.
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11. Prescriptive Package, p. 46.
12. DOCS, "Facility Health Services Director: Role and Responsibility," PPGM-24, August 1, 1974.
13. DOCS, "Inmate Grievance Procedure," Directive #4040, March 25, 1980.
14. DOCS, "Elective Surgery Procedures," PPGM-59, February 11, 1976.
15. DOCS, "Prior Approval for Outside Hospital Admission," PPGM-G-401, July 21, 1980.
16. Ibid., pp. 1-2.
17. AMA 101; ACA 4253.01.
18. Correction Law, Section 70(2).
19. See DOCS, Employee Manual.
20. Letter to LCER staff from DOCS Facility Operation Specialist, December 4, 1980.
21. Ibid.

22. AACP 10.
23. Commission of Correction, Medical Review Board, Mortality Reviews, 78M03, 78M22, 78M12, 79M48.
24. Correction Law, Section 45(3-15).
25. Ibid., Section 45(1,2).
26. Ibid., Section 47.
27. Commission of Correction, "Explanation of Agency and Program Functions, 1979-80 (budget justification)", p. 17.
28. Information for this section from LCER staff interview with Director, Bureau of State Correctional Facility Review, December 8, 1980.
29. LCER staff interview with Chairman, Commission of Correction, December 15, 1980.
30. New York State Office of the State Comptroller, Selected Operating Practices, Executive Department, State Commission of Correction, March 31, 1978, (Albany: the Comptroller, 1978), pp. 8-9.
31. Ibid., pp. 20-21.
32. N. 29.
33. N. 30, pp. 21.
34. Correction Law, Section 45(6).
35. LCER staff interview with Counsel to Commission of Correction, December 21, 1980.
36. Commission of Correction, MRB, minutes of meeting, June 5, 1978.
37. NN. 28, 29, 35.
38. N. 30, p. 50.
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40. N. 30, p. 25.
41. N. 39.
42. Ibid.
43. Commission of Correction, Health Services Evaluation, Ossining Correctional Facility (Albany: the Commission, September 17, 1979); January 15-16, 1980.
44. DOCS, Memorandum to Deputy Commissioner from Assistant Commissioner for Health Services, March 26, 1980.
45. Public Health Law, Section 201(1)(j)(l)(r); 206.1(f)(g); 1350; 1351.
46. Established and subject to amendment by the Public Health Council whose members are appointed by the Governor with the advice and consent of the Senate. Public Health Law, Sections 225(4), 228, 229.
47. Public Health Law, Section 201(1)(j)(l)(r); 1351, 206(1)(g).
48. LCER staff interview with Department of Health Deputy Director, Local Health Management and Director, Division of Food and Drug Protection.
49. Public Health Law, Section 206.1(g).
50. DOH, Office of Public Health, Report of Inspection 6/11-12/80.
51. 9NYCRR 1.23. Executive Order 23, May 23, 1967.
52. Education Law, Section 6804.

IV Financing Inmate Health Services

1. Memorandum to LCER staff from DOCS, Associate Budget Analyst, "Cost Impact of Todaro Decision at Bedford Hills" February 19, 1981.
2. LCER staff interview with Assistant Director of Correctional Services Finance and Chief Budget Analyst, November 6, 1980.
3. Ibid.
4. Novick, pp. 181-194.
5. Letter to LCER staff from Director of Marketing, Correctional Medical Systems, St. Louis, Missouri, March 23, 1981.
6. LCER staff phone conversation with Chief, Office of Health Care, Michigan Department of Corrections, February 20, 1981.

APPENDIX A

INTERVIEWS AND CONTACTS

New York State Agencies

Commission of Correction.

Chairman; Chairman, Medical Review Board; Counsel; Director, Bureau of Administrative Services; Director, Bureau of State Facilities; Facility Health Services Evaluators (2).

Department of Audit and Control

Assistant Director, Bureau of State Accounting Systems; Supervisor of State Appropriations, Division of Audits and Accounts.

Department of Correctional Services

Deputy Commissioner Administrative Services; Deputy Commissioner Correctional Facilities; Special Legal Assistant to the Commissioner, Office of Counsel; Confidential Assistant to the Commissioner.

Division of Health Services. Assistant Commissioner, Health Services; Dental Services Director/Regional Health Services Director; Health Services Coordinator/Regional Health Services Director; Health Services Administrative Coordinator/Regional Health Services Director; Regional Health Services Director; Associate Budget Analyst; Research Assistant; Utilization Review Coordinator; Principal Statistics Clerk.

Division of Support Operations. Director, Assistant Director, Laundry and Housekeeping Services Supervisor, Director of Nutritional Services.

Correctional Emergency Response Team. Facility Operations Specialist.

Division of Budget and Finance. Chief Budgeting Analyst; Assistant Director, Correctional Service Finance; Senior Budget Analysts (2); Principal Account Clerk.

Division of Management Information Systems. Director.

Division of Program Planning, Research and Evaluation. Director, Computer Programmer; Research Analyst; Director, Bureau of Records and Statistics.

Bureau of Classification and Movement. Supervisor, Inmate Classification; Coordinator, Inmate Movement.

Division of Facilities Planning and Development. Assistant Director, Facilities Planner II, Principal Account Clerk.

Central Pharmacy (New York City). Supervising Pharmacist, Senior Pharmacist.

Department of Health

Regional and Local Health Management, Deputy Commissioner, Associate Radiological Health Specialist.

Division of Food and Drug Protection, Director.

Division of the Budget

Deputy Chief Budget Examiner, Senior Budget Analyst, Management Systems Unit.

Facilities Development Corporation

Director, Finance and Fiscal Management; Supervisor; Purchasing Operations; Supervisor; Purchasing Agent.

Health Planning Commission

Vice-chairman.

Office of Mental Health

Bureau of Forensic Services, Director, Assistant Director, Program Evaluation Director.

Office of Budget and Fiscal Management, Director of Budget Services, Senior Budgeting Analyst.

Special Projects Unit, Director.

State Education Department

Office of Vocational Rehabilitation, Chief, Bureau of Interagency Programs.

State Board of Pharmacy, Executive Secretary.

LCER Sample Correctional Facilities

Camp Adirondack. Superintendent, Institutional Steward, Principal Clerk, Nurse II, North Country Family Physicians Group, Inmate Grievance Resolution Committee, Inmate Liaison Committee.

Arthur Kill. Superintendent, Deputy Superintendent for Programs, Deputy Superintendent for Administration, Deputy Superintendent for Security, Nurse Administrator, Facility Health Director, Pharmacist, Inmate Grievance Resolution Committee Coordinator, Inmate Grievance Resolution Committee, Dentist, Psychiatrist, Psychologist, Dental Assistant, Account Clerk, Inmate Liaison Committee.

Attica. Superintendent, Deputy Superintendent for Administrative Services, Deputy Superintendent for Program, Nurse Administrator, Director of Satellite Center, Inmate Grievance Resolution Committee, Inmate Liaison Committee, Senior Budget Analyst, Facility Medical Director, and Pharmacist.

Auburn. Superintendent, Deputy Superintendent for Administration, Facility Health Director, Director of Satellite Center, Nurse Administrator, Institution Steward, Pharmacist, Inmate Grievance Resolution Committee, Inmate Liaison Committee.

Bayview. Superintendent, Nurse Administrator, Facility Health Service Director, Psychologist, Inmates.

Clinton. Superintendent, Health Service Administrator, Nurse Administrator, Nurse II, Clinical Director, Pharmacist, Dentist, Inmate Grievance Resolution Committee, Director of Satellite Center, Director of Merle Cooper Program, Institutional Steward, Budget Analyst, Psychiatrists (OMH) (2), Psychologist I (Merle Cooper Program).

Coxsackie. Acting Superintendent, Deputy Superintendent for Administration, Nurse Administrator, Psychologist, Facility Health Service Director, Inmate Grievance Resolution Committee, Institutional Steward, Pharmacist, Senior Accounts Clerk.

Elmira. Superintendent, Deputy Superintedent for Security, Facility Health Director, Clinical Physician I, Nurse Administrator, Pharmacist, Director of Satellite Center, Principal Psychologist, Inmate Grievance Resolution Committee, Inmate Liaison Committee, Institutional Steward.

Fishkill. Superintendent, Deputy Superintendent for Administration, Facility Health Services Director, Nurse Administrator, Director of Satellite Center, Pharmacist, Institution Steward, Budget Analyst, Principal Clerk.

Lincoln. Superintendent, Deputy Superintendent for Administration, Deputy Superintendent for Program, Senior Account Clerk, Nurse Administrator for Centralized Services, Nurse, Facility Health Director, Psychologist, Inmates, Correction Officers.

Mt. McGregor. Superintendent, Deputy Superintendent for Administration, Deputy Superintendent for Security, Institution Steward, Clinical Physician, Nurse II, Head Cook, Inmate Grievance Resolution Committee, Inmate Liaison Committee.

Queensboro. Superintendent, Deputy Superintendent for Administration, Facility Health Services Director, Nurse Administrator, Psychologist, Institution Steward, Inmate Grievance Resolution Committee, Inmate Liaison Committee.

Woodbourne. Superintendent, Deputy Superintendent for Administration, Deputy Superintendent for Security, DOCS, Regional Health Services Director, Facility Health Service Director, Nurse Administrator I, Dentist, Principal Psychologist, Pharmacist, Institutional Steward, Inmate Grievance Resolution Committee, Inmate Grievance Resolution Committee Supervisor, Inmate Liaison Committee.

Other Persons and Agencies

Riker's Island Montefiore Hospital and Medical Center

Administrators, Medical Director, Attorney, Department of Social Medicine.

State University of New York at Stony Brook

School of Medicine, Professor of Family Medicine.

