AN EVALUATION

Prison Health Care

Department of Corrections

01-9

May 2001

2001-2002 Joint Legislative Audit Committee Members

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CONTENTS

Letter of Transmittal 1

Summary 3

Introduction 11

Health Care Standards 12
Health Care Organization and Staffing 13

Expenditures for Health Care 17

Trends in Prison Health Care Costs 17
Factors Affecting Health Care Costs 18
Pharmaceutical Expenditures 20
Staffing Levels 23
Professional Medical Services Expenditures 25
Hospital Services 26
Health Care Expenditures in Other States 28

Delivery of Emergency Care 31

Volume of Emergency Requests 31
Emergency Health Care Training for Correctional Officers 32

Delivery of Routine Medical Care 35

Volume of Routine Medical Care Requests 35
Health Requests by Inmates in Segregation 37
Inmates with Chronic Illnesses 38
Initial Health Assessments 41
Distribution of Controlled Medications 44
Health Care Staff Training 46

Delivery of Health Care in Out-of-State Facilities 49

Contract Monitor Visits 49
Enforcement of Contract Provisions 50

Delivery of Mental Health Care 53

Ambulatory and Intermediate Mental Health Care 54
Wisconsin Resource Center 58

Assessing Quality of Care 61

Internal Reviews 61
Accreditation Options 62
Professional Health Care Staff Licensing 65
Health-Related Legal Settlements 66
Mortality Reviews 67

Future Considerations 69

Governor's 2001-03 Prison Health Care Budget Proposal 69
Registered Nurse Staffing Increase 70
Other Health Care Staff to Support Return of Out-of-State Inmates 71
24-Hour Nursing Coverage 72
Additional Physicians 74
Alternatives to Reduce Prison Health Care Costs 75
Improved Contract Management 77
Medical Assistance Funding for Eligible Inmates 80
Improvements in the Transportation of Inmates 81
Increased Use of Telemedicine 83
Increased Medical Co-Payment Fees 85

Appendix 1—Locations of Adult Correctional Institutions

Appendix 2—Institution Profiles

Appendix 3—NCCHC Standards

Appendix 4—Women's Health Statistics

Appendix 5—Results of Self-Evaluation of Compliance with NCCHC "Essential" Standards

Appendix 6—Response from the Department of Corrections

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May 15, 2001

Senator Gary R. George and
Representative Joseph K. Leibham, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator George and Representative Leibham:

We have completed an evaluation of health care in Wisconsin's adult prisons, as requested by the Joint Legislative Audit Committee. In fiscal year (FY) 1999-2000, the Department of Corrections spent $37.2 million and employed 232.5 full-time equivalent medical professionals and other support staff to provide health care to approximately 14,900 adult inmates.

The Department currently receives as many as 1,000 requests for health services from inmates each working day, approximately 60 percent of which are for prescription refills. Staff also responded to 8,137 emergencies during FY 1999-2000. We found that approximately 5,000 inmates, or one-third of the population, suffer from at least one chronic illness, and we conclude that improvements are needed in the management of chronic illnesses, contract oversight, and mental health services.

The Governor's 2001-2003 Biennial Budget Proposal provides an additional $37.6 million in general purpose revenue and an additional 157.5 positions for prison health care, including $17.3 million and 118.0 positions for new institutions and facility expansions. We reviewed this proposal and several alternatives to determine whether costs associated with additional prison health care staff could be offset through management improvements or other changes. We found limited opportunities and significant challenges for reducing health care expenditures as costs for certain medical services and pharmaceuticals, which are not subject to the Department's control, continue to increase.

We appreciate the courtesy and cooperation extended to us by Department of Corrections management and staff. The Department's response is Appendix 6.

Respectfully submitted,

Janice Mueller
State Auditor

JM/KW/cm

Summary

In fiscal year (FY) 1999-2000, the Department of Corrections spent $37.2 million and employed 232.5 full-time equivalent (FTE) staff to provide health care to approximately 14,900 adult inmates. Inmates receive routine medical care in health services units, which operate like outpatient clinics at each of the 14 adult institutions. Health services units treat inmates' illnesses, manage chronic conditions, provide basic dental and optical services, and process prescription orders.

Specialized care is provided at the University of Wisconsin Hospitals and Clinics (UWHC), local hospitals, and a 64-bed infirmary at the Dodge Correctional Institution. The Department also provides mental health care in psychological services units at each institution, as well as in specialized units at three institutions and at the Wisconsin Resource Center and the Winnebago Mental Health Institution.

The unexpected death of a female inmate during an asthma attack at Taycheedah in February 2000 raised concerns about inmates' access to health services and the quality of those services. As a result, the Joint Legislative Audit Committee directed an independent review of prison health care services.

Inmates in all states have a constitutional right to health care that meets minimum adequate standards. However, the Supreme Court has found that inmates are not guaranteed the right to the best heath care available in a community. Wisconsin law currently requires the Department to provide health care based on the standards of any professional organization that establishes standards for health services in prisons. The Department has referenced several sets of standards since 1981, but has recently looked to the National Commission on Correctional Health Care (NCCHC) for standards in providing health care to inmates.

Since FY 1994-95, both the number of inmates and the cost of their health care have increased significantly. The inmate population increased 56.4 percent, from 9,544 in 1994-95 to 14,926 in FY 1999 2000. During the same period, inmate health care expenditures increased 120.1 percent, from $16.9 million to $37.2 million. Costs can be expected to increase with the number of inmates served. However, the average cost per inmate has also increased. On a per inmate basis, health care spending increased 40.8 percent, or $723, since FY 1994-95 and averaged $2,495 in FY 1999-2000.

Health care expenditures have increased significantly in all categories. However, spending for pharmaceuticals, which totaled $6.6 million in

FY 1999-2000, accounts for the greatest percentage increase in health care costs. The number of prescriptions filled by the Department increased from 142,041 in FY 1994-95 to 309,332 in FY 1999-2000. On average, inmates who received at least one prescription in December 2000 had 3.12 open prescription orders; available data indicate prescription costs have increased from $13.37 per order in FY 1994-95 to $23.24 per order in FY 1999-2000. The six drugs for which expenditures are greatest are Seroquel and Risperdal, both of which are used to treat psychotic disorders; Paxil and Zoloft, which are used to treat depression; Rebetron, which is used to treat hepatitis-C; and Neurontin, which is used as a mood stabilizer and to treat seizures. The Department is taking steps to control prescription drug costs, including more closely monitoring the contract with its central drug supplier and advising its physicians on more cost-effective prescribing practices. However, newer, more expensive drug therapies are likely to be a source of continuing expenditures for the Department.

The Department's salary and fringe benefit costs for permanent and limited-term health care employees increased from $7.9 million in FY 1994-95 to $15.3 million in FY 1999-2000. We note, however, that newer institutions (those opened after 1995) have fewer inmates per health care employee than older institutions do.

In FY 1999-2000, the Department also contracted with 315 vendors for $3.9 million in supplementary medical, laboratory, dental, and optical services that its own health services units could not provide with current staff or could not provide cost-effectively. Expenditures for these services increased 160.0 percent from FY 1994-95 through FY 1999-2000. We found that the Department has not regularly reviewed basic management information related to professional medical services contracts. A review of some contracts was begun in February 2001, and we have recommended that the Department identify and review all professional medical services contracts to determine whether costs can be controlled by seeking better rates or through consolidation.

Expenditures for hospital services increased 62.5 percent from FY 1994-95 through FY 1999-2000, from $4.8 million to $7.8 million. The principal provider of these services is UWHC; however, local hospitals provide emergency and other services. Expenditures for inmate care at local hospitals increased nearly 92 percent since FY 1994-95.

In FY 1999-2000, UWHC received $5.5 million to provide inpatient and outpatient services to inmates in the adult system. That amount was $800,000 more than budgeted, because of increased base contract rates and increased use for both inpatient and outpatient care. Of the $2.3 million the Department paid local hospitals in FY 1999-2000, Waupun Memorial Hospital received $700,000 and Agnesian healthcare in Fond du Lac received $500,000. We note that Waupun Memorial Hospital is paid usual and customary rates because the Department has

not established a contract with it. However, the Department is attempting to control hospital services costs by taking steps to ensure that all appointments are medically necessary.

Although costs have increased significantly since FY 1994-95, Wisconsin spends less per inmate for health care than several neighboring states, and less than states that have comparable prison populations and rates of growth. For example, only two of six other states for which we gathered data—Illinois and Tennessee—had lower per inmate expenditures for prison health care than Wisconsin's in FY 1999-2000.

Wisconsin has no formal guidelines to ensure that inmates at all institutions receive comparable levels of service through equivalent staffing levels. On average, Wisconsin has one health care provider who is either a registered nurse, nurse practitioner, physician assistant, or physician per 123 inmates. The other states we surveyed had staffing ratios ranging from 50 to 178 inmates per health care provider in FY 1998-99.

In FY 1999-2000, health services unit staff responded to 8,137 medical emergencies, or approximately 22.2 per day. Of these, 746 required transportation to an emergency room at a local hospital, either by an institution vehicle or by ambulance. Correctional officers play an important role in responding to medical emergencies because they determine whether health services staff should be called. Although the Department requires that each facility develop an emergency response policy that meets specific minimum requirements, not all facility policies are up-to-date. In addition, some institutions report having lapsed nearly all correctional staff's CPR certifications because of a lack of training resources. In April 2001, the Secretary issued a directive that correctional officers be trained and updated in first aid, CPR, and the use of defibrillators and that staffing patterns provide trained officers who will provide CPR on all shifts.

Providing routine medical care to inmates is challenging, given the large number of requests the health services units receive each day and the significant incidence of chronic illnesses in Wisconsin's adult inmate population. Staff in health services units review as many as 1,000 requests for non-urgent medical care each working day, including requests for prescription refills, appointments with medical staff, dental services, and medical information. The number of requests per 100 inmates differed significantly by institution and ranged from a high of 82.1 percent at Taycheedah, which houses female inmates, to a low of 10.1 at Prairie du Chien, which houses younger male offenders. Clinic managers at all institutions except Taycheedah report that the forms inmates use to request health services were reviewed within 24 hours of their receipt by health services unit staff, as the Department requires. Reliable data are not available to determine how long inmates must wait for appointments with health care staff.

Inmates in segregated custody or solitary confinement must obtain health services request forms from correctional officers, who are to forward the forms to health services unit staff. Health services staff report substantial variation in the frequency with which they visited inmates in segregated custody. National standards require daily visits. However, in Wisconsin the frequency ranges from daily to several times per week or upon request.

Approximately one-third of Wisconsin's inmates have at least one chronic illness, but the rate varies widely by institution. At Taycheedah, which houses most female inmates, an estimated 72.1 percent of the inmate population had at least one chronic illness in December 2000. The lowest rate of chronic illness was 18.4 percent at Prairie du Chien. In December 2000, we counted 7,867 cases of chronic illness among the 5,110 inmates with at least one chronic illness. An estimated 2,642 inmates were diagnosed with a mental illness, 1,636 with cardiac conditions, and 1,239 with asthma.

The Department requires that all inmates receive a health assessment within 14 days of admission to the system. Concern about whether important medical information accompanies inmates who are transferred from one institution to another was recently addressed by the Legislature in 1999 Wisconsin Act 151, which requires either a medical record or a one-page health summary transfer form to be transported with every inmate moved between any prison or jail in Wisconsin, or when inmates leave institutions for off-site appointments.

Under current procedures, controlled medications are delivered by correctional officers at 11 of the 14 adult institutions. The officers receive fewer than four hours of related training, and the current collective bargaining agreement exempts them from disciplinary action for unintentional errors made during the delivery of medications. The Department has acknowledged the need for improvements in training for both correctional officers and health care staff.

In FY 1999-2000, the Department spent $84.9 million to house 4,665 inmates, or approximately 23.6 percent of its population, in contract bed facilities. About 70 percent of these inmates were male and housed in institutions operated by the Corrections Corporation of America (CCA). The Department's contract with CCA states, "inmates needing regular, reoccurring, off-site specialty referrals for medical concerns" will not be housed in CCA facilities. The contract also requires that CCA physical, mental, and dental health care be provided according to NCCHC standards.

The Department employs health services contract monitors to determine whether CCA institutions meet the health care requirements defined by the contract. We found that most of the monitors' site visit activities pertained to addressing individual inmate complaints and did not include

a systematic review of compliance with contract requirements. Although the monitors recorded 63 separate problems related to administration, health care delivery, and infection control, the Department has not sought to assess any damages for these problems and reports that all the cited problems have been addressed.