New York City Department of Health

Prison Health Services, Executive Director.

APPENDIX B

AUDIT METHOD

To evaluate the State Prison Inmate Health Care delivery system, 13 of the 33 correctional facilities were selected for concentrated review. Their choice was based upon considerations of size, security level and auxiliary facilities (e.g., reception and classification centers, OMH satellite services, elderly and handicapped programs, youth and female clientele). Table B-1 shows that the sample includes five maximum, four medium, and four minimum security facilities. Their 10,495 inmates comprised 56 percent of the total general confinement inmate population of 18,701 as of July 2, 1980.

During August, September and October 1980, LCER staff visited each of the 13 facilites to:

--Collect information previously requested,

--Interview correctional facility staff and inmates (See Appendix A for persons interviewed),

--Conduct on-site inspection of health services, psychiatric services and tour the facility.

--Search a pre-selected sample of inmate health records to ascertain:

-Inmate health problems/history and medical/psychiatric status,
-Inmate use of health services, and
-The condition/adequacy of those records.

For the inmate health records survey, LCER staff drew a simple random sample* of inmates from a DOCS alphabetized master list, dated July 2, 1980. The list contained only inmates in the general prison population. Inmates in reception and classification were excluded because of the high probability of their transfer to another correctional facility. To provide a 95 percent confidence with level ±five percent margin for error for the 10,494 inmates in the 13 selected facilities, a sample of 371 was needed. As shown on Table B-1, 379 inmate records were included in the study. For purposes of confidentiality, all personally identifiable data were excluded from inmate records survey data collected.

Table B-1

Correctional Facilities Visited by LCER Staff

Correctional Facilities Visited	July 2 Inmate Population	Number of Inmates in Sample
Maximum Security:		
Attica	1,648	57
Auburn	1,568	76
Clinton	1,899	54
Coxsackie	696	18
Elmira	1,170	41
Subtotal	6,981	246
Medium Security:		
Arthur Kill	745	27
Fishkill	1,183	54
Queensboro	290	11
Woodbourne	669	23
Subtotal	2,887	115
Minimum Security:		
Bayview	122	3
Lincoln	142	2
Mt. McGregor	151	4
Camp Adirondack	212	9
Subtotal	627	18
Total	10,495	379

Source: LCER staff.

*Without replacement, random start.

APPENDIX C

STATISTICAL TABLES

Table C-1

DOCS Division of Health Services Expenditures by Funding Source 1975-76 through 1980-81

Fiscal Years	Source of Funds State	Federal	Total
1975-76	$ 63,132	$413,132	$476,264
1976-77	78,356	659,140	737,496
1977-78	249,445	249,346	498,791
1978-79	231,864	69,914	301,778
1979-80	244,242	--	244,242
1980-81	285,785*	--	285,785

*Appropriation.

Source: LCER staff from New York State Department of Audit and Control data.

Table C-2

DOC's Division of Health Services Staffing 1975-76 through October 1980

Type of Staff	Number as of March 31 1976	1977	1978	1979	1980	October 29 1980
State Funded:						
Full-time Professional	1	1	5	4	5	10
Non-professional	1	1	4	6	6	5
Subtotal	2	2	9	10	11	15
Federally Funded:						
Full-time Professional	7	8	--	--	--	--
Non-professional	5	5	--	--	--	--
Subtotal	12	13	--	--	--	--
Total	14	15	9	10	11	15

Source: LCER staff, October 1980.

Table C-3

OMH Bureau of Forensic Services Administrative Costs for Services to Correction and Parole 1977-78 through 1979-80

Fiscal Year	Personal Service	Other Than Personal Service	Total
1977-78	$38,616	$ 5,792	$44,408
1978-79	19,137	2,869	22,006
1979-80	38,353	5,752	44,105
1980-81*	71,577*	10,737*	82,314*

*Estimated by LCER staff.

Source: OMH, Bureau of Forensic Services, December 23, 1980.

Table C-4

State/Local Inmate Health Related Expenditures and Staffing
Commission of Correction Medical Review Board
Health Services, State Units

Source of Funds and Unit	1976-77	1977-78	1978-79	1979-80	1980-81[a]
State:					
Commissioner's Office[b]	$ 56,400	$ 56,400	$ 52,400	$ 53,900	$ 51,000
Medical Review Board	2,746	11,068	15,454	14,527	12,666
Health Services Unit	--	--	--	111,325	97,997
State Facilities	--	132,292	174,251	234,027[c]	188,937
Subtotal	$ 59,146	$ 200,760	$ 242,105	$ 413,779	$ 350,600
Federal:					
Medical Investigation and Improved Medical Services to Prisoners	$ 16,094	$ 62,880	$ 133,935	$ 26,096	--
Total	$ 75,240	$ 263,640	$ 376,040	$ 439,875	$ 350,600
Total Commission Expenditures					
State Purposes	$ 777,804	$ 919,303	$1,076,521	$1,284,602	
Federal Funds	498,280	387,577	418,556	293,416	445,147
Total	$1,276,084	$1,306,880	$1,495,077	$1,578,018	$1,662,447
Filled Positions					
State Funded:					
Commissioner's Office	1	1	1	1	1
Medical Review Board	1	1	1	1	1
Health Systems Unit	--	--	--	5	5
State Facilities	--	9	9	11	10
Federal Funded:					
Medical Investigation to Improved Medical Services to Prisoners	--	2	5	--	--
Total	2	13	16	18	17
Commission Staff					
State	45	48	55	61	57
Federal	7	17	17	8	7
Total	52	65	72	69	64

[a]Estimated.
[b]Estimated by allocating one-third Commission of Correction office expense plus Commissioner's salary.
[c]Includes unusual overtime expense due to correctional officers strike.

Source: Commission of Correction, Bureau of Administrative Services.

Table C-5

Security Staffing of LCER Sample
Correctional Facilities
1980

LCER Sample Facility	Correctional Officer FTES Medical	Satellite	Other	Total
Maximum				
Attica	10.0	12.6	92.0	114.6
Auburn	10.2	9.0	10.2	29.4
Clinton	25.1	15.3	53.6	94.0
Coxsackie	6.1	--	6.0	12.1
Elmira	8.5	11.9	1.5	21.9
Subtotal	59.9	48.8	103.3	272.0
Medium				
Arthur Kill	6.8	--	3.4	10.2
Fishkill	14.0	13.6	1.0	28.6
Queensboro	6.8	--	--	6.8
Woodbourne	23.0	--	4.0	27.0
Subtotal	50.6	13.6	8.4	72.6
Minimum				
Bayview	1.0	--	--	1.0
Lincoln	--	--	--	--
Mt. McGregor	0.5	--	--	0.5
Camp Adirondack	1.0	--	--	1.0
Subtotal	2.5	--	--	2.5
Total	113.0	62.4	171.7	347.1
Merle Cooper	--	--	69.0	69.0
Grand Total	113.0	62.4	240.7	416.1

Source: LCER staff.

APPENDIX D

AGENCY RESPONSES

Department of Correctional Services
Office of Mental Health
Commission of Correction
Department of Health
Health Planning Commission

Page numbers of the preliminary report differ from those in this printed report. Thus page numbers mentioned in the agency response have been changed by LCER staff to correspond to this final report.

With the agreement of DOCS LCER staff revised and shortened the DOCS response to eliminate text no longer relevant because of changes made in this printed report. The full copy of DOCS initial response to the LCER audit is available for inspection at LCER offices.

STATE OF NEW YORK
DEPARTMENT OF CORRECTIONAL SERVICES
THE STATE OFFICE BUILDING CAMPUS
ALBANY, N.Y, 12226

THOMAS A. COUGHLIN III
COMMISSIONER

April 7, 1981

COPY

Mr. Sanford E. Russell
Director
Legislative Commission on
Expenditure Review
111 Washington Avenue
Albany, New York 12210

Dear Mr. Russell:

This is in response to your request for a review of the confidential draft of the report on "State Prison Inmate Health Services".

We have attempted to deal with this report in its entirety. Therefore, as you will see, we have an extensive response. As I understand it, however, several other agencies have been asked to comment and will be submitting their responses directly to the Commission. Consequently, we will not reply to certain aspects of the report.

I would like to point out as a way of introduction to our response that the attainment of an efficient delivery of quality health services is a major goal of this Agency as evident in the importance it holds in the Five-Year Master Plan, which was recently released, and also in the Agency's Budget Request for 1981-82. I believe the L.C.E.R.'s report should take cognizance of this and give it greater prominence than it has in the draft report.

Thank you for the opportunity to review this draft. I hope our comments will be useful in your revisions.

Sincerely,

Thomas A. Coughlin III
Commissioner

Department of Correctional Services' Response to LCER Program Audit

Foreword

The Department of Correctional Services welcomes the opportunity to respond to the Preliminary and Confidential State Prison Inmate Health Services Report compiled for the Legislative Commission on Expenditure Review. The report highlights many of the areas which the Department perceives as major impediments to further improvement of our health delivery capability and in this regard is a very important contribution to addressing the issues of health care. The report, however, misses the mark in several areas because of an inadequate understanding of the mechanisms by which health services are organized and delivered within the Department.

Each area of the report with which the Department has differences will be addressed separately in the body of the Department's response. There appears, however, to be a fundamental contradiction between Sections I, II, III of the report, and Section IV which needs to be addressed at the onset.

Sections I-III seem to be written from the perspective of actions the Department must take to bring its health delivery practices into compliance with professional standards. This would entail the commitment of substantially more resources to the health care of inmates than the Department currently enjoys. On the other hand, Section IV seems to put forth a rather distorted financial picture of the costs related to direct health care. The authors of Section IV have attributed many costs to the provision of health care to inmates which are not directly budgeted for health services. While this is informative, the inclusion of these "indirect" costs in per capita expenditure calculations gives a distorted picture of health costs. Indeed, the Division of Health Services is a consumer of Security Services, and services from other State agencies (Health, Educaiton, Mental Hygiene, and Commission of Corrections). With the exception of the Commission, the Division of Health Services is a relatively minor consumer of these services (using the report's inflated figures for security costs*, Health Services accounted for only 7 percent of Security personnel costs for fiscal year 1979-80) in comparison with the costs of providing these services to other organizations and agencies.

The Department is certainly not insensitive to the costs of Health Services. Many of the actions taken by the Department in the past 18 months have been directed towards containing costs. In this area, the Department has created additional secure wards to reduce Correction Officer overtime; instituted utilization monitoring and control of hospital care to treat more inmates in the same number of days; and attempted to upgrade the capabilities for diagnosis and treatment of inmates within correctional facilities.

In order to make further progress toward the goal of increasing quality health care to inmates while controlling escalating costs, direct support by the Legislature and Governor's Office will be necessary.

The Department has made a very concerted effort to establish multi-year goals for itself. The Department has recently completed a strategic Master Plan which sets forth goals to be attained over the next five years. The Master Plan provides the foundation for Departmental activities including financial planning and budgeting, and population management. The LCER Report almost completely ignores this effort as evidenced by its conclusion that "Insufficient attention has been given to the planning, organization, management and oversight of State prison inmate health services."

In order to build a rational integrated health delivery system for inmates, the following issues will have to be resolved:

--Medical Fee Schedule-The Medical Fee Schedule has served the State well, but it must be understood that the schedule was designed to provide reimbursement for indigents and it has serious limitations when it is applied to a correctional setting. The low rates of reimbursement for clinical specialists and the providers of medical devices make it unattractive for them to enter correctional facilities. By the same token, because the majority of our inmates require armed Correction Officer escort to leave a facility, inmates are not especially welcome in the offices of providers either.

It would be most beneficial if a mechanism could be devised which would allow the Department to attract consultants who would be willing to provide services within facilities.

--Staffing-The Departments is at a competitive disadvantage in this area not only with regard to outside health providers, but with other State agencies as well. The Department's competition for health manpower can offer facilities, equipment and support networks which the Department cannot. Our recruitment and retention problems include not only physicians, but physician assistants, pharmacists, nurses and X-ray technicians.

It would be helpful to explore and implement some of the techniques currently being discussed by the Armed Services. Because our setting is so demanding, assistance to attract high quality practitioners who can cope is a necessity.

--Facilities and Equipment-Action in the first two areas will allow the Department to improve its health care capacity, but to maximize its internal care capacity action will also have to be taken in ths area. Although renovation is being undertaken in some facilities and planned in others, serious deficiencies still remain.

Our diagnostic equipment also merits serious attention. A limiting factor in many facilities' use of outside consultants is the inability to provide these practitioners with the minimum level of equipment necessary for them to work.

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*See Page 104.

Action in this area will allow a program of long term internalization of care with a corresponding reduction in this cost center.

I. General Comments

The Department of Correctional Services has completed its five year Master Plan (1980-1985). The Master Plan identifies goals for future policy and management initiatives. The goals for health services are: provide quality health services to inmates and improve the effectiveness and efficiency of their delivery. These goals are further defined by the following objectives and indicate some directly related activities:

Establish standards for the provision of Health Services:

--The Division of Health Services is currently evaluating standards promulgated by professional groups for Prison Health Care Systems, i.e., AMA, ACA, and Federal.

--The Division is currently updating all previous policies, procedures and guidelines for incorporation into the Department's Administration Manual.

Improvement in the recruitment and retention of Health Care Professionals:

--The Division is a participant on an Interagency Committee under the auspicies of the New York State Health Planning Commission studing recruitment and retention problems of Health Manpower in State service.

--All health personnel (as noted in the report) are properly registered and/or licensed.

Development of an information system to evaluate service delivery:

--Currently evaluative mechanisms:

-a procedure to control and monitor LOS in Community General Hospitals;
-utilization of infirmaries;
-outside consultants;
-provider profiles; and
-mortality reviews.

--The Division of Health Services has initiated a program to study and improve current health record practices.

Strengthen the overall management of the Health Services Delivery System:

--Budget request '81-'82 reflects additional items required for strengthening the overall management of the Health Services Delivery System.

Efficiency Actions

In June of 1980, the Assistant Commissioner for Health Services proposed six efficiency actions to the Facility Health Services Directors to ensure Health Services are made available in the most efficient and effective way possible. Progress to date:

--An effective system of prior approval for planned admissions to community general hospitals, including peer review and a "holding" mechanism to eliminate transferring inmates prior to admission.

--163 fewer admissions in 1980 than 1979 with 1,139 less patient days.

--Percentage utilization of secure units has increased to 68 percent of total inpatient care.

--Efforts continue to recruit qualified consultants to provide clinics within correctional facilities.

--Day surgery is now being used by certain facilities, i.e., Elmira, Attica and Auburn.

--A mechanism to determine inmates' eligibility to enter a hospital without security escort is being determined as part of the "prior approval" for admission.

--Eligibility for care and treatment via Veteran's Administration is being investigated.

--'Operation Benefit' is researching the potential of inmate eligibility for Medicare reimbursements to the Department.

--Prior approval for outside dental treatment policy has been revised and implemented.

--Ancillary services in facilities will be assessed and evaluated in the near future.

Health Services Program Initiatives, Accomplishments 1980-81 and Program Proposals 1981-82

--The Correctional Special Bill Appropriation of 1980-81 provided funding for the development of a secure ward at the Helen Hayes Hospital which will focus mainly on the provisions of orthopedic care. This unit is slated to open in March, 1981. Additionally, funding was made available to initiate two six-month Intermediate Care Programs at Bedford Hills and Auburn respectivefully, which are now operational.

--Expansion of training opportunities for Department's high level facility and Central Office managers.

--A concerted effort regarding vacancy control policies in order to maintain essential health services has reduced the overall Division of Health Services vacancy rate to 9.6 percent (March '80).

--Funding to provide additional pharmacy staff has brought the Department into compliance with State laws. Eight new part-time pharmacist items were created and filled.

--The Department has developed a program to assess the intake health status of inmates at the Downstate Reception Center. These findings will be considered in inmate placement and transfer decisions. This program will eventually be used throughout the system.

--The Health Services Division continues to monitor and improve the utilization of existing secure-ward arrangements.

--Initiatives have been undertaken to increase the use of on-site specialty clinics in an effort to control outside hospital trips and Correction Officer overtime expenses.

The Governor's 1981-1982 Budget Request recommends a number of health service initiatives aimed at further improving the Department's health delivery capability. These include:

--Funding for the developmnt of a new secure ward in a mid-Hudson region community hospital. This action will bring the number of secure wards utilized by the Department to six and further reduce consumption of Correction Officer overtime in support of health activities.

--Security funding to permit the expanded operation of a systemwide unit for the physically disabled at Green Haven to care for inmates with serious multiple, chronic health problems.

--Funding of 26 medical positions for the Department's capacity expansion.

--The development of health standards for the provision of equal and consistent quality health care throughout the system.

To conclude that Inmate Health Care in State Correctional Insiitutions was found "wanting" when measured against nationally accepted standards is perhaps an over-statement. Many of the "National" Standards are still in a state of revision. The AMA Standards were not published until July 1979. The Federal guidelines became available to the Department only in January of 1981. General acceptance to a particular set of standards has not been determined by most states at this time.

One determining conclusion to the delivery of quality health care is the rate of mortality. The Department's mortality rate continues to be below the documented figures for the population in New York State; 9.1 deaths per 1,000 in New York State with 1.5 deaths per 1,000 in the Department of Correctional Services for the year 1979.

II. Concurrences

Many of the areas highlighted in the preliminary report are areas which are also of concern to the Division of Health Services, i.e., Medical Fee Schedule, inadequacies of the current health record system, recruitment and retention of staff, etc.

The final report of the LCER can accomplish a great deal if several of these outstanding concerns can be resolved.

Reference "The outdated Medical Fee Schedule means that specialists and consulting physicians have little incentive to attend clinics in correctional facilities." Page 25.

Comments. Refer to our comments on the first page of this response.

Reference. "The recruitment of qualified health services personnel has been a problem." Page 48.

Comments. The Division concurs with the LCER's findings regarding the recruitment and retention of qualified health personnel. Historically, our most significant problem has been in the recruitment of physicians for the many reasons cited in the report. Staff from the Division have been serving on the Health Planning Commission's Interagency Task Force group which is studying the recruitment-retention issue. It is hoped that meaningful reforms which will allow for more flexibility in providing physician coverage will be recommended and approved.

It should be noted that vacancy rate has shown a steady decline over the past year. This decline in the vacancy rate can be attributed to favorable new policies forwarded by the Commissioner, increase vigilance on the part of Central Office staff and the Acting Regional Health Services Directors. At this writing, the health services vacancy rate is approximately 9.6 percent.

Reference. "There were no mechanisms to review the health delivery system in any of the facilities visited by the LCER staff." Page 40.

Comments. The lack of an adequate mechanism for the review of the health delivery system has been a priority issue with the Department. The importance of this issue is reflected in the Department's 1981-82 budget submission where staff was requested to establish a medical audit team. Funding was not approved for this function. However, the Division currently is reviewing the feasibility of contracting with the Office of Health Systems Management for medical audits of six facility health units.

Reference. ". . . health service personnel in the institutions told LCER staff that inmates were receiving better medical care in prison than they did when they were on the outside. . . several health providers said that the care received by inmates was better than the average individual could expect. . ." Page 40.