As noted, the Department provides mental health care at each institution and in specialty units, including the Wisconsin Resource Center for male inmates and the Winnebago Mental Health Institute for female inmates. The Department does not maintain statistics on the number of inmates with diagnosed mental illnesses. However, based on the number of inmates who had been prescribed psychotropic medications or were receiving treatment at the Wisconsin Resource Center, we estimate there were 2,642 inmates with mental illness in December 2000. We reviewed prescription orders for psychotropic medications over time and found a 68 percent increase from FY 1996-97 through FY 1999-2000. The inmate population increased 17.5 percent over the same period. Overall, the number of mental health staff increased at a rate consistent with the inmate population, but the number of mental health staff decreased or remained unchanged at 6 of the 14 institutions.

We found variations in mental health staffing levels among institutions that do not appear to be related to differences in the incidence of mental illness. For example, there are 132 mentally ill inmates per psychological staff position at Taycheedah, compared to 14 at Jackson. The availability of psychiatrists, who prescribe and monitor psychotropic medications, also varies by institution. For example, there is the equivalent of 1 FTE psychiatrist per 772 inmates prescribed psychotropic medications at Oshkosh, 1 FTE psychiatrist per 550 inmates prescribed psychotropic medications at Taycheedah, and 1 FTE psychiatrist per 165 inmates prescribed psychotropic medications at Oakhill. The Department notes that variation in mental health staffing is affected by both population and specialized programming provided at each institution. We include a recommendation for the Department to examine the allocation of available mental health resources to ensure that they are used to meet inmates' needs in an equitable and efficient manner.

The Department's capacity to provide mental health services to inmates with acute mental illness has been constrained since the Wisconsin Resource Center began to house sexually violent persons committed under ch. 980, Wis. Stats. In FY 1999-2000, 224 of the 438 individuals the Center housed had been committed under ch. 980, Wis. Stats., and 214 were inmates. Because bed space is limited, only the Department's most severe cases of acute mental illness can be transferred to the Center, and some inmates with acute mental illnesses who would benefit from treatment at the Center are being cared for at correctional institutions. This places an extra burden on the capacity of mental health staff to deliver ambulatory and intermediate mental health services. Wisconsin Resource Center staff report that a significant number of sexually violent

persons may be transferred to a new facility, Sand Ridge, by October 2001. Assuming no budget reductions, beds in the Center may again be available for acutely mentally ill inmates at that time. The Governor's 2001-03 Biennial Budget Proposal includes funding for 314 beds at the Center for inmates with acute mental illness.

In recent years, the Department has initiated numerous internal reviews to help assess the quality of prison health care, including ongoing development and implementation of its health services action plan. Since FY 1991-92, it has contracted with two firms to provide external review and quality improvement services. To ensure some level of external review consistent with the Department's past efforts, we include a recommendation for the Department to begin regular, random review of medical charts by a physician.

The Department currently requires contractors that provide health care services in Wisconsin institutions to be NCCHC-accredited, and it recently completed an internal assessment based on NCCHC standards. The Department believes that based on current procedures and staffing, it meets 14 of 37 "essential" standards defined by NCCHC, and that 8 more of these standards could be met by making minimal procedural or policy changes. However, the Department believes it will need significant additional funding to comply with one of the standards NCCHC defines as essential: daily health assessments of inmates in segregation. We estimate that meeting this standard would require at least an additional $1.1 million for 20.0 FTE registered nurses. The Department believes that additional correctional officers would also be required to provided increased security for daily health assessments in its segregation units.

The number of deaths among Wisconsin inmates has increased from 12 in 1995 to 31 in 1998. Among our comparison states, only Minnesota had fewer deaths as a percentage of average daily population. Since 1998, Wisconsin's inmate death rate has remained stable. There were 20 deaths in FY 1998-99, and 25 in FY 1999-2000. Data for other states are unavailable after 1998.

The Governor's 2001-03 Biennial Budget Proposal seeks an additional $37.6 million in general purpose revenue funding and authority for 157.5 FTE new positions related to prison health care. The proposal includes $18.0 million for pharmaceuticals, professional medical services, other variable health costs, and other initiatives. Most of the remaining funding and positions have been proposed for new institutions and facility expansion. However, $2.3 million and 39.5 FTE positions would be directed to increase health care staffing levels at existing correctional institutions. Major provisions include:

- 16.0 FTE registered nurses, 2.0 FTE licensed practical nurses, and 2.0 FTE medical assistants to increase staffing ratios and reduce overtime costs at 11 institutions;

- 10.0 FTE for Dodge and Racine to adjust for increases in population related to the return of inmates from out-of-state contract beds, including 6.0 FTE registered nurses, 2.0 FTE dental hygienists, and 2.0 FTE health information technicians;

- 5.75 FTE registered nurses to provide 24-hour nursing care at Columbia, Oakhill, and Taycheedah;

- 1.0 FTE hemodialysis technician and 0.75 FTE registered nurses to assist with hemodialysis treatment at Dodge; and

- 1.0 FTE physician to increase the level of physician services at Racine, and 1.0 FTE physician at Dodge to provide coverage for other institutions with physician vacancies.

We reviewed and have suggested the Legislature consider five alternatives for management improvements or other changes that could offset costs associated with additional prison health care staffing: improving contract management, seeking Medical Assistance eligibility for some inmates, improving the process for transporting inmates to medical appointments, increasing the use of telemedicine, and increasing the co-payment fee for inmate-initiated visits to health services units.

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Introduction

The Department provided health care to an average daily population of 14,926 adult inmates in FY 1999-2000.

In fiscal year (FY) 1999-2000, the Department of Corrections spent $37.2 million in general purpose revenue (GPR) and employed 232.5 full-time equivalent (FTE) staff to provide health care to an average daily population of 14,926 inmates in 14 adult institutions and 18 minimum-security facilities. Health care for another 4,665 inmates was provided under contract with out-of-state prisons, federal facilities, and Wisconsin county jails.

Adult inmates in Wisconsin receive routine health care through health services units that operate like outpatient clinics at each of the 14 adult institutions shown in Appendix 1. The units, which are staffed primarily by registered nurses, treat illnesses, manage chronic conditions, provide basic dental and optical services, and process prescription orders. Specialized care is provided at the University of Wisconsin Hospitals and Clinics (UWHC), local hospitals, and a 64-bed infirmary located at the Dodge Correctional Institution. Special units at Dodge and the Columbia Correctional Institution provide enhanced mental health services to male inmates. Male inmates with acute mental illness may be transferred to the Wisconsin Resource Center, which is operated by the Department of Health and Family Services. Female inmates with acute mental health care needs may be treated at the Winnebago Mental Health Institute. The health services environment in individual institutions is profiled in Appendix 2.

Concerns about delivery of health services to inmates arose after a death in 2000.

The unexpected death of a female inmate during an asthma attack at the Taycheedah Correctional Institution in February 2000 raised concerns about inmates' access to health services and the quality of those services. The Department's internal investigation in March 2000 found that staff had not properly followed policies and procedures, and the Department subsequently developed a health services action plan to guide continuing internal review and ultimately improve health services. At the request of the Joint Legislative Audit Committee, we independently reviewed prison health services by:

- reviewing the Department's implementation of selected portions of the health services action plan;
- assessing the Department's oversight of health services provided under contract to inmates in Wisconsin institutions and in out-of-state facilities;

- comparing standards for health care delivery in other states' correctional institutions and in federal prisons to Wisconsin's standards;
- evaluating the Department's efforts to identify staffing needs and to provide cost-effective health services; and
- reviewing mental health services provided to inmates.

To conduct our evaluation, we interviewed health care professionals and correctional management staff at 9 of Wisconsin's 14 adult institutions and at the Wisconsin Resource Center. We collected information pertaining to health services directly from all 14 in-state adult institutions, as well as the minimum-security correctional centers operated by the Division of Community Corrections. We also collected information regarding correctional health care standards published by several national accreditation organizations and contacted correctional health care staff in six states and the federal Bureau of Prisons. In addition, we analyzed expenditure and staffing information and reviewed budget documents and information related to health services contracts, including health service contract monitor reports from out-of-state site visits. Finally, we contacted interested private citizens, representatives of the correctional officers union and the correctional nurses union, and other advocacy and interest groups. It should be noted that during the course of our audit fieldwork, we also received over 90 letters from inmates or family members expressing concern about access to care or quality of care.

Health Care Standards

Inmates in all states have a right to adequate health care that is guaranteed by the prohibition against cruel and unusual punishment in the Eighth Amendment of the United States Constitution. In 1976, the U.S. Supreme Court addressed minimum requirements for prison health care in *Estelle* v. *Gamble,* which found that inmates have a constitutional right to health care that meets minimum adequate standards, and "deliberate indifference" to an inmate's serious health need by a correctional system is a violation of the Eighth Amendment.

The U.S. Supreme Court has defined minimum requirements for prison health care.

In the 25 years since this case, courts have ruled that inmates have a constitutional right to access to health care, a professional medical judgment, and medical care as ordered. However, the Supreme Court has found that inmates are not guaranteed the right to the best health care that is available in the community. For example, there is no

constitutional protection against medical malpractice, although inmates may file lawsuits that allege malpractice.

The Legislature has modified Wisconsin law regarding the Department's provision of health care to inmates several times. Chapter 221, Laws of 1979 directed that the delivery of health care in Wisconsin prisons should be based on standards developed by the American Medical Association (AMA) and required the Department to report to the Legislature regarding the implementation of these standards. Four years later, 1983 Wisconsin Act 27 removed the reporting requirement. Requirements were further relaxed when 1997 Wisconsin Act 289 removed the statutory reference to AMA standards, based on the Department's argument that these standards were outdated and the Department required flexibility in choosing which standards to implement. State law currently requires the Department to provide inmates with health care that is based on the standards of any professional organization that establishes standards for health care in prisons.

Several national standards for prison health care have been established.

Since 1981, the Department has referenced several sets of standards to develop its internal health care policies, including standards from the AMA, the American Public Health Association, the American Nurses Association, the American Dental Association, and the Joint Commission on Accreditation of Healthcare Organizations. However, it has increasingly looked to standards developed by the National Commission on Correctional Health Care (NCCHC) because of their focus on prison health care, because they are the current version of the AMA standards that had been required under 1979 ch. 221, Wis. Stats., and because they are more specific than other standards. The NCCHC standards are summarized in Appendix 3.

Health Care Organization and Staffing

Since 1998, wardens have been responsible for administration of institutions' health services units, which, as noted, are staffed primarily by registered nurses. Wardens' responsibilities include personnel matters, such as hiring, discipline, and training decisions for nursing and some other staff, as well as ordering basic supplies and minor medical equipment. As shown in Table 1, approximately 70 percent of all prison health care positions are assigned to individual institutions and supervised by wardens.

Table 1

Full-Time Equivalent Health Care Positions
FY 1999-2000

Position Category	Facility Positions*	Bureau of Health Services Positions	Total Positions
Supervisory and Management	15.0	10.0	25.0
Physician	0.0	12.0	12.0
Dentist	0.0	11.5	11.5
Psychiatrist	0.0	0.5	0.5
Pharmacist	0.0	8.0	8.0
Optometrist	0.0	1.0	1.0
Physician Assistant	2.0	0.0	2.0
Nurse Practitioner	6.6	0.0	6.6
Registered Nurse	76.8	0.0	76.8
Licensed Practical Nurse	15.2	0.0	15.2
Radiology Technician	2.0	0.0	2.0
Bureau Support**	0.0	12.9	12.9
Clinic Support**	32.5	0.0	32.5
Dental Support**	14.0	5.5	19.5
Pharmacy Support**	0.0	6.0	6.0
Optometry Support**	0.0	1.0	1.0
Total	164.1	68.4	232.5

* In July 2000, 54.5 FTE positions previously reporting to the Bureau of Health Services became the administrative responsibility of the warden at Dodge.

** Includes both program assistants and staff with patient care–related responsibilities such as phlebotomists, physical therapy assistants, and dental hygienists.

The remaining health care positions—including all medical doctors, dentists, psychiatrists, pharmacists, and an optometrist—are assigned to the Department's Bureau of Health Services, which is responsible for their supervision as well as for system-wide services such as operating the central pharmacy and managing the contract with UWHC. The Bureau also facilitates communication among the supervisors of each health services unit, pays for pharmaceuticals and major medical equipment, and collects some system-wide information regarding prison health care.

Wardens were given administrative authority over health services units as part of a 1998 program reorganization to improve operations. However, whether wardens should have authority over some health care staff has been the subject of some debate within the Department. Many health care professionals and at least one warden believe that all health care staff should report to supervisors with medical training in the

Bureau of Health Services in order to guarantee uniformity of health services unit procedures and to ensure that personnel decisions affecting professional health care staff are made by supervisors with medical backgrounds. A July 1995 consultant's assessment also recommended that all health care staff report to a central office authority rather than the wardens.

The Department cites improved communication between correctional officers and health care staff as a primary benefit of the 1998 program reorganization. However, its management and oversight efforts have not been adequate to monitor basic information about health care delivery, making it difficult to manage resources in an environment of increasing costs.

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Both the number of inmates in Wisconsin facilities and the cost of their health care have increased significantly from FY 1994-95, when expenditures totaled $16.9 million, to FY 1999-2000, when they were $37.2 million. Expenditures for health care can be expected to increase with the number of inmates served. However, the average cost per inmate has also increased with increases in pharmaceutical costs; staffing costs; costs for laboratory, dental, optical, and other medical services provided by contractors; and hospital costs. Wisconsin nevertheless spends less per inmate than several comparable and neighboring states.

Trends in Prison Health Care Costs

Inmate health care expenditures increased by 120.1 percent since FY 1994-95.

As shown in Table 2, the average daily inmate population increased by 56.4 percent from FY 1994-95 through FY 1999-2000. Inmate health care expenditures increased by 120.1 percent during the same period. The rates of increase in the average daily population and health care population are illustrated in Figure 1.

Table 2

Change in Inmate Population and Health Care Expenditures
FY 1994-95 through FY 1999-2000

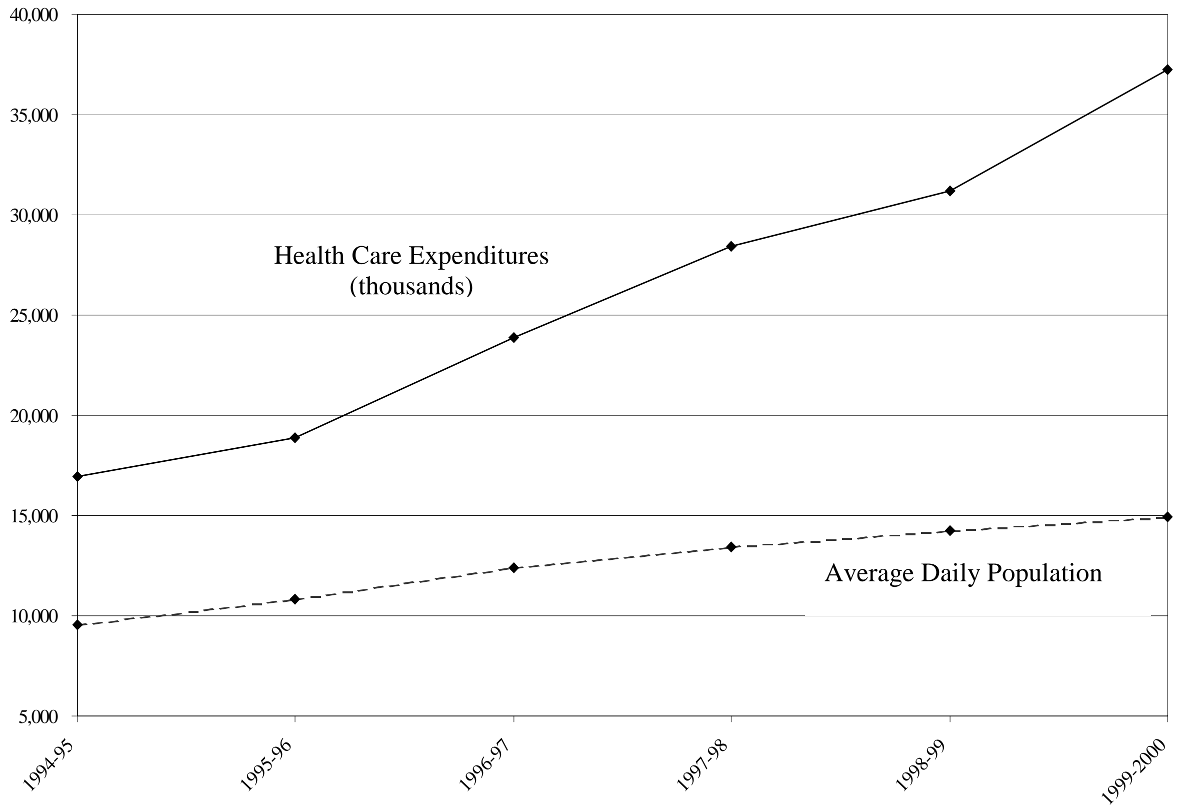
	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	Percentage Change
Inmates*	9,544	10,824	12,365	13,415	14,280	14,926	56.4%
Health Care Expenditures**	$16.9	$18.9	$23.9	$28.4	$31.2	$37.2	120.1

* Includes inmates in the Division of Adult Institutions and inmates in the Division of Community Corrections correctional centers. Does not include inmates in contract bed facilities or the Wisconsin Resource Center.

** In millions. Includes capital expenditures.

Figure 1

Increase in Health Care Expenditures and Average Daily Population
FY 1994-95 through FY 1999-2000



Factors Affecting Health Care Costs

Expenditures for pharmaceuticals have increased over 400 percent since FY 1994-95.

Even if the number of inmates stabilizes at the current level, total expenditures for health care are likely to continue to rise because of significant cost increases in all categories. As shown in Table 3, pharmaceutical expenditures increased 407.7 percent, from $1.3 million to $6.6 million from FY 1994-95 through FY 1999-2000. During the same period, costs for professional services provided by private vendors, as well as staffing costs associated with both permanent and limited-term employees (LTEs) and costs for local hospital services, increased by more than 90 percent.

Table 3

Change in Health Care Expenditures by Category
FY1994-95 through FY1999-2000
(in millions)

	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	Percentage Change
Salaries	$ 5.5	$ 6.8	$ 7.9	$ 9.0	$ 9.5	$ 10.3	87.3%
Pharmaceuticals	1.3	1.5	2.5	3.6	4.5	6.6	407.7
UWHC Contract	3.6	3.4	3.3	4.4	4.6	5.5	52.8
Professional Medical Services*	1.5	1.7	2.1	2.7	2.9	3.9	160.0
Fringe Benefits	1.8	2.2	2.8	3.1	3.2	3.5	94.4
Other**	1.4	2.0	2.3	1.9	2.6	2.4	71.4
Local Hospital Services	1.2	0.9	2.1	1.9	1.9	2.3	91.7
LTEs	0.6	0.4	0.9	1.2	1.4	1.5	150.0
Prison Health Services Contract***	n.a.	n.a.	n.a.	0.6	0.6	1.2	n.a.
Total	$16.9	$18.9	$23.9	$28.4	$31.2	$37.2	120.1%

* Includes medical, optical, dental, and laboratory services provided by private vendors.
** Includes medical, dental, and office equipment and supplies.
*** Contract for operating the health services units at Prairie du Chien and Supermax.

Health care expenditures per inmate increased 40.8 percent, or by $723, since FY 1994-95.

On a per inmate basis, health care spending increased 40.8 percent, on average, from $1,772 in FY 1994-95 to $2,495 in FY 1999-2000. As shown in Table 4, pharmaceutical expenditures accounted for $309 of the $723 per inmate increase.

Table 4

Factors Affecting Average Health Care Costs
FY 1994-95 through FY 1999-2000

	Per Inmate Increase	Percentage Change
Pharmaceuticals	$309	227.2%
Staffing:		
FTE salaries	112	19.3
LTEs	40	65.6
Fringe benefits	51	27.3
Subtotal	203	24.5
Professional Medical Services	104	65.4
Prison Health Services Contract	79	n.a.
Local Hospital Services	24	18.9
Other	12	8.4
UWHC Contract	(8)	(2.1)
Total	$723	40.8%

Pharmaceutical Expenditures

Most prescriptions are supplied to health services units by the Bureau of Health Services central pharmacy, which purchases pharmaceuticals in quantity through a national purchasing consortium that includes 36 states and the City of Chicago. Medications may also be purchased from local pharmacies if, for example, they are not available in the institution’s on-site stock and health services staff determine that the 24-hour wait for central pharmacy delivery would be too long for the inmate.

The Department requested additional funding for pharmaceuticals in both FY 1999-2000 and FY 2000-01.

In FY 1999-2000 and FY 2000-01, the Department faced budget shortfalls and requested additional funding from the Joint Finance Committee because its pharmaceutical expenditures outpaced budget increases based on state budget instructions. For example, the Department limited its FY 2000-01 budget request to a 3.8 percent increase per capita over its FY 1999-2000 base, although pharmaceutical costs increased approximately 47 percent from FY 1998-99 to FY 1999-2000. At its s. 13.10 meeting in April 2001, the Joint Finance Committee approved $4.2 million in additional funding for FY 2000-01.

As shown in Table 5, the number of new prescriptions and refill orders filled in the Department's central pharmacy has increased from 142,041 in FY 1994-95 to 309,332 in FY 1999-2000. Available data do not distinguish between new prescriptions and refills; however, a large number of the orders filled each month are refills, and we found that in December 2000, 6,747 inmates who were receiving at least one prescription had on average 3.12 open prescription orders. Available data indicate prescription costs have increased from $13.37 per order in FY 1994-95 to $23.24 per order in FY 1999-2000.

Table 5

Number of Prescription Orders Filled
FY 1994-95 through FY 1999-2000

Fiscal Year	Number of Inmates*	Percentage Change	Prescriptions and Refills	Percentage Change
1994-95	9,544	n.a.	142,041	n.a.
1995-96	10,824	13.4%	160,230	12.8%
1996-97	12,365	14.2	192,651	20.2
1997-98	13,149	6.3	237,344	23.2
1998-99	13,983	6.3	261,711	10.3
1999-2000	14,528	3.9	309,332	18.2

* Excludes inmates at Supermax and Prairie du Chien, who do not receive prescriptions from the central pharmacy.

The Department believes that the availability of newer drug therapies, such as Rebetron for treatment of hepatitis-C, has increased the number of inmates receiving treatment, which increases overall expenditures for pharmaceuticals. Newer drug therapies are also likely to be expensive because generic substitutes are not yet available. For example, according to a recent consultant's evaluation of pharmaceutical utilization, one day's treatment of Rebetron costs $43.30. As shown in Table 6, Rebetron ranked fifth in central pharmacy expenditures in calendar year 2000. Corrections staff in six other states also cited the rising cost of pharmaceuticals, particularly psychiatric drugs and drugs to treat HIV-AIDS, as a significant factor in increasing health care costs.

Table 6

Central Pharmacy Service Top 20 Drugs by Expenditure
Calendar Year 2000

Brand Name	Commonly Prescribed for	Total Expenditure
Seroquel	Psychotic disorders	$593,164
Risperdal	Psychotic disorders	553,531
Paxil	Depression	349,752
Zoloft	Depression	242,289
Rebetron	Hepatitis-C	239,371
Neurontin	Mood stabilizer, seizures	225,735
Prilosec	Ulcer, gastroesophageal reflux disease	224,107
Depakote	Mood stabilizer	219,542
Prozac	Depression	215,571
Zyprexa	Psychotic disorders	204,398
Zerit	HIV/AIDS	181,647
Epivir	HIV/AIDS	175,273
Lipitor	High cholesterol	141,376
Prevacid	Ulcer, gastroesophageal reflux disease	140,579
Pravachol	High cholesterol	138,808
Combivir	HIV/AIDS	131,805
Buspar	Anxiety	109,324
Remeron	Depression	104,051
Sustiva	HIV/AIDS	103,198
Celexa	Depression	83,285

The Department is acting on a consultant's recommendations for managing pharmaceuticals.

The Department has chosen to implement most, but not all, of the recommendations the consultant included in the evaluation of pharmacy costs and utilization patterns. For example, the Department will:

- use a lower-cost antihistamine that has sedative side effects unless alertness is required for inmate work responsibilities;
- stock ibuprofen as the only anti-inflammatory in health services units; and
- use controlled-release morphine, which costs $0.22 per dose, in place of Oxycontin, which costs $1.50 per dose.

However, the Department questions whether it is legal to buy larger doses of medications and split them with a pill cutter, as was recommended.

In addition to reviewing the consultant's recommendations, the Department is taking other steps to control costs, including more closely monitoring the contract with its central drug supplier, advising its physicians on more cost-effective prescribing practices, and carrying out quarterly inspections of health services units to assess inventory management.

Staffing Levels

Newer institutions have greater numbers of health care staff.

In FY 1999-2000, the Department's salary and fringe benefit costs for permanent and LTE health care employees totaled $15.3 million, compared to $7.9 million in FY 1994-95. As was shown in Table 1, the Department's 232.5 FTE health care positions include 76.8 registered nurses, 12 physicians, and 2 physician assistants. More of these health care staff have been assigned to newer institutions than to older ones. As shown in Table 7, as a group, institutions opened before July 1995 are staffed with 1 registered nurse per 198 inmates. At institutions opened after July 1995, the average staffing ratio is 1 registered nurse per 115 inmates. At the Dodge Correctional Institution, which serves as the intake institution for the entire adult system and provides 24-hour health care to seriously ill inmates from all adult institutions, there are fewer inmates per provider in each category.