Comments. It is the general feeling of the agency that the qualtiy and level of care rendered within facility health units meets Medicaid program requirements. As cited elsewhere in the LCER report, all providers were found to be properly licensed to function in their positions. Furthermore, the agency has endeavored to integrate the provision of care within the facilities with the mainstream of health care in the community as evidenced by the utilization of community general hospitals for outpatient and inpatient care. Our attempts to improve the medical records program, and establish a medical audit mechanism will further embellish the quality of care available to the inmate population.

Reference. "The baseline indicator of the health care received by inmates is the health record. The importance of the record being complete, legible, and properly filled out is a generally accepted standard of the medical profession." Page 41.

Comments. The Division concurs with the LCER statement referenced above. A good medical records system is one of the building blocks in the development and organization of a quality health care delivery system. The medical records serve as a source of information concerning the health status of our inmate-patients, the levels of care rendered, the involvement of our health care staff, and the general level and quality of professional activity. Management of a statewide ambulatory care system hinges upon a good records system. The medical records system is a determinant of the effectiveness and a mark of the efficiency with which health care is provided.

Development of a sound management information system has been identified as a major objective in the Department's Master Plan. Therefore, the Division has increased emphasis on the review of the current system with the purpose of improving its utility to the health care provider and the health care manager. As a first step in this review process, we have pressed for the establishment of additional Senior Medical Records Clerk items for those facilities without items and the filling of Senior Medical Records Clerk items where vacant.

Reference. Inconsistency in documentation on Ambulatory Health Care Record. Page 15.

Comments. The Department has verified the LCER finding that several of the facilities cited were not consistently making entries to the Ambulatory Health Record as directed by Division of Health Sevices' policies. Steps have been taken to ensure the continuous proper utilization of the Ambulatory Health Record in the future.

Reference. "Prisoners appear to have certain special health needs in addition to those in common with the non-incarcerated population." Page 8. ff.

Comments. The Department concurs with the LCER's findings. While we have not done any epidemiological surveys it appears that our population does have a higher prevalence rate of hepatitis, chronic liver disease, sexually transmitted diseases, hypertension, tuberculosis, and seizure disorders. According to data submitted in 1980, upper respiratory, skin disease/rashes, uncomplicated hypertension and asthma were among the top ten diseases diagnosed for all facilities.

An epidemiological study would be beneficial to our health planning.

Reference. Exhibit I-"adherence to standards." Page 12.

Comments. The Department concurs with the LCER that the application of nationally recognized standards to the area of prison health care is advisable. To this end we have undertaken a review and comparison of the various standards: AMA, ACA, DCJS, and APHA. This evaluation is not complete at this time because most of the standards are still in draft form. We have tried to apply the AMA Standards; this is evident in our 1981-82 budget submission. Furthermore, LCER recognized the fact that our Division's Policies, Procedures and Guidelines Manual was generally in compliance with AMA Standards.

Reference. Inmate Orientation. Page 13.

Comments. The Department appreciates the merit of an orientation program. Unfortunately, sufficient staff does not exist in the facilities, or Central Office staff to prepare such a program at this time. The LCER is correct when it states that we have not developed a statewide policy to carry out the AMA and ACA Standards which would require an orientation to the health delivery system. However, a limited orientation is given to all new inmates at the Department's major classification center, Downstate Correctional Facility.

Reference. "A single uniform pharmacy management system (should) be developed for use in all facilities and that it be formalized in a policy and procedure." Page 16.

Comments. The Division concurs that a standardized operational manual is necessary for the uniform operation of all facility pharmacies. Such a policy is being formulated at this time by the Central Pharmacy staff. However, it should be noted that the Central Pharmacy staff's first obligation is the proper operation of the supply/support function.

Reference. "The DOCS-DHS did not maintain information on the number and type of specialty clinics held at the various correcitonal facilities." Page 24.

Comments. The LCER's citation is correct. The Division of Health Services has recognized this deficiency among others in its data retrieval system. Therefore, a new consultant form has been designed. The form HS-50 is to be used by all consultants and will provide among other information the site at which the consultation took place.

Reference. "The availability of specialty health clinics at the correctional facility varied among the 13 facilities." Page 24.

Comments. The development and utilization of in-facility specialty clinics has always been encouraged by the Division of Health Services. However, the number and type of these clinics must be determined at the local level based upon inmate needs, the availability of providers, as well as facility staff and space available at the individual correctional facility. Present resources limit certain types of specialty clinics.

Reference. "Overall admission/discharge and patient days increased by two-thirds during this period (1975-1979). Inmate population increased by 28.3 percent for the same period of time." Page 29.

Comments. The Division of Health Services recognizes that inpatient utilization of community general hospital and tertiary hospital services dramatically increased during the period cited. Inasmuch as this represents the appropriate integration of facility services with those of the community at large, this increase is warranted.

However, the Division also recognizes its responsibility to ensure appropriate utilization of inpatient days and the value of monitoring. To this end, the Division has developed a utilization review mechanism which:

a) reviews all requests for planned admissions,
b) categorizes approved requests on the basis of need,
c) ensures physician monitoring and follow-up of case,
d) monitors lengths of stay,
e) reviews all cases where length of stay exceeds Medicaid norms.

Reference. "Generally, the areas were found to be adequate with the basic equipment needed to provide routine and emergency care. However, most were not as clean or well equipped as a community hospital should be. The most serious deficiencies were at Fishkill... Bayview... Arthur Kill... Attica." Page 38.

Comments. Remedial action is being undertaken at several of the facilities cited to maintain adequate emergency equipment. It sould also be noted that several faciltiy health units are also under renovation or about to be renovated, the facilities include Fishkill, Bayview, Ossining, and Auburn. The Division's staff is also involved in planning health units for three new facilities. Division of Health Services' staff is also reviewing Departmental plans for capacity expansion to determne its impact on health delivery capabilities in the affected facilities.

Department health units cannot be compared to a community hospital; the Department operates Ambulatory Health Care Units, provides infirmary care and treatment, and provides emergency care as indicated.

Reference. Dental Care. Page 16.

Comments. The Division of Health Services and the administration of Arthur Kill Correctional Facility are acutely aware of Arthur Kill's insufficient dental resources relative to existing dental caseload. To correct this deficiency, a dental assistant item was converted into a dental hygienist to increase the level of paraprofessional support. An additional half-time dentist position was also requested by the facility and supported by the Division of Health Services in both the 1980-81 and the 1981-82 budgets. The items were not included in the final budget document in either year, therefore further reclassification is being investigated.

III. Variances Section

The variances that the Division found in this report appear to generally reflect a lack of understanding of the concept and mechanism for an ambulatory health care delivery system. We have found a number of areas where the LCER Report is at variance with the concept of an ambulatory health care system, with the mechanisms for delivering such care, and with the facts as presented by the Department. Some of these points are differences of interpretation, but where clarification is needed we have separated these parts out here and in the next section.

Reference. Physician Manpower Alternatives:

-contract
-coordination with area medical schools/teaching hospitals
-expansion of "Physician Shortage Area." Pages 91-92.

Comments. Of the three alternatives suggested in the report, two have been previously attempted by the Division of Health Services. The suggestion to use contracts which feature fully funded benefits was attempted in the spring of 1980. The Division identified three physicians who were interested in working under this type of arrangement and the contract was submitted to Civil Service for approval. Civil Service (Office of the Counsel) disapproved the contracts on two grounds: first, the inability to recruit physicians to regular State item had not been demonstrated to their satisfaction, and second, a physician working under contract may not supervise the activities of State employees.

Both Attica and Green Haven Correctional Facilities have been officially designated as medically underserved areas by the appropriate Health Systems Agencies. The Division of Health Services attempted to secure National Health Service Corps Physicians in both these facilities.

Appropriate sharing arrangements had been worked out with local health agencies to increase the viability of our proposals. Unfortunately, the Division of Health Services' efforts coincided with Federal cutbacks in this program and the effort was not successful.

The approach of using post-graduate physicians-in-training is much more difficult to implement. The Board of Regents has established stringent criteria which must be met before an institution can be certified for teaching purposes; these criteria would be very difficult to achieve within a correctional setting. The reconstructive surgery programs cited in the report are wholly under the control of the contracting institutions and draw on nearly all the facilities to provide enough cases to support the program. This situation is clearly different than provision of routine primary care services.

The Division is entertaining the possibility of developing a program in conjunction with a medical school or teaching hospital to conduct regional clinics in specialty or sub-specialty areas within a correctional facility. Success of this type of program rests not only with developing a suitable contractual foundation with the provider, but in providing suitable facilities and equipment for the process. Other problems included in development of a project of this type are: movement of inmates; processing inmates into and out of the host institution; and securing holding of inmates from participating facilities separate from each other.

Reference. "Type of Provider." Pages 21-22.

Comments. An inadequate understanding of the primary care delivery system used by the Department is demonstrated in this section. Primary care in the DOCS is based upon treating inmates at the level of care dictated by their conditions. This delivery system features registered nurses who provide the initial sick call screening, and treatment based on their level of competency and in accordance with approved joint protocols. Referrals to physician assistants and/or physicians are made accordingly. This enables the Department to maximize its limited resources while assuring inmates full access to the primary care network.

Facilities which have the use of physician assistants have a pattern of care whereby approximately 60 percent of encounters may be handled by the nurse, 30 percent by the physician assistant, and 10 percent by a physician.

The goal of the Division of Health Services is to provide a health delivery system in which inmates have ready access to the level of care required by their condition. To a very large extent, this goal has been achieved even within the severe fiscal and environmental constraints imposed upon this Department.

Reference. Correctional Officers at Attica and Auburn "administering controlled substances." Page 16.