While the inmate population in older institutions increased by 2,494 inmates, or 33.9 percent, from FY 1994-95 through FY 1999-2000, staffing levels at these institutions increased by 0.3 FTE registered nurses, 3.6 FTE physician assistants or nurse practitioners, and 0.5 FTE physicians, which is a total position increase of 7.8 percent.

Table 7

Staffing Ratios at Adult Correctional Institutions
FY 1999-2000

	Inmates per Physician	Inmates per Physician Assistant and Nurse Practitioner	Inmates per Registered Nurse
Institutions Opened Before July 1995			
Columbia	808	--	162
Fox Lake	1,112	--	222
Green Bay	1,002	--	200
Kettle Moraine	2,466	2,055	196
Oakhill	1,128	n.a.	161
Oshkosh	1,859	1,859	266
Racine	1,414	1,414	257
Taycheedah	1,288	644	107
Waupun	1,225	--	188
Average, Older Institutions	1,315	2,739	198
Institutions Opened After July 1995			
Jackson	971	971	194
Prairie du Chien*	1,188	594	85
Racine Youthful Offender	790	--	99
Supermax**	1,010	101	36
Average, Newer Institutions	954	706	115
Dodge Correctional Institution****	495	371	83
Total, All Institutions	1,062	1,298	158

* Health services unit operated by Prison Health Services.

** Health services unit operated by Prison Health Services. Ratio of inmates to staff is based on contract specifications for 101-200 inmates.

*** Dodge Correctional Institution includes staff for the infirmary, the dialysis unit, and the health services unit.

Professional Medical Services Expenditures

315 vendors received payment for professional medical services in FY 1999-2000.

Supplementary medical, laboratory, dental, and optical services, including orthopedic, radiology, and nursing services that health services units are either unable to provide with current staff or cannot provide cost-effectively, are provided under professional medical services contracts. As shown in Table 8, total expenditures for these services have increased steadily from $1.52 million in FY 1994-95 to $3.93 million in FY 1999-2000. Our review of the Department's accounting records indicates that a total of 315 vendors received payment for professional medical services in FY 1999-2000.

Table 8

Professional Medical Services
FY 1994-95 through FY 1999-2000
(in millions)

	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000
Medical	$1.26	$1.35	$1.58	$2.13	$2.11	$2.82
Laboratory	0.18	0.24	0.33	0.37	0.50	0.69
Dental	0.07	0.11	0.14	0.22	0.29	0.39
Optical	0.01	0.01	0.03	0.02	0.04	0.03
Total	$1.52	$1.71	$2.08	$2.74	$2.94	$3.93

Improved management of contracts for professional medical services is necessary.

The increase in total expenditures for professional medical services can be explained, in part, by changes in the inmate population. For example, higher optical expenditures are likely to result from the increasing number of older inmates, who are more likely to need optical health care. However, we found that the Department does not regularly or centrally review all of its professional medical services contracts. Because there is no regular review of basic management information regarding professional medical services contracts, such as how many are currently in effect and contract rates, there is no assurance that individual institutions are obtaining the best value in their contracting practices.

The Department recently began investigating the feasibility of internally reallocating a full-time business manager position to improve contract

management in the Bureau of Health Services, and in February 2001 it began an internal review of two significant contracts. However, because of the significant growth in expenditures for professional medical services, *we recommend the Department of Corrections identify and review all professional medical services contracts, including those for medical, laboratory, dental, and optical services, to determine whether costs can be controlled by either seeking better rates with alternate vendors or consolidating contracts*.

Hospital Services

UWHC received $5.5 million in FY 1999-2000 to provide both inpatient and outpatient care to inmates.

As shown in Table 9, expenditures for hospital services increased 62.5 percent from FY 1994-95 through FY 1999-2000, from $4.8 million to $7.8 million. UWHC, which contracts with the Department to provide inpatient and outpatient care for the adult system, minimum-security correctional centers operated by the Division of Community Corrections, and juvenile institutions, is the principal provider for hospital services. In FY 1999-2000, UWHC received $5.5 million for services provided to inmates in the adult system. Local hospitals provide emergency services and may be used to reduce travel costs associated with trips to UWHC.

Table 9

Hospital and Clinic Expenditures
FY 1994-95 through FY 1999-2000
(in millions)

	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	Percentage Change
UWHC	$3.6	$3.4	$3.3	$4.4	$4.6	$5.5	52.8%
Local Hospitals	1.2	0.9	2.1	1.9	1.9	2.3	91.7
Total	$4.8	$4.3	$5.4	$6.3	$6.5	$7.8	62.5%

Local hospitals are providing more medical services to inmates.

Expenditures for inmate care at local hospitals, which totaled $2.3 million in FY 1999-2000, have increased by nearly 92 percent since FY 1994-95. In FY 1999-2000, they included approximately $700,000 paid to Waupun Memorial Hospital for male inmates, as well as approximately $500,000 to Agnesian Healthcare in Fond du Lac for

female inmates at the Taycheedah and Dodge Correctional Institutions. We note that Waupun Memorial Hospital is paid usual and customary rates because the Department had not established a contract with it. The degree of savings that could have been generated if a contract containing a discounted rate had been in place is not known.

Based on data collected by UWHC in 1999, the typical inpatient stay for inmates is approximately five days, and their average age is just over 41. On a single day in December 2000, 15 inmates whose diagnoses included skin ulcers, vertigo, gastrointestinal bleeding, and cardiac problems received inpatient services at UWHC. In FY 1999-2000, the UWHC clinics most frequently visited by inmates receiving either inpatient or outpatient services were:

- ophthalmology;
- orthopedics;
- general, neurological, plastic, and thoracic surgery;
- infectious disease and immunology;
- otolaryngology (ear, nose, and throat);
- gastroenterology;
- urology;
- cardiology, cardiac surgery, and hypertension;
- transplants and podiatry; and
- the cast room.

Although UWHC is the Department's principal off-site health care provider, we found that contracts for service have not been signed before the beginning of each of the past five fiscal years, when the previous contract would have expired. For example, the FY 2000-01 contract for services was not signed until March 2001. UWHC officials have expressed frustration with delays in reaching a contract agreement with the Department, and the FY 2000-01 contract has been changed to address payments for inmates who are treated at other hospitals when UWHC has insufficient beds. However, the number of inmate visits to UWHC projected in the contract for billing adjustment purposes remained unchanged from the previous contract: 5,000 outpatient days and 450 inpatient visits. As shown in Table 10, the number of visits, particularly outpatient visits, exceeded this target.

Table 10

Change in the Number of Medical Visits to UWHC
FY 1994-95 through FY 1999-2000

Type of Visit	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	Percentage Change
UWHC Inpatient	440	401	491	485	466	495	12.5%
UWHC Outpatient	4,655	4,240	4,030	4,686	5,343	7,202	54.7
Total Visits	5,095	4,641	4,521	5,171	5,809	7,697	51.1%

Increased inmate use of health care at UWHC has led to higher contract costs.

The Department's FY 1999-2000 payment of $5.5 million to UWHC was approximately $800,000 more than budgeted. Higher costs for UWHC services appear to result from increased base contract fees, an increased number of outpatient and inpatient visits, and moderately higher billing adjustments for more visits than were projected in the contract. The base contract fee increased 328.3 percent, from an estimated $196,500 in FY 1994-95 to an estimated $841,600 in FY 1999-2000. The largest single-year increase occurred between FY 1995-96 and FY 1996-97, when the base fee increased by $325,150.

Through a central review process for each scheduled visit, the Department attempts to minimize the number of individuals receiving care at UWHC by taking steps to ensure no inmate has an appointment at the hospital or clinics unless it is medically necessary.

Health Care Expenditures in Other States

Although health care costs have increased significantly since FY 1994-95, Wisconsin spends less per inmate for health care than several neighboring states, and less than states that have comparable prison populations and rates of growth. We collected information on prison health care from Michigan, Minnesota, and Illinois, as well as from Colorado and Tennessee, which have comparable inmate populations and rates of growth, and Arizona, which the Department has used as a comparison state when analyzing staffing levels. It should be noted, however, that direct comparisons are not always possible because these states' correctional systems differ from Wisconsin's in terms of the number and size of facilities, distance between facilities, types of inmate health problems, levels of care provided, security issues, and use of private vendors.

As shown in Table 11, among the other six states for which we gathered data, only Tennessee and Illinois had lower per inmate expenditures for prison health care than Wisconsin's in FY 1999-2000. Illinois' costs are lower than Wisconsin's, in part, because Illinois figures do not include costs for inmates with HIV. In addition, Illinois contracts with private health care vendors for all its prison health care clinics. Illinois officials believe they have been able to control prison health costs through competitive bidding and aggressive contract oversight.

Table 11

Comparison of Average Health Care Cost per Inmate
FY 1995-96 through FY 1999-2000

State	1995-96	1996-97	1997-98	1998-99	1999-2000
Colorado	n/a	n/a	$2,000	$3,216	$3,935
Minnesota	$3,880	$3,402	3,708	3,427	3,536
Arizona	2,160	2,143	2,319	2,571	2,616
Michigan	2,368	2,353	2,311	n/a	n/a
Wisconsin	1,745	1,929	2,120	2,182	2,495
Tennessee	2,499	2,477	2,242	2,130	2,177
Illinois*	1,352	1,291	1,298	1,364	1,506

* Illinois figures do not include costs for inmates with HIV/AIDS.

Tennessee officials report that they reduced health care expenditures through volume purchasing, centralized budgeting and supervision of health care, and a utilization management system for review of referrals for specialty care. In addition, all state agencies in Tennessee use the same multi-state alliance to purchase prescription drugs that Wisconsin's Department of Corrections uses. Although Minnesota's average health care costs per inmate were higher than Wisconsin's in each of the five years for which we collected information, Minnesota reported that its cost savings from FY 1995-96 through FY 1999-2000 were created by closing a secure unit at a local hospital; using centralized purchasing; and employing less-expensive health professionals, such as licensed practical nurses and certified medical assistants, whenever possible.

With the exception of Tennessee, Wisconsin employs significantly fewer professional health care staff per inmate than our comparison states. For example, as shown in Table 12, Minnesota has nearly three times as many registered nurses per inmate as Wisconsin does.

Unlike Wisconsin, Arizona, Colorado, and Michigan have formal staffing guidelines to ensure that inmates at all institutions receive comparable levels of service through equivalent staffing levels. However, we were unable to determine the extent to which these states actually meet their guidelines.

Table 12

Comparison of Health Care Staffing Ratios
FY 1998-99

	Inmates per Physician	Inmates per Physician Assistant and Nurse Practitioner	Inmates per Registered Nurse	Inmates per Health Care Provider*
Minnesota	1,194	1,492	54	50
Colorado	746	522	99	75
Arizona	625	1,188	107	85
Michigan	2,027	3,586	107	99
Wisconsin	1,023	1,377	156	123
Tennessee**	1,735	1,252	236	178

* Includes physicians, physician assistants, nurse practitioners, and registered nurses.
** Tennessee data are for calendar year 1999.

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Emergency health care is provided to inmates when an acute illness or an unexpected health need cannot be deferred. Correctional officers play an important role in responding to medical emergencies because they determine whether health care staff should be called. If an inmate is unable to speak, is unconscious, or is otherwise unable to communicate his or her own needs, correctional officers contact the health services unit by telephone or radio. Health care staff may respond to calls for emergency health needs in three ways: by attending to the inmate wherever he or she is located, by requesting that the inmate come to the health services unit, or by calling for emergency ambulance service.

Not all institutions' emergency response plans and procedures meet the Department's requirements.

Department policies require that each institution develop its own emergency response plan and procedures and establish certain minimum requirements, including that health services unit staff coordinate the provision of 24-hour emergency health care and that staff capable of providing basic life support—that is, early recognition of a cardiopulmonary or cardiovascular emergency and the attempt to resuscitate the victim—be on site. A recent internal audit of seven health services units and the infirmary at the Dodge Correctional Institution found that all had developed emergency medical plans, although four of the seven did not meet requirements for training and practice drills, and two did not have required plans for emergency medical evacuation.

Volume of Emergency Requests

In FY 1999-2000, health care staff responded to 8,137 medical emergencies.

As shown in Table 13, health care staff responded to 8,137 emergencies in FY 1999-2000, or approximately 22.2 per day. Of these, 746 required transportation to an emergency room at a local hospital, either by an institution vehicle or by ambulance.