Comments. To administer a medication implies that the person administering the medication:

1) verifies the physician's orders,
2) assures identification of the person receiving,
3) assures correct medication is being administered,
4) documents medication taken,
5) person administering is aware of expected results and any untoward reaction.

In no way are Correctional Officers charged with these responsibilities. Due to the number of patients, and the logistics of programming and security requirements, Correctional Officers are requested to distribute the prescribed medication (individually packaged and adequately labeled) at the required time. In all facilities except Auburn and Attica, all State and Federal controlled medications are being administered by licensed personnel. In these two facilities, medications are distributed by the Correctional Officers.

Reference. Physicians. Pages 34-36.

Comments. The report is based upon a survey during a period when the Department's vacancy rate was high (refer to the section on vacancies). In the interim, the Department has successfully filled all but 1.5 funded physician items Departmentwide. This effort has successfully overcome the glaring imbalances noted.

Within the framework of a less than optimal strategy on the part of New York State Government, the DOCS has done quite a remarkable job of providing highly competent licensed physicians in a less than attractive setting. These physicians provide clinical services, some hospital care, and 24 hour on-call coverage.

Facilities now have a mix of primary care providers adequate to provide for the basic health needs of the inmates. Because the Department has had difficulties in recruiting physicians, a strategy has been developed which converts certain unfilled physician items into physician assistants. This trade-off has proved to be beneficial in those instances where it has been accomplished. The Department gains two physician assistant items from each physician item converted, and physician assistants have proved to be much easier to recruit than physicians. The presence of physician assistants has allowed us to make very timely responses to inmate primary health care needs and to meet all applicable standards. The Division of Health Services has been most satisfied with the performance of physician assistants within the correctional setting.

Reference. Staffing Standards. Pages 35-37.

Comments. The Division of Health Services has previously developed model staffing plans for each of four sizes of facilities. These model staffing plans, even though they were far less rich in terms of the numbers of staff involved, are being used as the basis for budget requests and a basis for allocation of resources.

The LCER Report seems to indicate that staffing patterns could be determined in multiples of the recommended pattern for a 500 bed facility. This does not take into consideration any economies of scale and are not very useful.

Reference. Inmate Health Providers. Page 37.

Comments. The report is accurate when it states that understaffing has resulted in the use of inmate workers. Characterization of these workers as health providers is, however, inaccurate.

Inmates hold health unit jobs as porters, laundry and linen workers, clerks, and health assistants. The only inmate job which is in direct support of health care activities is the inmate health assistant title which functions at the level of a nurse's aide, and functions under the direct and immediate supervision of a health professional.

The Division of Health Services encourages the use of inmate health assistants; a formal training course had been developed in the past to train carefuly selected inmates. Three released inmate health assistants have passed their State Boards for professional nursing. Reportedly others have obtained employment in health care facilities.

The use of inmates for clerical functions which involve the handling of health records poses much more of a problem. The Division of Health Services is definitely opposed to this practice. However, this opposition is tempered by the reality of insufficient clerical staffs in nearly all our facilities and our inability to acquire additional clerical support. Since health care cannot adequately be provided without the medical record the choice is clear; compromise by letting inmates handle records rather than risk an unacceptable level of practice without the medical record.

Clinton is cited in the report for employing an inmate in its pharmacy; this issue needs to be clarified. In the past, Clinton did use a carefully screened inmate under the direct and immediate supervision of the pharmacist to pre-package medication (generally non-prescription). However, this practice was discontinued when a pharmacy aide item was made available.

IV. Financing

Reference. "During 1979-80, the State spent more than $42.4 million or $2,079 per inmate to provide health services to inmates of the 33 State correctional facilities." Page 79.

"To report inmate health services expenditures, DOCS includes only the Division of Health Services and direct inmate health services expenditures. . . . The Department's expenditure data usually have understated program costs." Page 81.

Comments. There has been no attempt by the Department to understate these costs. The health services appropriation and expenditures are currently presented to show actual direct costs associated with the provisions of such services. These include all facets of personal service and the whole range of other than personal service expenses. The Department's (DOCS) annual total appropriations and expenditures are readily available to the Legislative Finance Committees and the Division of the Budget through the Department of Audit and Control's monthly expenditure reports R-6, R6C, and others. The same expenditure data for other agencies providing services to DOCS is available from these source documents and reports. Any changes in this arrangement as suggested by the report would require detailed adjustment and revision of the Department of Audit and Control's account system to accomodate the development of a new expanded account coding capability together with an enlarged, compatible computer component. In addition, new clerical items would be required in the Department as well as Audit and Control for the additional workload generated by the new processing requirements. While neither of these

elements is available within present funding allocations, such a system capability is eventually contemplated in the future as per the Department's five year Master Plan, p. 69, Standard B; p. 86, Articles F and G.

Reference. The report lists an array of figures in its analysis with explanatory narrative. Page 79.

Comments. For example, one section of narrative states that "Inmate health services provided by DOCS in 1979-80 amounted to $13.4 million ($658.30 per inmate), significantly higher than the $10.4 million ($508.61 per inmate) reported in the Division of Health Services 1981-82 request. The $10.4 million figure quoted in the report as 1979-80 expenditures is actually a health service appropriation figure for 1979-80.

Reference. "Several State agencies provide health services to inmates of State correctional facilities. Each employs its own budgeting and accounting procedures to record inmate health service expenditures; however, no common purpose or subpurpose category facilitates aggregation of such expenditures. . . ." Page 87.

"Because inmate health expenditures are not consolidated by the budgeting and accounting process, the Legislature, the Governor and the public do not have complete financial and performance data on the inmate health services program." Page 87.

Comments. The present Department of Audit and Control account system does provide expenditure data relative to any agency's participation in DOCS programs. However, in order to consolidate these multi-agency expenditures into a single health services report capability, substantial changes would have to be made to the Audit and Control computerized accounting and expenditure systems. As we pointed out previously, this would require the development of new computer programs, and increased computer processing capability and capacity. In addition, increased clerical support would be required to handle the processing of this additional workload. Before the development of such an accounting capability, a feasibility and cost-effectiveness study analysis should be conducted to ascertain the practicality of such a venture. This study and analysis should have central, coordinated direction, such as from the State's Division of the Budget because of the number of agencies involved. Should the study show that the system is cost effective and feasible, the development effort could be included as part of the DOCS five year Master Plan endeavors pending appropriate funding support. See page 86, Articles F and G of the DOCS Master Plan.

Reference. "DOCS Central Office does not audit health service vouchers or monitor health service expenditures; these roles are viewed as facility responsibilities." Page 89.

Comments. The auditing of health service vouchers is a responsibility of the Department of Audit and Control. The vouchers are, in fact, processed at each facility and copies are forwarded to the Department of Audit and Control for recording, payment authorization, and collecting of expenditure data. To duplicate any of this clerical processing at Central Office would be a costly, unnecessary duplication of effort. Health Service expenditures are monitored quarterly at Central Office Health Services for managerial oversight purposes.

Reference. "In conversations with finance officers at the 13 facilities, LCER staff found some dissatisfaction with and confusion about DOCS financial management and policies. Specifically indicated were needs for clarification of DOCS budgeting and accounting policies and for inservice training of facility finance management personnel." Page 89.

Comments. Central Office does conduct periodic meetings for facility stewards to clarify budgeting and accounting policies and promulgate related financial information. Positive steps are to be taken relative to the Department's five year Master Plan to improve the scope and timeliness of such training needs and to strengthen training programs for supervisors, and middle and executive management. Page 86, Articles D and G.

Reference. "DOCS does not have a financial management policy and procedure manual for inmate health service expenditures and payments." Page 87.

Comments. There is a Policy and Procedure Guidelines Manual for health services which has been made available to each facility for use in any area not specifically covered by the State Finance Law, the OGS purchasing policy and the Department of Audit and Control accounting directives. These latter laws, policies, and directives have been promulgated for the purpose of providing uniformity and consistency in the Statewide procedures related to voucher processing, payments and expenditures.

Reference. "Though institutional stewards were responsible for correctional facility financial management, they were unable to effectively monitor and control health service outlays at the facilities LCER staff visited." Page 89.

Comments. In most instances where such inadequacies occurred, the shortage of clerical support personnel was the underlying cause of the problem. The amount of paper work processed in facilities has continued to steadily increase but requests for new clerical items to handle this workload increase, brought about by the growing inmate population, have not been approved. There has to be recognition of this need at the State budget development level. It is anticipated that two of the elements in the Department's five year Master Plan, p. 69, Standard B and p. 86, Improvement of Managerial Effectiveness, Articles D and F, will result in improvement in this situation.

Need to indicate the structuring of O.T.P.S accounts does not lend itself to detailed monitoring of expenditures. Further, the cash accounting system employed by New York State creates lags in the report of expenditures. A change in accounting system as recommended by the Governor and Comptroller (G.A.A.P.) is necessary before close monitoring of expenditures can take place.

V. Clarification Section

There are a number of points which need to be clarified. The LCER report fails in many cases to use the information available, and in other cases may not have understood the particular situation. Consequently, a separate section is devoted to clarifying several points.

Reference. Sick Call. Page 14.

Comments. Sick call at the facility is not constrained as to time, but rather determined upon the demand for health screening or program/security requirements, i.e., lock in time. Further discussion on this assumption is listed under the Variances Section.

All facilities including Attica and Elmira conduct routine general sick call four times a week with twenty-four hour emergency capabilities in accordance with AMA Standards. The fifth day is reserved for "reception-history and physicals, periodic physicals and monitoring of the chronic-ill."

Reference. Dental Care. Page 16.