The Department has taken some steps to reduce the number of off-site emergencies. For example, in January 1998 the Department began on-call physician coverage for evenings and weekends when physicians are not at institutions. On-call coverage allows health services staff to consult a physician to determine whether it is necessary to send an inmate to a local emergency room.

Table 13

On-site and Off-site Emergency Treatment
FY 1994-95 through FY 1999-2000*

Fiscal Year	On-site Treatment	Off-site Transfer	Total Emergencies
1994-95	5,424	757	6,181
1995-96	5,090	714	5,804
1996-97	5,229	920	6,149
1997-98	5,720	1,440	7,160
1998-99	6,195	572	6,767
1999-2000	7,391	746	8,137

* Supermax did not report emergency data.

Emergency Health Care Training for Correctional Officers

Not all correctional officers are current in CPR and emergency training.

Correctional officers are typically the first staff to attend to inmates who need health care, and NCCHC standards require that each correctional officers who works with inmates be trained at least once every two years in cardiopulmonary resuscitation (CPR), first aid, procedures for appropriate referral for health complaints, and recognition of the need for emergency care in life-threatening situations. Not all of the Department's correctional officers are CPR-certified, and some institutions report having lapsed nearly all correctional staff's CPR certifications because of a lack of training resources.

In 2000, the Department assessed whether to require all institutions to implement an emergency medical first responder program. First responders are trained and equipped to deal with a wide range of medical emergencies beyond those covered by basic life support, CPR, and defibrillator training.

As a result of this assessment, an internal working group recommended:

- training in basic first aid and basic life support/CPR, including a defibrillator component for all institution staff;

- establishment of a medical first responder program in all institutions where it is documented that the emergency medical response service from a 911 call to patient contact is ten minutes or more; and

- 24-hour on-site health care staffing at all institutions.

The Department has determined, however, that it will not implement 24-hour health coverage at all institutions and that because of the costs involved, each institution will determine its own need for a first responder program.

In April 2001, the Secretary issued an executive directive requiring that correctional officers be trained and updated in first aid, CPR, and the use of defibrillators and that staffing patterns provide trained officers who will provide CPR on all shifts. Other officers may elect not to provide CPR for personal, medical, or religious reasons. The Governor's 2001-03 Biennial Budget Proposal includes $264,200 in GPR over the biennium for CPR and defibrillator training.

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As many as 1,000 requests for routine medical care are received daily.

Providing routine medical care to inmates is challenging, given the large number of requests the health services units receive each day and the significant incidence of chronic illnesses in Wisconsin's adult inmate population. Staff in health services units review as many as 1,000 requests for non-urgent medical care each working day, including requests for prescription refills, appointments with medical staff, dental services, and medical information. In addition to addressing requests for care of chronic illnesses or routine health matters, they must also successfully manage health assessments and screenings for new inmates, schedule appointments in order to avoid excessive waits for service, conduct follow-up appointments as needed, process prescribers' orders and prescriptions, and monitor the effects of prescriptions on inmate health.

Volume of Routine Medical Care Requests

Health services unit staff at the 14 adult institutions received 5,161 requests for non-urgent medical care during a five-day week that we sampled in October 2000, when the inmate population was 13,377. Requests are made in writing. In most institutions, inmates place their written request forms in a box or bag in their housing unit, and a correctional officer, nurse, or inmate worker collects the forms and delivers them to the health services unit.

As shown in Table 14, the number of requests per 100 inmates differed significantly by institution and ranged from a high of 82.1 at Taycheedah to a low of 10.1 at Prairie du Chien. Both Prairie du Chien and the Racine Youthful Offender Correctional Facility, which are two of the three institutions with the lowest number of requests per 100 inmates, house younger offenders. Department staff indicates these inmates are typically healthier than older inmates and, therefore, they may submit fewer requests for health care.

Table 14

Health Services Requests in One Five-Day Week*

Institution	Number of Requests	Inmate Population	Number of Requests per 100 Inmates
Taycheedah	494	602	82.1
Oakhill	283	560	50.5
Jackson	476	976	48.8
Waupun	537	1,220	44.0
Fox Lake	570	1,329	42.9
Oshkosh	780	1,893	41.2
Columbia	290	823	35.2
Dodge	438	1,282	34.2
Supermax	104	320	32.5
Kettle Moraine	395	1,238	31.9
Racine	453	1,439	31.5
Racine Youthful Offender	95	399	23.8
Green Bay	216	998	21.6
Prairie du Chien	30	298	10.1
Total	5,161	13,377	38.6

* For all but three institutions, data are based on a single week in October 2000. Columbia, Racine Youthful Offender, and Supermax data are from different weeks in October and November 2000.

According to health services unit staff, most inmate requests involve prescription refills that do not always require an appointment with a health care provider. Data for all institutions were not available, but in a review of health services request forms from one institution for one week in October 2000, we found:

- 63.9 percent were for prescription refills;
- 18.2 percent were requests to see health services unit staff;
- 9.9 percent were requests for dental services; and
- 8.0 percent were for medical information, for which health services unit staff commonly provide a written response.

Department policy requires written requests for health care to be reviewed within 24 hours.

The Department's written policy requires health services request forms to be reviewed within 24 hours so that inmate health needs can be prioritized within each institution. In our fall 2000 survey of health services units, clinic managers at all institutions except at Taycheedah reported that requests are reviewed within 24 hours of receipt by health services unit staff. Taycheedah reported a backlog of 218 health services request forms.

During a site visit to Taycheedah in October 2000, we found a file of 243 health services request forms for which inmates were waiting to see a medical professional, although the request forms had been reviewed. Of these forms, 105 were dated more than three weeks prior to our visit. We noted no similar volume of pending requests at other health services units. Taycheedah staff report that beginning March 1, 2001, staffing changes were implemented to allow health services unit staff there to review all request forms within 24 hours. The backlog occurred because of staffing difficulties, and as of March 13, 2001, the Department reports all pending requests have been resolved.

We were not able to determine how long it takes a prisoner to see health care staff because the Department does not maintain this information. Information retrieved from health services units' appointment schedules would not necessarily reflect backlogs or waiting lists for services, because some follow-up appointments are scheduled weeks or months in advance.

Health Requests by Inmates in Segregation

With the exception of Supermax and Prairie du Chien, inmates in segregation are not visited daily by health services unit staff.

Inmates held in segregated custody or solitary confinement for their own protection or because they violated the Department's rules must obtain health services request forms from correctional officers, who then forward the forms to health services unit staff. The Department does not collect data regarding the number of times that inmates in segregation have not been able to see health care professionals. However, for our survey period, health services unit staff reported substantial variation in the frequency with which they visited inmates in segregation. For example:

- at Prairie du Chien and Supermax, health services unit staff—who are employed by a vendor working under contract with the Department—report that they visit segregated inmates every 24 hours, seven days a week;

- at Columbia, Dodge, and Waupun, health services unit staff report visiting segregated inmates every 24 hours, although it is not clear whether daily visits include weekends;

- at Green Bay, Racine Youthful Offender, and Taycheedah, health services unit staff report visiting segregated inmates every 48 hours;

- at Fox Lake and Kettle Moraine, health services unit staff report visiting segregated inmates three times per week;

- at Jackson, health services unit staff report visiting segregated inmates less than once every four days; and

- at Oakhill, Oshkosh, and Racine, health services unit staff report visiting segregated inmates as needed or upon request.

The NCCHC standards require direct access to health care staff for inmates in segregation, as well as daily visits. Health care staff in Arizona, Colorado, Illinois, Michigan, Minnesota, and the federal Bureau of Prisons are reported to visit segregated inmates daily, including weekends. Health care staff in Tennessee report visiting segregated inmates five days per week.

Inmates with Chronic Illnesses

Because the Department does not maintain reliable system-wide data regarding all chronic illnesses in the adult inmate population, we estimated the number of chronically ill inmates using surveys of each health services unit, an analysis of central pharmacy data, inpatient and outpatient visit information collected from UWHC, and additional information obtained from the Bureau of Health Services. In our estimate, chronically ill inmates include inmates with:

- mental illness, narrowly defined as those who were prescribed psychotropic medications by a psychiatrist and those receiving treatment at the Wisconsin Resource Center;

- cardiac conditions, including hypertension, angina, heart murmur, and congestive heart failure;

- asthma, narrowly defined as those who received treatment with an inhaler or nebulizer;
- neurological conditions, including multiple sclerosis, epilepsy, spina bifida, and Parkinson's disease;
- diabetic conditions, both insulin-dependent and non-insulin dependent;
- gastrointestinal conditions, including irritable bowel syndrome, ulcers, and gastroesophageal reflux disease;
- hematological conditions, including anemia, leukemia, and sickle cell anemia;
- women's health conditions, including irregular Pap test results, estrogen replacement therapy, hysterectomy, and pregnancy; and
- other chronic illnesses or conditions, including cancer, HIV/AIDS, cirrhosis, paraplegia and quadriplegia, deafness, blindness, osteoarthritis, orthopedic conditions, and hepatitis-C.

Approximately one-third of Wisconsin's inmates have at least one chronic illness.

Using this definition of chronic illness, an estimated 5,110 adult inmates, or one-third of those held in Wisconsin correctional institutions, have at least one chronic illness or condition. An estimated 61.2 percent of female inmates are chronically ill. Additional information on female inmates' health is provided in Appendix 4.

As shown in Table 15, the percentage of each institution's population that is chronically ill varies considerably. An estimated 72.1 percent of inmates at Taycheedah, which houses most but not all female inmates, had at least one chronic illness in fall 2000, compared to 18.4 percent at Prairie du Chien and 22.7 percent at the Racine Youthful Offender Facility.

Inmates at Taycheedah have the highest incidence of chronic illness.

The prevalence of chronic illness appears to affect how difficult it is for health services unit staff to manage inmates' health care needs. For example, health care staff at Prairie du Chien, who are employed by a vendor working under contract with the Department, indicated to us that managing the health care needs of the inmates was less complex than some of their previous jobs in the health care industry, because the population they serve is generally healthy. On the other hand, staff at Taycheedah report that they face significant challenges because of the number of chronically ill inmates they care for.

Table 15

Number of Inmates with at Least One Chronic Illness
Fall 2000

Institution	Number Chronically Ill (Estimated)	Institution Population	Percentage of Population
Taycheedah	465	645	72.1%
Columbia	361	797	45.3
Oshkosh	735	1,879	39.1
Dodge	474	1,464	32.4
Waupun	391	1,211	32.3
Kettle Moraine	383	1,206	31.8
Oakhill	162	545	29.7
Green Bay	278	1,008	27.6
Supermax	86	314	27.4
Jackson	261	964	27.1
Racine	391	1,447	27.0
Fox Lake	341	1,327	25.7
Racine Youthful Offender	89	392	22.7
Correctional Centers	361	1,625	22.2
Prairie du Chien	54	293	18.4
Wisconsin Resource Center	278	278	100.0
Total	5,110	15,395	33.2

The most common chronic illnesses are mental illness, cardiac conditions, and asthma.

The most common chronic illnesses in Wisconsin prisons are mental illness, cardiac conditions, asthma, and neurological disorders, and chronically ill inmates may have more than one of these conditions. As shown in Table 16, we counted 7,867 cases of chronic illness among the 5,110 inmates diagnosed with at least one chronic illness.

Table 16

Number of Diagnosed Chronic Conditions
Fall 2000

Condition	Estimated Number of Cases
Mental Illness	2,642
Cardiac	1,636
Asthma	1,239
Neurological	805
Diabetic	414
Gastrointestinal	317
Hematological	159
Endocrine	156
Women's Health Conditions	135
Other	364
Total	7,867

Initial Health Assessments

All inmates are to receive health assessments within 14 days of admission to the system.

According to the Department's written policy, all inmates must receive a health assessment within 14 days of admission to the system. A health assessment includes a medical history obtained from the inmate upon admission, a physical examination, a tuberculosis test, and the collection of other health-related information. Inmates are also required to receive health screenings whenever they are transferred to new institutions, and a medical chart or a health transfer summary form is required to be transported with an inmate.

Most inmate health assessments take place at the Dodge Correctional Institution, which is the primary facility for receiving new inmates. Health assessments are expected to be completed before inmates are transferred from Dodge because decisions about the institutions at which they will serve their sentences are based, in part, on medical conditions.

Information regarding the amount of time it takes to complete an initial health assessment is limited, but it supports the Department's belief that most, but not all, inmate assessments are completed within 14 days. For example, health care staff at Dodge indicate that the maximum time any male inmate waited for an initial health assessment in calendar year 2000 was 20 days, and the maximum wait for a female inmate was

24 days. Staff also reported that only a small number of inmates are transferred from Dodge to their assigned institutions without health assessments being completed.