Comments. Pain is a symptom and not a diagnosis. The diagnoses resulting in pain would no doubt be considered under the diagnoses for emergency care and treatment. Emergency care for dental is treated the same as emergency care for health services. Referrals are made to outside providers if treatment can not be rendered appropriately within the facility at any given time.

Reference. Ambulatory Health Care. Page 17.

Comments. It was not the intent of the Division of Health Services that Ambulatory Health Care Record by considered a complete record of inmates' ambulatory care. The AHR was and is intended as the sole means of recording ambulatory encounters with DOCS providers. The AHR is but a portion of the inmate's complete medical record which includes consultation reports by outside providers, as well as records of infirmary care and reports of outside hospitalization.

Reference. The tendency for a few inmates to draw heavily on the health service delivery system. . ." Page 19.

Comments. It would perhaps be improper to assume this analogy is at variance with general population or community at large in their utilization of the community health care facilities

Reference. "An increase in the availability of clinics was suggested to reduce the cost of inpatient and ambulatory care as well as the attendant cost for security." Page 25.

Comments. Though the LCER points to the increase and availability of specialty clinics as a means to reduce the cost of inpatient care, the Division of Health Services recognizes no direct correlation between the two. The inherent value of specialty clinics lies in their use as an efficient means to improve a facility health unit's ability to distinguish need for inmate inpatient care from demand for such care.

Reference. Medical Hold. Page 29.

Comments. The LCER has inadequately characterized the Division of Health Services' policy on medical hold. In actuality medical hold is applied only to priority cases awaiting planned hospital admissions. The intent of this policy is to assure that inmates receive scheduled surgery and to assure the acute care needs of the inmates are addressed on a planned basis as efficiently as possible.

Reference. Table: Allocation of Inmate Health Resources; Health Services positions. Page 33.

Comments. In reporting the allocations of the inmate health resources, the LCER overlooked the twenty hours of physician coverage available at Fishkill. Reportedly this analysis was made during the on-site visit. It does not indicate positions versus hours on-site. On-site hours does not reflect the call backs, or the available 24 hour on-call coverage for a physician or physician assistant.

Reference. Regional Director. Page 51.

Comments. To say that Regional Directors must perform their duties on a part-time basis does not adequately reflect the comprehensive role of such directors. It also ignores the fact that there are two Regional Health Services Directors engaged in full-time oversight of their facilities, as well as the recent appointment of Health Services Administrators at Attica, Bedford Hills and Clinton.

Reference. Inmate Grievance Procedure. Page 51.

Comments. The inmate grievance procedure in its totality is not represented by the LCER. Not included in their description of the grievance process is the role planed by the Central Office Review Committee (CORC).

Reference. Utilization Review. Pages 51-52.

Comments. Prior to the establishment of a utilization review system in the summer 1980, the Division of Health Services had no basis for a comprehensive utilization review effort; that being a program encompassing prospective, concurrent, and retrospective elements.

The goal of our system is the rational allocation of hospital based health services to those in need. This is accomplished by means of answering specific questions regarding whether or not care professionally recognized as appropriate to a problem requires services be provided in an inpatient setting.

Though it is correct for the LCER to state in the third paragraph on page 52 that a more rigorous request and review procedure was initiated, the purpose of a prospective effort has been misrepresented. Correctly, the purpose of a prospective UR system is to prevent inappropriate hospital admissions. These occur when there is no medical necessity for hospitalization or when the hospital is not the appropriate site for care.

The role of the utilization review coordinator in this effort is to confirm the apropriate documentation for each inmate planned admission request and not solely requests for elective surgery. Assignment of categories by the Physician's Revciew Committee to such request is according to the severity and manageability of particular health problems within the correctional facility setting and is not based on their urgency. Urgency is a word that characterizes emergency admissions and not those that can occur on a planned basis.

A description of concurrent utilization review as attempted by the LCER without much success in paragraph three should more accurately state that the monitoring of hospital stays in excess of nine days is aimed at detecting lapses in the concurrent review activity of hospitals as mandated by Section 405.24 of the State Hospital Code.

By way of clarifying the LCER description of retrospective review in paragraph five, it is the role of the Utilization Review Coordinator to examine each case to determine the degree to which the duration of diagnoses specific stays are in complance with recognized length of stay standards.

Reference. Outside Ambulatory Care. Page 53.

Comments. In the description of the outside ambulatory care, the LCER does not mention that the AHR was not designed and therefore should not be used for recording and generating informaiton regarding outside ambulatory care. To use it as such would serve to misrepresent the status of the health unit triage.

Reference. Security Staffing of LCER Sample Correctional Facilities in 1980 Table C-5. Page 103.

Comments. There is a variance with DOCS statistics regarding this Table C-5.

VI. Mental Health

General

The Correctional Services Master Plan clearly indicates its position concerning the need to establish and maintain special services and programs for inmates with specific types of problems. Included among the several sub-populations identified as being in need of special services are: the mentally retarded; inmates with acute and chronically disabling psychiatric disturbances.

In an effort to address the needs of the above sub-populations, the Department determined to:

1. Develop the capacity to identify, habilitate and reintegrate the retarded inmates.
2. Review OMH services and develop capacity to house and treat chronic cases.
3. To establish Intermediate Care Programs.
4. To develop the capacity to provide and coordinate psychotherapeutic services systemwide in a joint effort with OMH.

The ensuing discussion will address the degree to which the Department has accomplished its stated mission, as well as future projections.

Positive

I. Mentally Retarded Inmates

Reference. "The Department has no special programs or treatment for an estimated 1,750 retarded and developmentally disabled inmates currently in the system. Approximately 450-650 of these inmates are retarded." Page 6.

Comments. While current literature suggests that as much as 9 percent of the National offender population is retarded, recent research efforts conducted at Clinton, Elmira and Downstate Reception and Classification Units suggests that an estimated 2 percent of the NYS Department of Correctional Services inmate population are retarded. A subsequent study by Syracuse University is supportive of the 2 percent estimate, and allowing further that approximately 400 inmates within the system would require placement in long term sheltered environment programs.

The Department is taking a holistic approach in its efforts to adequately service the needs of the retarded inmate. This requires continuing dialogue between our Department, the Bureau of Forensic Services, and the Office of Mental Retardation and Developmental Disabilities. The above has been ensured through the formulation of a Special Task Force on the retarded offender which includes representatives from the aforementioned bodies.

Currently, services for retarded inmates are provided in the following manner:

1. The Extended Classification Unit at Downstate is designed to identify the MRDD person so that special programming may be made available to them. This effort is further augmented by a grant made to Syracuse University by OMR/DD entitled, "Expanded Programming for the Incarcerated Mentally Retarded and Developmentally Disabled Person."

2. The Academic Vocational Program at Green Haven, which has the capacity for 25 mentally retarded cases.

3. The Residential Activity Program at Attica.

4. The Sheltered Workshop at Elmira.

5. The Merle Cooper Program at Clinton.

6. The Assessment and Program Preparation Unit (Victim-Prone) Program at Clinton which became operational in February of this year.

7. OMR/DD person who also suffer from acute or chronic mental illness may also be serviced by OMH Satellite Units and/or Central New York Psychiatric Center.

II. Inmates with Psychiatric Problems

Reference. ". . . State inmate mental health care needs are pervasive. . . ." Pages 21, 23-24.

Comments. Although the report alludes to the seven OMH Satellites, Central New York Psychiatric Center, seven non-satellite OMH units, Merle Cooper, and RAP, it neglects to mention that two Intermediate Care Programs have been operational for four months. The one at Auburn has a bed capacity of 48 and the one at Bedford Hills 18. Additionally, it should be indicated that in addition to two new Satellites (one at Downstate became operational in February of this year and the other at Ossining is projeced to become operational in September), that the Commissioner has mandated that Satellite Units be incorporated in the planning of all new DOCS facilities. The recent opening of the Assessment and Program Preparation Unit (Victim-Prone) at Clinton and the projected development of four additional Intermediate Care Programs in the forthcoming fiscal year will substantially increase the Department's ability to provide diagnostic and psychiatric care to inmates who require said services. Also, a proposal which would address the special needs of sex offenders is currently under study by the Department.

III. Bureau of Forensic Services

Reference. "There is no formal procedure for regular review or evaluation of satellite center services, facilities, procedures, and staff competence." Page 59.

Comments. Joint audits involving DOCS and OMH were completed in January of this year. The report does address the concern raised by the LCER Report. These joint audits will continue on an annual basis.

Negative

LCER cited several deficiencies which are directly related to differences in policy and procedures under which DOCS and OMH respectfuly operate.

Reference. Lack of access to medical/psychiatric records. Page 61.

Comments. This is a problem area which is the direct result of confidentially legislation. However, there is a proposed Agreement for the Exchange of Information between the two Departments currently under review.

Reference. Transfer of inmate clients without prior notification to the Satellite Unit. "A major criticism documented in LCER staff interviews and found in Commission of Corrections mortality reviews, was the lack of pre-notice of transfer for inmates who were active users of satellite center services. This resulted in gaps in care and delayed follow-up of psychiatric treatment and medication with these patients. Lack of continuity of mental health care had been a contributing factor to inmate deaths resulting from suicide." Page 61.

Comments. This is a problem area which resulted from such variables as the lack of clearly delineated policies and procedures, lack of formalized linkages between the Satellite Units and facilty administration, confidentiality guidelines, and, in certain instances, the need to effectuate an immediate transfer without pre-disclosure of the intent for security purposes. This was an area of focus during the joint audits which has resulted in the Satellite Unit Chiefs meeting regularly within facilty Executive Staff, thus creating a formalized linkage between the facility and satellite. Head Clerks are instructed to notify the satellite at least 24 hours before an inmate receiving mental health services is transferred; and DOCS is considering a proposal to assign all inmates receiving mental health services under a single counselor which will further strengthen the communications between the satellite and the facility-at-large.