As shown in Table 17, the number of initial health assessments required for new inmates has increased each year since FY 1994-95. In FY 1999-2000, 7,550 inmates entered the system at Dodge, which means that health services unit staff there had to conduct an average of 29 assessments per working day. They note, however, that assessments are occasionally conducted on Saturdays. Health services unit staff estimate that each intake physical requires approximately 40 minutes, for a total of 19.3 hours of nursing time per day.

Table 17

Health Assessments for New Inmates at Dodge Correctional Institution
FY 1994-95 through FY 1999-2000

Fiscal Year	New Inmates	Percentage Change
1994-95	5,918	n.a.
1995-96	6,423	8.5%
1996-97	6,619	3.1
1997-98	6,797	2.7
1998-99	7,383	8.6
1999-2000	7,550	2.3

Nearly all of the 7,550 inmates admitted to Dodge in FY 1999-2000 were subsequently transferred to other institutions. Department policy requires a separate health screening upon arrival at the assigned institution, both for continuity of care and to alert health services unit staff to incoming inmates' medical needs. Transfer screenings are less comprehensive than initial health assessments and include, at a minimum, a review of each inmate's medical record to determine if there is a need for an in-person exam. Transfer screenings are also required when inmates are re-assigned for other reasons, such as a change in security level or to receive specific programming. Department policy requires that current medications, diet, and upcoming medical appointments be reviewed on the date of transfer.

The Department does not track the average amount of time required for transfer screenings when inmates are moved to other institutions. However, a significant number of inmate transfers occur each year. Our survey of health services units showed that during one week in October 2000:

- 11 institutions reviewed 100 percent of the medical records for inmates arriving that week, which ranged from 4 at the Racine Youthful Offender Facility to 49 at the Fox Lake Correctional Institution;

- the Jackson Correctional Institution reviewed 39 percent;

- the Racine Correctional Institution reviewed 46 percent; and

- the Dodge Correctional Institution did not document how many records were reviewed for the 205 inmates arriving by transfer during the week of the survey.

As shown in Table 18, the number of inmates transferred within the state from Dodge, which represents the majority of inmate transfers, has increased from 13,543 in 1995 to 17,116 in 2000. This 26.4 percent increase resulted from:

- an increased inmate population;

- a greater number of institutions in the system; and

- an increase in transfers between institutions of the same security level, because of differences in program availability at different institutions.

Table 18

Transfers from Dodge Correctional Institution
1995 through 2000

Year	Inmates Transferred	Percentage Change
1995	13,543	n.a.
1996	19,170	41.5%
1997	16,747	(12.6)
1998	15,283	(8.7)
1999	15,844	3.7
2000	17,116	8.0

The Legislature recently required health summary forms to accompany inmates being transferred.

Concern about whether important medical information accompanies inmates who are transferred from one institution to another was recently addressed by the Legislature in 1999 Wisconsin Act 151, which requires a one-page health summary transfer form to be transported with every inmate being moved from any prison or jail in Wisconsin to another prison or jail in Wisconsin, or when inmates leave institutions for off-site appointments. The form must be completed only if an inmate's medical record is not available to send with the inmate, although it is most commonly used for inmates going to court or to temporary work assignments.

Because the transfer form was implemented on November 1, 2000, it is too early to tell whether communication of inmate health information between institutions has improved. However, early anecdotal evidence suggests that completing the form for all inmates leaving institutions for transfers, court appointments, and other off-site activities has added to the workload of health services units. The Department estimates it takes between 15 and 20 minutes to complete each form. Nonetheless, few delays in transporting inmates have been reported as a result of incomplete or missing forms.

Distribution of Controlled Medications

Under current procedures, controlled medications are delivered by correctional officers at 11 of the 14 adult institutions. Health care staff deliver most controlled medications at Green Bay and Prairie du Chien, although correctional officers deliver medications when health care staff are not present at Prairie du Chien, and they deliver most controlled medications to inmates in segregation at Green Bay. Supermax has 24-hour nursing coverage, and the Department reports that nurses

deliver all controlled medications there. Correctional officers deliver controlled medications to inmates at most institutions because the Department believes it is cost-prohibitive for health care staff to do so. For example, the Department estimates that in FY 2001-02, approximately 31 additional licensed practical nurses would be needed to deliver medications at all adult institutions.

Correctional officers are allowed to deliver controlled medications to inmates.

Controlled medications include federally controlled prescription drugs, such as sedatives and narcotic-containing painkillers, as well as other drugs that present a security risk in a prison setting because of their value for barter. The practice of having security officers deliver controlled medications is allowed by Wisconsin law and was affirmed in a 1977 Attorney General's opinion (OAG 48-77), which concluded it is acceptable for jail attendants, pursuant to instructions of a physician, to deliver controlled medications. However, NCCHC standards state that it is "always preferable" for qualified health care professionals to deliver medications, although that is not required as long as the correctional staff receive appropriate training. NCCHC staff recommend that both the correctional officer and the inmate co-sign a form confirming that the medication was delivered.

Correctional officers receive minimal training in medication delivery.

Compared to staff who deliver medications in other institutional settings, correctional officers receive only minimal training, which consists of one four-hour segment at the Department's training academy prior to their initial assignment. This training includes administrative and legal aspects of medication delivery, as well as common types of drugs and methods of delivery. However, correctional officers are not tested on the material. In contrast, staff at community-based residential facilities receive eight hours of training in medication delivery.

Staff in the Department reported a number of problems resulting from controlled medications being delivered by correctional officers rather than health care staff:

- It is often difficult to determine whether inmates are taking medications as prescribed, because medication administration reports are not always completed or are completed inaccurately by correctional officers. In some cases, correctional officers refuse to sign report forms, which ask for a nurse's signature. Incomplete or inaccurate reports make it difficult for health care staff to assess whether observed symptoms are a result of inmates not taking medication properly or of inappropriate dosage.

- Correctional officers are not trained to identify side effects of medications. For example, some psychotropic medications can have serious withdrawal symptoms if stopped abruptly. Staff reported several instances of inmates experiencing severe withdrawal symptoms when medications were interrupted because of problems with correctional officers getting medications to inmates.

- A study of FY 1998-99 medication incident reporting, performed for the Department by a private consulting firm, found evidence of significant underreporting of medication incidents by correctional officers. The study found that when nurses administered medications, institutions reported 6.6 times the number of incidents that were reported when correctional officers administered medications. However, the report emphasized that this difference reflected more reporting, and not necessarily more incidents.

Correctional officers cannot be disciplined for unintentional errors in delivering medications to inmates.

It should be noted that the current collective bargaining agreement between the Department and correctional officers exempts correctional officers from disciplinary action for unintentional errors made during the delivery of medications. The Department indicates that intentional actions by correctional officers to alter the way that inmates receive medications will result in disciplinary measures. Collective bargaining agreements covering nurses and other health care staff contain no similar exemptions. Therefore, nurses can face disciplinary action by the Department in addition to action by the Department of Regulation and Licensing if they make errors during the delivery of medications to inmates.

Health Care Staff Training

The Department believes both correctional officers and health care staff should receive more health-related training. Nursing staff in health services units receive some training to maintain their knowledge of current medical practices, but they have fewer requirements for annual training than nurses in other states we contacted. The Department also does not meet the NCCHC standard requiring a minimum of 12 hours of continuing education per year for its health care staff, and it requires less training than three of the six other states we contacted and the federal Bureau of Prisons.

The health services units at Supermax and Prairie du Chien are NCCHC accredited, and the vendor that provides health care at these institutions

requires 12 hours of continuing education per year for its health care staff. Among other states, Arizona, Colorado, and Michigan require health care staff to have 40 hours of training or continuing education annually. The federal Bureau of Prisons has a national, mandatory curriculum for annual training that includes suicide prevention, infectious disease control, emergency first aid, and preventive medicine.

In contrast, the Department's only continuing education requirements for health services unit staff are basic life support training for early recognition and response to cardiopulmonary or cardiovascular emergencies, and annual blood-borne pathogens training that fulfills requirements of the federal Occupational Safety and Health Administration. The Department also provides some funding for tuition, and the current bargaining agreement for nursing staff allows for leave time to attend training.

Staff believe that regular, ongoing training is needed because of changes in medical knowledge and treatment methods and because inmates occasionally return from UWHC with prescribed medications with which staff are unfamiliar. For example, an inmate in the infirmary at Dodge received chemotherapy prescribed at UWHC that no infirmary staff were trained to deliver. Staff indicate that training needs include:

- new medication training to address necessary assessments, side effects, and required laboratory tests;

- updates on diseases, such as diabetes and cancer, because conventional treatments change over time; and

- chemotherapy training.

Records from the Department's centralized training program indicate that this program provided only nine nurse clinicians with training specific to health care delivery in FY 1999-2000. However, responses to our survey of health services units indicate that health care staff have received in-service training at their institutions or through other community-based training opportunities.

Although wardens' personnel authority includes budgeting for health services unit staff training, most of the institutions do not have training plans, which are required for NCCHC accreditation. According to our survey, only the two institutions whose health services units are operated by a contractor and are NCCHC accredited have written plans for health care staff training. However, four of the Department's health services units reported reviewing training needs quarterly or annually.

The Department acknowledges that improvements in training are needed. As part of its health services action plan, it has designed but not yet implemented an orientation program for health services unit staff and all newly hired health care managers. To improve training provided to correctional officers and staff, *we recommend the Department of Corrections*:

- *develop a plan to provide at least 12 hours of annual continuing education and staff development for health care staff; and*

- *provide correctional officers with increased training in the delivery of controlled medications*.

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In FY 1999-2000, the Department spent $84.9 million to house 4,665 inmates, or approximately 23.6 percent of its population, in contract bed facilities. About 70 percent of these inmates were male and housed in out-of-state facilities operated by a single contractor: the Corrections Corporation of America (CCA). In December 2000, the Department housed male inmates at five out-of-state CCA facilities: Appleton, Minnesota; North Fork, Oklahoma; Whiteville, Tennessee; Mason, Tennessee; and Tallahatchie, Mississippi. Some female inmates were held in a Correctional Services Corporation facility in McCloud, Oklahoma. The Department also held contracts for bed space with the federal Bureau of Prisons and with the Columbia, Jefferson, Manitowoc, Oneida, Outagamie, St. Croix, and Vilas county jails. Because of the relatively small number of inmates held in federal and county facilities, and because the female inmates have been returned to Wisconsin, we limited our review to the Department's oversight of health care provided in CCA facilities.

The Department's contract with CCA requires compliance with NCCHC standards.

The expectations for delivery of health care to inmates are included in the contract between CCA and the Department. The contract requires CCA to provide physical, dental, and mental health care according to the standards identified by NCCHC, although accreditation is not required. Whenever the Department determines that a CCA facility is out of compliance with any of the terms of the contract, the Department may seek financial damages or terminate the contract. However, the contract states that "inmates needing regular, reoccurring, off-site specialty referrals for medical concerns" will not be sent to CCA facilities.

Contract Monitor Visits

The contract monitors do not systematically review compliance with contract requirements.

Site visits, both announced and unannounced, are the Department's primary method for determining whether the CCA facilities meet the health care requirements defined by the contract. In FY 1999-2000, the Department employed 3.0 FTE health services contract monitors to conduct these visits and provide oversight of the health care elements of the CCA contract, at an estimated cost of $161,100 for salary, fringe benefits, and travel expenditures. Our interviews and review of site visit reports conducted in FY 1999-2000 found that most of the contract monitors' activities pertained to addressing individual inmate complaints. In addition, health services contract monitors evaluated other elements of health service delivery in CCA facilities. However, they did not conduct systematic reviews to determine the quality of care

provided, nor did they regularly seek to assess CCA compliance with NCCHC standards.

Health services contract monitors' position descriptions include on-site activities other than contract compliance monitoring, such as investigating inmate complaints regarding health care. In addition, the contract monitors analyze medical records for inmates who have been recommended for medical transfer back to Wisconsin and conduct meetings with inmates to assess satisfaction with services. Contract monitors receive individual complaints directly from inmates, as well as from the Department's other monitoring teams and from third-party sources that include inmates' families, advocacy groups, and legislators.

Investigation of inmate complaints may help to identify needed improvements of health service delivery; therefore, the investigation of complaints should be conducted consistently and systematically at all facilities. However, at the present time, the Department provides little guidance to ensure consistency. Because it appears staff allocate the majority of their site visit time to pursuing complaints, the Department could consider developing a system to prioritize the complaints that require review by the health services contract monitors.

The Department could also consider improving the site visit process by ensuring tasks that can only be completed on-site are addressed first during facility visits. We found that in 10 of the 12 reports completed in FY 1999-2000, the monitors reported spending time reviewing medical records to assess compliance with a number of requirements or to determine whether an inmate should be recommended for medical transfer. If monitors requested pertinent portions of the medical records to be delivered to them before their site visits, the reviews could be conducted in Wisconsin and site visit time could be allocated to other contract monitoring activities.

Enforcement of Contract Provisions

In an 18-month period, contract monitors recorded 63 separate problems in out-of-state facilities.

Although we found that most health services contract monitors' activities pertain to addressing individual inmate complaints, one of their primary responsibilities is to ensure CCA's compliance with the terms of its contract, which include delivery of health care according to NCCHC standards. Contract monitors frequently find problems with health care provided to inmates in CCA facilities and work with the vendor to correct them. For example, in the site visits conducted between June 1999 and January 2001, the contract monitors recorded a total of 63 problems in their monitoring reports. These problems in CCA facilities were in three categories: administrative, health care delivery, and infection control. The contract monitors state that all of the problems identified in their findings have been addressed by CCA.

According to the administrative findings in the reports, monitors found staff vacancies in health services units at three institutions. In addition, monitors expressed concern regarding differences between the Department's drug formulary and the formulary used by the CCA facility in Appleton, Minnesota. Monitors also noted that four CCA health services units were using forms that were either different from or duplicative of forms required and used by the Department. It should be noted that even though this latter concern was first identified at North Fork, Oklahoma, in July 1999, and a letter to the facility from the Division Administrator was sent in October 1999, the contract violation was not resolved by CCA until March 2000. Department health services contract monitors continue to monitor the facilities' compliance with this requirement.

Monitors have reported problems with staffing and health service delivery at some CCA facilities.

Problems with health care delivery noted in the site reports include concerns at the Whiteville and North Fork facilities regarding medication administration practices and documentation. In addition, monitors reported that some inmates who needed dental, optometry, and radiology services, as well as hearing tests and devices, were being denied those services while at the Whiteville facility. In August 2000, the contract monitors reported insufficient dental services at the facility in Appleton, Minnesota. The warden at the facility indicated that some requests for dental and hearing devices were not met, in part, because the needs were identified before inmates were transferred to the facility. The Department responded that CCA was obligated by contract to fulfill the medical needs of these inmates, who the Department did not believe exhibited health conditions that precluded their transfer to a CCA facility. The dentist at the facility also contended that the Department was sending too many prisoners who needed "extensive" dental work. Later reports did not indicate whether the inmates received the needed services.

Other concerns noted by the monitors pertained to infection control. Specifically, the monitors reported findings in July 2000 that the North Fork facility lacked guidelines for the appropriate treatment and monitoring of inmates with hepatitis-C. In addition, one report indicated that inmates shared blood testing equipment when checking their insulin levels. The monitors also could not determine whether CCA staff followed required protocol for inmates with positive skin tests for tuberculosis.

The Department reports it is continuing to monitor the contracts and notes that the number of inmates housed in out-of-state contract facilities is projected to decline to 1,292 by FY 2002-03.

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The Department provides three levels of mental health care to inmates:

- ambulatory, for inmates who have episodic or mild mental illness that is appropriately managed on an outpatient basis by clinical staff located in the institution;
- intermediate, for inmates whose conditions are ongoing and stabilized with medication, but which make them vulnerable in the general prison population; and
- severe, for inmates with acute mental illnesses whose conditions are unstable.

The Department provides mental health care at each institution and in specialty units.

Ambulatory care is provided at each of the 14 adult institutions by a psychological services unit, and the inmates receiving this care remain part of the institution's general population. Intermediate care for male inmates is provided at the special management units at Dodge and Columbia, and inmates receiving treatment at these units are separated from the general population. Female inmates receive intermediate care at Taycheedah. Male inmates with acute mental illnesses are transferred to the Wisconsin Resource Center, a medium-security treatment facility operated by the Department of Health and Family Services. Female inmates who require more intensive treatment than can be provided at Taycheedah can be transferred to Winnebago Mental Health Institute if a civil commitment is obtained.

Psychiatric prescription orders have increased 68 percent since FY 1996-97.

Although staff reported that the incidence of mental illness among inmates has increased in recent years, the Department does not maintain statistics on the number of inmates with a diagnosed mental illness. We estimate there were 2,642 mentally ill inmates in December 2000, based on the number of inmates for whom psychotropic medications were prescribed by the Department's psychiatrists, or who were receiving treatment at the Wisconsin Resource Center. To further evaluate the extent to which mental illnesses are treated in the prison system, we reviewed the number of prescription orders written by the Department's psychiatrists and filled by its central pharmacy from FY 1996-97 through FY 1999-2000. As shown in Table 19, the number of psychiatric prescription orders filled by the central pharmacy rose by 68.0 percent during this period.

Table 19

Inmate Population and Psychiatric Prescription Orders
FY 1996-97 through FY 1999-2000

	1996-97	1997-98	1998-99	1999-2000	Percentage Change
Number of Inmates*	12,365	13,149	13,983	14,528	17.5%
Psychiatric Prescriptions and Refills	60,389	83,025	88,278	101,456	68.0

* Includes correctional centers but does not include facilities that do not get their medications from central pharmacy: Prairie du Chien, Supermax, and the Wisconsin Resource Center.

Ambulatory and Intermediate Mental Health Care

A primary resource for mental health treatment is the staff in the institutions' psychological services units, which are separate from the health services units and are typically staffed with psychologists and crisis workers who provide mental health therapy to inmates. As shown in Table 20, the number of staff providing mental health care in all adult institutions, excluding staff who provide sex offender, alcohol, and drug abuse programming, increased by 22.0 percent during the same period that the total inmate population increased 20.7 percent. However, the number of mental health staff decreased or remained unchanged at 6 of the 14 institutions. Although the increase in staff kept pace with the increase in the inmate population, it did not increase at the same rate as the increase in the incidence of mental illness in the population.

Table 20

Psychological Services Staffing in Adult Institutions
FY 1996-97 through FY 1999-2000

	1996-97	1997-98	1998-99	1999-2000	Percentage Change
Psychological Services Staff Positions*	56.75	67.25	65.25	69.25	22.0%
Inmate Population	12,365	13,415	14,280	14,926	20.7
Inmates per Position	218	200	219	216	(0.9)

* Does not include psychiatrists or staff for alcohol, drug, and sex offender programs.

Expenditures for psychological services were $5.4 million in FY 1999-2000.

System-wide expenditures for psychological services staff have increased at a faster rate than the inmate population. As shown in Table 21, mental health expenditures other than pharmaceutical expenditures, which are primarily staffing costs, rose 73.4 percent, from $3.1 million in FY 1996-97 to $5.5 million in FY 1999-2000. The reasons for this increase include significantly increased expenditures for psychiatrists, increases in amounts paid for contracted psychiatric services, and increases in expenditures for psychological services staff. While psychologists and other psychological services professionals provide counseling and day-to-day monitoring of inmates' conditions, it is the psychiatrists who prescribe psychotropic medications and monitor the effectiveness of those treatments.

Table 21

Mental Health Expenditures*
FY 1996-97 through FY 1999-2000

	1996-97	1997-98	1998-99	1999-2000	Percentage Change
Psychological Services Staff	$2,609,323	$3,081,669	$3,618,213	$3,878,277	48.6%
Psychiatrists	374,274	571,374	696,563	975,694	160.7
Contracted Clinical Services	n.a.	339,016	301,415	466,920	n.a.
Central Office Costs	83,212	158,469	125,213	78,158	-6.1
Supplies and Services	78,988	38,138	75,939	57,034	(27.8)
Total	$3,145,797	$4,188,666	$4,817,343	$5,456,083	73.4

* Excludes pharmaceutical costs and costs for sex offender, alcohol, and drug abuse programming.

Taycheedah has the most mentally ill inmates per psychological services staff position.

We compared the number of staff who provide therapy services to the number of mentally ill inmates at each institution and found significant variation by institution, as shown in Table 22. For example, among medium-security institutions, Oshkosh had 86 inmates per psychological services staff position in December 2000, while Jackson had 14. Excluding the Wisconsin Resource Center, where all inmates have a mental illness, Taycheedah has the largest inmate to staff ratio for psychological services staff.

Table 22

Psychological Services Staffing Ratios*
December 2000

Institution	Mentally Ill Inmates per Psychological Staff
Taycheedah	132
Correctional Centers	87
Oshkosh	86
Columbia	42
Green Bay	42
Kettle Moraine	37
Waupun	35
Racine	32
Fox Lake	28
Dodge	20
Supermax	16
Prairie du Chien	14
Jackson	14
Oakhill	13
Racine Youthful Offender	10
System-wide Ratio	34

* Excludes psychiatrists.

Because psychotropic medications prescribed by psychiatrists can have serious side effects, and reactions to medication can change over time, the American Psychiatric Association recommends a minimum of 1 psychiatrist for every 150 patients on psychotropic medications. While this standard has not been specifically suggested for a correctional environment, it is an indication of community standards. None of the institutions appears to meet this standard. Furthermore, as shown in Table 23, the ratio for all adult institutions is 1 psychiatrist per 426 inmates prescribed psychotropic medications, which is nearly three times the American Psychiatric Association recommendation.

Table 23

Psychiatric Staffing Ratios
December 2000

Institution	Psychiatrist Positions*	Mentally Ill Inmates**	Mentally Ill Inmates per Psychiatrist
Oshkosh	0.50	386	772
Kettle Moraine	0.23	165	733
Racine Youthful Offender	0.10	60	600
Green Bay	0.30	177	590
Racine	0.33	189	582
Fox Lake	0.20	110	550
Taycheedah	0.60	330	550
Supermax	0.10	48	480
Waupun	0.40	191	478
Jackson	0.19	82	437
Correctional Center System	0.30	87	290
Prairie du Chien	0.10	27	270
Columbia	1.00	249	249
Dodge	1.00	230	230
Oakhill	0.20	33	165
Total/System-wide Ratio	5.55	2,364	426

* Full-time equivalent LTEs.
** Excludes 278 mentally ill inmates at the Wisconsin Resource Center.

Availability of psychiatric services, including medication monitoring, varies among institutions.

There also does not appear to be a direct relationship between the number of hours psychiatrists spend at individual institutions and the number of inmates being treated with psychotropic medications. Based on scheduling information for LTE psychiatric services at the institutions, we determined that the ratio of psychiatrists to inmates taking psychotropic medications ranges from 1 psychiatrist per 772 inmates at Oshkosh, or more than five times what the American Psychiatric Association recommends, to 1 psychiatrist per 165 inmates at Oakhill. The Department notes that variations in mental health staffing are affected by population and specialized programming provided at each institution.

Because of the apparent increase in the incidence of mental illnesses, and because variations in staffing and expenditures among institutions do not appear to be related to levels of mental illness at the institutions, *we recommend the Department of Corrections examine the allocation of mental health resources to ensure that, within available resources, the mental health needs of inmates are met in an equitable and efficient manner*.

Wisconsin Resource Center

The Wisconsin Resource Center houses both sexually violent persons and inmates with acute mental health needs.

The number of beds available at the Wisconsin Resource Center for inmates requiring acute psychiatric and psychological care has been reduced in recent years because of the large number of sexually violent persons being civilly committed under ch. 980, Wis. Stats. Chapter 980 was enacted in 1994 and provides for the civil commitment of persons who have been convicted of sexual offenses and who have completed their prison sentences, but who are considered dangerous due to a mental disorder that makes it probable they will engage in further acts of sexual violence. Wisconsin Resource Center officials reported that the Department originally expected only six to eight commitments per year. However, as shown in Table 24, 94 sexually violent persons were civilly committed in FY 1995-96, and by FY 1999-2000 the number of civilly committed sexually violent persons totaled 224. These individuals occupied almost half of the beds available at the Center.

Table 24

Wisconsin Resource Center Population
FY 1995-96 through FY1999-2000

Fiscal Year	Civil Commitments of Sexually Violent Persons	Inmates	Total
1995-96	94	71	165
1996-97	116	57	173
1997-98	148	129	277
1998-99	198	230	428
1999-2000	224	214	438

The opening of a new facility for sexually violent persons should result in more beds for acutely mentally ill inmates.

Because bed space is limited, only the Department's most severe cases of acute mental illness can be transferred to the Center, and some inmates with acute mental illnesses who would benefit from treatment at the Center are being cared for at correctional institutions. Staff have reported that this, in turn, has placed an extra burden on an already strained mental health system for adult inmates. A new facility for sexually violent persons—the Sand Ridge Secure Treatment Center, which will be operated by the Department of Health and Family Services—is scheduled to open in June 2001. Wisconsin Resource Center staff report that a significant number of sexually violent persons may be transferred to Sand Ridge by October 2001 and, assuming no budget reductions, beds in the Center may again be available for acutely mentally ill inmates. The Governor's 2001-03 Biennal Budget Proposal includes funding for 314 beds at the Center for inmates with acute mental illness.