Reference. Closing of Satellite Ward without prior approval of OMH. Page 61.

Comments. There is ongoing dialogue between DOCS and OMH concerning the closing of the inpatient unit at Attica. OMH has provided DOCS with statistical data which relates to what they perceive to be the impact in their service delivery capability caused by the unit's being closed. This information is currently under review by the Department.

VII. Environmental Health (Pages 54-57).

The following are comments on the draft presentation:

1. It is true that we have never had 100 percent compliance in the completion of form 1500. This is because of the lack of staff to accomplish any meaningful nutritional reporting system. This Division, along with the Deputy Commissioners, continue to press this matter.

2. Menus are only a tableau of how finished products will be presented. They are not a gauge or measurement of nutritional intake.

   The record of the integrity and quantities of specific food commodities consumed in each of the 12 nutritional food groups is measurable. This information appears on the Form 1500 on a monthly basis, and on the Form 1527 on a daily basis. This information is used to determine the nutritional adequacy of any menu. This information is also compared against a standard (see A.C.A. -Manual of Standards for Adult Correctional Institutions, August, 1977 -Food Services No. 4224).

   The ability to develop, apply and monitor nutritional policies or standards does not require a staff "dietitian." Nor is a dietitian required for training programs. A trained dietitian (trained in Dietetic Administration) with a therapeutic background, is needed to advise the Director of Correctional Nutritional Service and/or the Health Services Staff.

   We have long recognized this need, specifically, in the therapeutic diet area. We are currently working with the Director of the Administrative A.D.A. Internship (Department of Mental Health), Health Services, and our own facility nutrition services staff in the development of a therapeutic diet manual which will be acceptable to health and food services staff.

3. The Directive (No. 3002) covering the Sanitation Schedule, Procedure and Reports states that this is to be a "self inspection". It was primarily designed as a management tool for the individual facilty management teams.

4. The Directive (No. 3009) covering Sanitary Inspections by the Department of Health was developed on December 1, 1980 at Support Operations request as we too recognized the then problems. It would appear initially, that this new procedure will assist in alerting the Central Office in a more timely fashion.

5. We certainly agree that there is a need for training programs for all food service staff. A training relief factor, additional personnel to supplement an already insufficient number of staff is needed to allow operations to function at a reasonable level during training period.

6. The information on the lack of submission of Housekeeping Reports is accurate.

May 7, 1981

NEW YORK STATE
OFFICE OF MENTAL HEALTH 44 Holland Avenue, Albany, New York 12229

JAMES A. PREVOST, M.D., Commissioner

April 22, 1981

COPY

Mr. Sanford E. Russell
Director
New York State Legislative
Commission on Expenditure Review
111 Washington Avenue
Albany, N.Y. 12210

Dear Mr. Russell:

In response to your communication of March 2, 1981, I would like to provide you with my comments and suggested corrections pertaining to the LCER report on "State Prison Inmate Health Services."

First as a general comment, I am concerned with the general tone and perception of the Office of Mental Health's Forensic Service System as portrayed in the report. The report outlines a number of areas of deficiency rather than noting OMH's responsiveness in providing mental health resources to the correctional system particularly over the last five years when this agency's commitment to the needs of the forensic population was escalated dramatically. Since the inception of OMH's correctional mental health program, I believe that this Department has made a significant contribution toward improving the quality of care to the mentally disabled offender incarcerated in New York State prisons. The report neither draws historical comparison to the quality of mental health services as they existed when under the auspice of the Department of Correctional Services nor does it compare the extent of mental health services in the New York State prison system to what currently exists in other states. I am aware that this Department's relationship with DOCS requires improvement in order to foster the evolution of a viable system. However, I believe that a national and historical comparison will reveal that New York State is currently in the forefront of providing a mental health delivery system in corrections at least comparable to any available in the country.

Turning now to specific comments related to elements of the report, I will respond by citing page number and paragraph with corresponding comment:

Page S-3, third paragraph: In addition to the description of services provided, Forensic Services provides consultative mental health services to all of the State's 33 correctional facilities. Furthermore, Forensic Services operates a Parole Mental Health Clinic at 40th Street, Parole Office in New York City, which in addition to meeting the mental health needs of parolees in the metropolitan New York area, also provides mental health services to inmates of metropolitan New York correctional facilities operated by D.O.C.S.

Page S-3, fourth paragraph: The Satellite Units are currently not providing cost center information. However, in January of 1981, the Bureau of Forensic Services developed a new manual reporting system to supplement DMHIS information currently being provided. This new reporting system details services provided in the seven Satellite Units, as well as services provided to all other correctional facilities within the state system and the services provided by the Parole Mental Health Clinic in New York City.

Page S-3, fifth paragraph: From July 1980 to January 1981, OMH in conjunction with DOCS conducted a survey/audit of all seven Satellite Units. This joint agency endeavor included a review and evaluation of the Satellite Units and included review of procedures and staff performance.*

Page S-3, sixth paragraph: Concerning the sharing of clinical information between OMH and DOCS, the report cites that meetings have occurred between the two agencies. In addition to the meetings, it should be noted that a memorandum of understanding which delineates clear guidelines for the sharing of information has been prepared by OMH Counsel's office and has been reviewed by DOCS Counsel's office. In a March 19 letter from the Associate Commissioner for Health Services in Corrections, the Department of Correctional Services has suggested two minor modifications to this agreement. In turn, OMH has officially adopted these suggestions and the two agencies are prepared to sign a final memorandum in the early part of May.*

Page 58, third paragraph: It should be clearly stated that vacancy levels are determined by a number of factors, not the least of which is the requirement by the Division of the Budget that programs operate within an authorized fill level. The number of authorized positions for Services to Correction and Parole is currently 107 positions and as of March 11, 1981, the number of positions filled was at this level.

Page 59, second paragraph: The poll of each "satellite unit and other units" was conducted as a double check of available personnel and payroll data, not because such data were not readily available.

Page 59, last paragraph: As cited above, the Office of Mental Health and the Department of Correctional Services have conducted a survey/audit of the seven Satellite Units. This process exceeds the recommendations of the American Association of Correctional Psychologists to have a yearly study conducted by headquarters personnel or an outside group. Rather, it incorporates the recommendations and exceeds them in line with the need expressed by both OMH and DOCS.

In addition, since the inception of the Central New York Psychiatric Center/Satellite Unit system, monthly meetings have been held on a regular basis between field and Central Office staff to provide a consistent forum by which evaluation of the effectiveness of the system occurs and necessary policy decisions receive broad based input from the field.

Page 60, second paragraph: It should be noted that in addition to the outside agencies responsive to inmate grievances, all OMH complaints are subject to review by the Mental Health Information Services and the Prisoner's Legal Services. Both of these agencies have had constant communication with the Central Office of the Bureau of Forensic Services.*

Page 60, third and fourthparagraph: There is in fact a standardized reporting format which has been implemented (effective January 1, 1981) and this narrative format, in conjunction with a comprehensive monthly statistical summary supported by an array of source documents, is currently providing necessary service data.

The Bureau of Forensic Services would be more than happy to meet with you or your staff to further explain the comments above. I would like to thank you for the opportunity to comment on the Commissioner's draft report.

Sincerely yours,

James A. Prevost

James A. Prevost, M.D.
Commissioner

*Audit text revised

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CHAIRMAN
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KATHARINE WEBB

March 11, 1981

COPY

Mr. Sanford E. Russell
Director
Legislative Commission on
Expenditure Review
111 Washington Avenue
Albany, New York 12210

Dear Mr. Russell:

A copy of the report "State Prison Inmate Health Services" was given to me by Chairman Stephen Chinlund for my review.

I wish to compliment your staff for the methods used in auditing the Medical Review Unit of this agency. They acted in a very professional and ethical way in dealing with our staff.

I just wish to call your attention to page 71 which, in my opinion, seems to give the impression that the BSCFR (Bureau of State Correctional Facility Review) are under the jurisdiction of the Chairman of the Medical Review Board and a part of the Medical Review Bureau.*

This statement is incorrect since the Chairman of the Commission has complete jurisdiction over that unit and the scheduling of inspections, reviews, analyses, and reports are channeled directly to the Chairman of the Commission and not through this Unit.

I would appreciate your correcting the final copy of the report to reflect that division.

Trust I may have the opportunity to meet you in person at some future time.

Very truly yours,

JOSEPH WASSER
Commissioner and Chairman
Medical Review Board

JW:lk

*Audit draft revised

STATE OF NEW YORK
DEPARTMENT OF HEALTH
ALBANY

DAVID AXELROD, M.D.
COMMISSIONER

March 23, 1981

COPY

Dear Sandy:

Thank you for the opportunity to review your preliminary report on State Prison Inmate Health Services.

The report generally reflects the powers, responsibilities, functions, and activities of the Department of Health in monitoring environmental and food sanitation services in Correctional facilities. I have attached a list of the concerns of the Department that I believe should be incorporated into the final report. With these suggested amendments, the final report will be a sound document that could assist the Department in carrying out its environmental and food programs in State Correctional facilities.

Commission staff provided a full opportunity for my staff to advise on the program. They are to be congratulated on the professional manner in which they approached this complex and sensitive program review.

Sincerely,

David Axelrod, M. D.
Commissioner of Health

Mr. Sanford E. Russell
Director
State of New York
Legislative Commission on
Expenditure Review
111 Washington Avenue
Albany, New York 12210

NEW YORK STATE DEPARTMENT OF HEALTH

Comments on Report on State Prison Inmate Health Services

Prepared by Legislative Commission on Expenditure Review

Court Mandates (p.3)

Partially as a result of the review afforded by the LCER study, the Department of Health has initiated a program for the training of Department of Corrections food handlers. The initial program is being conducted in April at the Attica Correctional Facility. It will be videotaped and used in all correctional facilities.

Authority of the Department (p.8)

The specific authority of the Department of Health is set forth in PHL 8206-1(g). The clause requires examinations and inspections of the sanitary conditions of State institutions, copies of the reports and recommendations to be provided to the Commissioner of Corrections. Such specific delegation by the Legislature is the authority for the reports provided to the Commissioner rather than the generic authority of clause (f) relating to enforcement of the law and the code or the specific authority of clause (h) relating to migrant labor camps.

Distribution of DOH Reports (p.56)*

Although distribution of the reports and recommendations of the Department of Health is a responsibility of the Department of Corrections, it may be helpful to include a note that copies of the field inspection report and forms are left with the appropriate facility official at the conclusion of the inspection to avoid delays in corrective action.

Environmental Inspections (p.73)

Food sanitation receives top priority because of its known risks. The policy of the Department of Health has been to include the inspection of one or more cell blocks for environmental sanitation as well, time permitting. About 40% of the 79 inspections made between October, 1977, and June, 1980, involved such inspections, and eight reports included recommendations for improvements. The Department of Health now requires that environmental sanitation be included in all inspections.

Inspection Findings, Food Service (pp.73-74)*

The summary appears to emphasize the importance of the presence of vermin. Food-handling deficiencies, particularly proper attention to time and temperature criteria in the storage, preparation, and service of food, are, or should be, the principal concern. Standards used in inspecting all State institutions are equal to those used in commercial establishments, they are not "lower" as cited. In general, the sanitary aspects of food service in State institutions is better than that found in commercial establishments of similar size.

Water Purity (p.74)

Continous monitoring of public water supplies is performed by the Department's Division of Environmental Health, including the water supplies to correctional facilities.

X-Ray Monitoring (p.74)*

The Department's Division of Radiologic Health conducts the x-ray monitoring program.

*Audit text revised.

New York State Health Planning Commission

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HUGH L. CAREY
GOVERNOR

KEVIN M. CAHILL, M.D.
CHAIRMAN

ROBERT P. WHALEN, M.D.
VICE-CHAIRMAN

COPY

March 23, 1981

Dear Mr. Russell:

Thank you for sharing your preliminary report "State Prison Inmate Health Services." I have reviewed the report's comments regarding the Health Planning Commission. As the text on pages 105-106 indicates, the Health Planning Commission has not reviewed the Department of Correctional Services' plans for the provision of health services to inmates.

The Commission is responsible under Executive Order No.6.2 for advising on a broad range of health and health related issues affecting all the people of the State. As a small agency, the Commission must carefully focus its activity across an entire spectrum encompassing the environment, prevention and health service delivery aspects of significance to health. Correctional Services, serving a population of 22,000, has a minimal impact on the generic health system serving over 17,000,000.

It should be noted, however, that issues affecting Correctional Services have received the attention of the Health Planning Commission.

1. The HPC has been concerned with physician recruitment and retention problems of New York State government, including DOCS, since 1978. I have attached a recent update of physician recruitment and retention problems which specifically references DOCS (pages 22-23, 43).

2. The HPC has assisted the Division of the Budget and the Office of Employee Relations in the development of a request for a proposal to undertake a major consultant study of New York State government recruitment and retention problems of health personnel among State agencies, including DOCS.

3. In 1979, the HPC intervened to resolve a potential withdrawal of back-up acute care services provided by the U.S. Public Health Service Hospital to the Arthur Kill Correctional Facility.

4. The HPC has reviewed Health Manpower Shortage Area requests made by regional health systems agencies to the National Health Service Corps which designated the Greenhaven Correctional Facility and the Attica Correctional Facility as HMSA's. The HMSA designations make these sites eligible for National Health Service Corps physician placement.

5. The HPC participated in Department of Correctional Services-Office of Health Systems Management discussions opening up an approach to use OHSM for surveillance of DOCS health care services.

These activities indicate that DOCS concerns have not been completely ignored in the health planning program as suggested by the narrative in the report. I believe the text should be modified to recognize the above activities.

Thank you for the opportunity to comment on the report.

Sincerely yours,

Robert P. Whalen M.D.

Robert P. Whalen, M.D.
Vice-Chairman

Mr. Sanford E. Russell, Director
Legislative Commission on Expenditure Review
111 Washington Avenue
Albany, New York 12210

Attachment

PROGRAM AUDITS OF THE
LEGISLATIVE COMMISSION ON EXPENDITURE REVIEW

Manpower Training in New York State, February 16, 1971.*

Narcotic Drug Control in New York State, April 7, 1971.*

Fish and Wildlife Research in New York State, June 24, 1971.

Marital Conciliation in New York State Supreme Court, August 16, 1971.

Construction of Dormitories and Other University Facilities, December 1, 1971.

Office Space for New York State, January 17, 1972.

State Supplied Housing for Employees, February 11, 1972.

Middle Income Subsidized Housing in New York State, February 29, 1972,

New York State Criminal Justice Information System, March 17, 1972.

New York State Division For Youth Programs, April 21, 1972.

Snow and Ice Control in New York State, May 31, 1972.

Urban Education Evaluation Reports for the Legislature, June 30, 1972.

The Role of the Design and Construction Group in the New York State Construction Program, July 7, 1972.

Consumer Food Health Protection Services, August 17, 1972.

Milk Consumer Protection Programs, September 15, 1972.

State University Construction Fund Program, October 5, 1972.*

Surplus and Unused Land in New York State, January 15, 1973.

Evaluation of Two Year Public College Trends, 1956-1971, April 2, 1973.

Educational Television in New York State, July 6, 1973.

Construction of Mental Hygiene Facilities, October 3, 1973.

Community Mental Health Services, October 10, 1973.

The Acquisition and Construction of Drug Abuse Treatment Facilities, January 18, 1974.

State University Health Science Programs, January 24, 1974.

Day Care of Children, February 14, 1974.

State Aid to Libraries, March 4, 1974.

Health Insurance For Government Employees, May 30, 1974.

Civil Service Recruitment of State Professional Personnel, June 17, 1974.

Retail Services in Government Agencies, September 10, 1974.

Nuclear Development and Radiation Control, October 1, 1974.

College for the Disadvantaged, October 15, 1974.

Driver Licensing and Control Programs, October 20, 1974.

State Historic Preservation Programs, November 1, 1974.

Industrial Development in New York State, November 25, 1974.

Programs for the Aged, March 31, 1975.

New York State Fair, April 15, 1975.

New York State Parkways, April 21, 1975.

Tri-State Regional Planning Commission Programs, May 5, 1975.

Foster Care For Children, May 29, 1975.

Disadvantaged Students in Public Two-Year Colleges, July 25, 1975.

Human Rights Programs in New York State, August 18, 1975.

Patients Released From State Psychiatric Centers, August 29, 1975.*

Financial Aid to Crime Victims, October 31, 1975.

Persons Released From State Developmental Centers, December 18, 1975.

New York State Job Placement Programs, December 30, 1975.

Pre-Kindergarten Programs, December 31, 1975.*

DOT Real Estate Program, April 15, 1976.

Solid Waste Management in New York State, May 20, 1976.

Boards of Cooperative Educational Services Programs, June 28, 1976.

Boards of Cooperative Educational Services Finances, June 30, 1976.

Workmen's Compensation Program for State Employees, July 30, 1976.*

Public Pension Fund Regulation, October 28, 1976.

Computers in New York State Government, December 1, 1976.

Health Planning in New York State, January 3, 1977.*

The Optional Service Charge Law, March 11, 1977.

Immunization of Children, May 27, 1977.

State Parks and Recreation Program, October 11, 1977.

State Travel Costs, December 15, 1977.

Venereal Disease Control, December 16, 1977.

State Environmental Permits, December 19, 1977.

Pupil Transportation Programs, January 30, 1978.*

Housing Maintenance Code Enforcement in New York City, March 31, 1978.

Vacation Credit Exchange, June 16, 1978.

Adirondack Park Planning and Regulation, July 31, 1978.

School Food Programs, August 7, 1978.

SUNY Developing and Nontraditional Colleges, September 26, 1978.

Newborn Metabolic Screening Program, October 31, 1978.

Fiscal Effect of State School Mandates, December 20, 1978.

School District Budget Voting and Contingency Budgeting, December 26, 1978.

State Aid for Operating Sewage Treatment Plants, April 16, 1979.

Crime Victims Compensation Program, April 23, 1979.

Drinking Driver Program, May 15, 1979.

Unemployment Insurance for State Employees, July 20, 1979.

Work Programs for Welfare Recipients, July 27, 1979.

CETA Programs in New York State, August 24, 1979.

Parole Resource Centers Program, August 31, 1979.

Local Government Use of State Contracts, October 15, 1979.

Use of State Adult Psychiatric Centers, February 29, 1980.

National Guard Strength and Armories, March 17, 1980.

School District Committees on the Handicapped, April 15, 1980.

Delinquency Prevention and Youth Development Programs, May 2, 1980.

Energy Use in State Facilities, June 11, 1980.

Occupational Education in Secondary Schools, July 8, 1980.

Use of State Developmental Centers, November 6, 1980.

Energy Research and Development Programs, December 24, 1980.

State Subsidized Low Rent Public Housing, December 31, 1980.

Taxpayer Services Program, March 9, 1981.

Title XX Social Services, March 13, 1981.

State Prison Inmate Health Services, June 19, 1981.

*Out of print; loan copies available upon request.

LEGISLATIVE COMMISSION ON EXPENDITURE REVIEW

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