Psychological services staff at each institution, rather than Wisconsin Resource Center staff, determine whether to seek an inmate's transfer to the Center. In some cases, the security level of the institution may play a role in their decision. For example, an inmate whose mental illness causes disruptive behavior may be a greater security risk at a minimum-security institution than at a medium- or maximum-security institution. Therefore, such an inmate may be transferred to the Center before an inmate with a more severe condition at a medium- or maximum-security institution.

Approximately 15 percent of the inmates at Supermax are taking psychotropic medications.

Concerns have also been raised about the transfer of mentally ill inmates to the Supermax Correctional Institution. When Supermax was planned, the Department adopted a policy that no mentally ill inmates would be transferred to Supermax. However, the Department indicated that policy was changed in 2000. Currently, a psychologist in the Department must evaluate an inmate and approve the transfer before it occurs. While a diagnosed mental illness alone is not sufficient grounds for denial of a transfer to Supermax, if the psychologist determines that transfer to Supermax would have a serious negative impact on the severity of the inmate's mental illness, the transfer can be denied. The Department does not keep records of transfer denials, but our analysis of pharmacy information shows that approximately 15 percent of the inmates currently at Supermax are receiving medications for a diagnosed mental illness, which is approximately the same percentage as the prison population as a whole.

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In recent years, the Department has initiated numerous internal reviews to help assess the quality of prison health care, including ongoing development and implementation of its health services action plan. There are, however, several other methods available to help assess quality of care, including conducting regular external review by peers, monitoring the licenses of health professionals, reviewing the legal challenges made in inmate lawsuits, and reviewing inmate deaths. A review of these other methods shows the quality of care has been mixed.

Internal Reviews

Physician reviews of medical charts is common in other states' correctional health care systems.

Periodic, random chart reviews by a licensed physician can help assess whether appropriate medical procedures have been followed. Regular physician review of medical records is an NCCHC standard, and five states we contacted—Arizona, Illinois, Michigan, Minnesota, and Tennessee—conduct regular physician reviews of medical records.

Bureau of Health Services staff indicate that with current staffing levels, the Department's physicians are unable to carry out a regular, random chart review. However, random chart reviews need not be carried out by the Department's physicians. Since FY 1991-92, the Department has contracted for external review and quality improvement services by two private-sector health care consulting firms. In FY 1999-2000, costs for these services were $109,539 for adult institutions. In February 2001, the Department reduced funding for contracted quality improvement services by $16,020 because of shortfalls created by the significant increase in pharmaceutical and other costs.

The importance of regular peer review of medical charts is evidenced in national standards for correctional institutions, is common practice among other correctional health care providers, and is consistent with other quality improvement efforts the Department has undertaken. Therefore, *we recommend the Department of Corrections begin regular, random reviews of medical charts by a physician to help ensure that proper medical procedures are being followed*.

Completing internal audits of health services unit policies and procedures is another quality assurance method. As part of the Department's ongoing health services action plan, Bureau of Health Services staff have carried out an internal audit of health services unit policies. Results from eight institutions show some differences in policies and operations that required corrective action. For example:

- Dodge did not include training or drills in its emergency plan;

- Oshkosh and Waupun emergency policies did not have a plan for medical emergency evacuation of inmates; and

- Dodge, Oshkosh, Taycheedah, and Waupun did not have policies regarding medication orders.

Examples of internal review also include evaluation by a quality improvement committee of the process by which Racine health services unit staff review and prioritize inmate requests, as well as a review by staff in the Department, the Department of Health and Family Services, and the State Laboratory of Hygiene of procedures to improve detection of hepatitis-C and chlamydia. Other internal reviews completed by the Department have included assessments of inmate health care complaints and tuberculosis screening practices at health services units.

The Department's court-ordered internal reviews of health care at Taycheedah, which occurred in 1992, 1993, and 1995, recommended:

- 12 hours of continuing education annually for health care staff;

- improvements to procedures for emergency care;

- improving management of inmates' chronic conditions by increasing the number of chronic illness clinics; and

- providing for private, face-to-face contact between health care staff and inmates in segregation, because access to care is otherwise limited.

The Department indicates that efforts to improve health care at Taycheedah are ongoing. For example, 24-hour health care coverage was implemented on March 1, 2001.

Accreditation Options

Although accreditation by NCCHC or any other organization cannot guarantee quality health care, it represents a means for policies and procedures to be reviewed by health professionals from outside the Department. Many health care organizations seek accreditation by a variety of organizations, and the Department requires NCCHC accreditation of the contractor that operates health services units at

Prairie du Chien and Supermax. However, among six other states we contacted, only two have any NCCHC-accredited institutions. All ten Arizona institutions are either NCCHC accredited or have begun the accreditation process. In Tennessee, one institution has NCCHC accreditation, while almost all others are accredited by the American Correctional Association (ACA). Colorado, Illinois, Michigan, and Minnesota report that the majority of their institutions are ACA accredited.

The Department has selected NCCHC standards for assessing its health care delivery.

The Department is using NCCHC "Standards for Health Care in Prisons" as benchmarks for a self assessment that was begun in January 2000, because these standards are the most specific standards available for health care delivery in a correctional environment. In addition, NCCHC standards were developed from the AMA standards that statutes required the Department to use as its basis for health care delivery from 1979 through 1997.

NCCHC standards include minimum requirements for the management of correctional health care in five general areas: care and treatment, health records, administration, personnel, and medical-legal issues. To achieve NCCHC accreditation, institutions must comply with all applicable "essential" standards and at least 85 percent of applicable "important" standards. NCCHC's 37 essential standards relate directly to the health, safety, and welfare of prison inmates and address such issues as access to care, emergency plans, and routine requests for care. NCCHC's 35 important standards represent recognized, acceptable practices for health care providers and include physician peer review, transfer of health records, and inmates' right to refuse treatment. Surveyors from NCCHC visit and assess accredited institutions every three years.

The Department's self-evaluation was performed by the Bureau of Health Services, using the same standards that would be applied by NCCHC surveyors. Results of the self-evaluation are summarized in Appendix 5.

The Department complies with less than half of the national health care standards it selected.

From its self-evaluation, the Department concluded that based on current procedures and staffing, it meets 14 of the NCCHC essential standards listed in Table 25. The Department believes 8 more of the NCCHC essential standards could be met by making minimal procedural or policy changes and that additional resources or review would be needed before 14 others could be met.

Table 25

Internal Assessment Results

NCCHC "Essential" Standards Met	NCCHC "Essential" Standards Not Met
✔ Accountable Health Authority	*Require Minimal Procedural or Policy Changes*
✔ Medical Autonomy	✘ Access to Care
✔ Administrative Meetings and Reports	✘ Policies and Procedures at All Institutions
✔ Staff Credentials	✘ Communication on Special Needs Patients
✔ No Inmate Health Care Workers	✘ Infection Control Program
✔ Direct Orders	✘ Continuing Education for Health Professionals
✔ Infirmary Care Available	✘ Inmate Orientation to Health Services
✔ Intoxication and Withdrawal Treatment	✘ Receiving Screening-Intake Unit
✔ Perinatal Care Available	✘ Emergency Services Available
✔ Health Records Format and Contents	
✔ Confidentiality of Health Records	*Require Workgroups and Possible Resources*
✔ Sharing of Information	✘ Quality Improvement Program
✔ Therapeutic Restraints and Seclusion	✘ Emergency Plan
✔ Forced Psychotropic Medication	✘ Safe and Sanitary Environment
	✘ Training for Correctional Officers
	✘ Medication Administration Training
	✘ Pharmaceuticals
	✘ Health Screening Upon Transfer
	✘ Initial Health Assessment in Seven Days
	✘ Mental Health Assessment
	✘ Dental Care
	✘ Handling of Routine Medical Requests
	✘ Sick Call
	✘ Special Needs Treatment Plans
	✘ Suicide Prevention
	Require Significant Staffing Resources
	✘ Daily Evaluation of Inmates in Segregation

Meeting all of NCCHC's essential standards may cost a minimum of $1.1 million annually for additional staff.

The Department believes that it will need significant additional funding to be in compliance with one of NCCHC's essential standards: daily health assessments of inmates in segregation. Although the Department has not yet developed a cost estimate, we estimate that meeting this standard would require at least an additional $1.1 million annually for 20.0 FTE registered nurses. In addition to nurses, the Department believes that additional correctional officers would be required to provide increased security for daily health assessments in its segregation units.

Arizona, where institutions maintain NCCHC accreditation, has more health care staff per inmate than Wisconsin does.

The system-wide cost of NCCHC accreditation fees for adult institutions is approximately $70,000 in the first year and $35,000 in each subsequent year. This amount does not include the cost of any needed staffing increases. Officials in Arizona have indicated that state's additional costs to seek accreditation were not significant, but Arizona appears to have significantly fewer inmates per health care staff position than Wisconsin does. In FY 1998-99, Arizona employed 1 health care professional—including physicians, physician assistants, nurse practitioners, and registered nurses—for every 85 inmates. In the same year, Wisconsin's average ratio for the same staff was 1 to 123.

The American Correctional Association, which serves as an umbrella organization for the correctional industry, has established standards in 20 areas, including correctional health care programs, that are the basis for facility-wide accreditation. ACA health care certification, which focuses solely on health care operations, is also available.

ACA is currently developing performance-based health care standards.

As noted, five of the states we contacted have facility-wide ACA accreditation in at least some of their adult correctional institutions. Nationally, only two institutions had earned ACA health care certification as of April 30, 2000. Both are in New York. ACA is currently developing performance-based standards for a form of health care accreditation that is separate from ACA facility-wide accreditation and more comprehensive than ACA health care certification. Such accreditation for all 14 of the Department's adult institutions would cost an estimated $99,600 for three years.

The Department requires institutions operated by the Corrections Corporation of America, which houses Wisconsin prisoners in Minnesota, Mississippi, Oklahoma, and Tennessee, to comply with some ACA standards, although accreditation is not required. However, CCA requires its institutions to be ACA accredited.

Because concerns about inmate health care exist despite the Department's efforts at quality improvement, *we recommend the Department of Corrections report by September 1, 2001, to the Joint Legislative Audit Committee on its progress toward meeting the standards it has selected as the basis for health care delivery*.

Professional Health Care Staff Licensing

Quality of health care can also be assessed by ensuring that the Department's professional health care staff have valid licenses to practice in their respective fields. Our review of licensing records maintained by the Department of Regulation and Licensing, as well as by other certifying organizations, indicates that as of June 2000, all professional health care staff in the Department, including LTE psychiatrists and physicians, had current licenses.

In June 2000, all professional health care staff had current licenses.

Nursing staff, dental hygienists, and dentist management staff had the fewest disciplinary actions, and none were employed with a limited license as of June 2000. Registered nurse managers, dentists, physicians, and other staff had relatively larger numbers of disciplinary actions noted in their records. As shown in Table 26, 11 of the Department's 213 licensed health care staff in June 2000 had disciplinary records, and 2 were practicing with limited licenses.

Table 26

Disciplinary Records of Licensed Health Care Staff
June 2000

	Number of Staff	Number with Disciplinary Record	Number with Limited License
Dentist	17	2	1
Dental Hygienist	4	0	0
Dentist Management	1	0	0
Physician*	38	4	1
Registered Nurse	103	1	0
Licensed Practical Nurse	18	0	0
Nurse Management	15	2	0
Other**	17	2	0
Total	213	11	2

* Includes psychiatrists.
** Includes pharmacists, radiology technicians, optometrists, physician assistants, and nurse practitioners.

Health-Related Legal Settlements

The Department has paid almost $600,000 since 1991 to settle health-related claims.

Legal settlements related to inadequate health care provide another method of assessing the quality of care provided in the prisons. The Department has been involved in 183 legal settlements involving cash payments since FY 1990-91, of which approximately 19.1 percent involved inadequate health care. Health care–related settlements cost a total of $599,766 over ten years. Of this amount, $475,000 was paid in a single wrongful death suit that occurred in FY 1996-97. Some of the other settlements included:

- $7,500 for an inmate whose health services request form was not forwarded to the health services unit by correctional officers;

- $5,250 for an inmate who was not allowed to see a physician to have a prescription renewed; and

- $1,000 for an inmate who received psychotropic medications inappropriately.

Mortality Reviews

Finally, we reviewed the number of deaths in Wisconsin prisons and CCA contract institutions and compared them with inmate mortality trends in other states. As shown in Table 27, the number of deaths among Wisconsin inmates has increased from 12 in 1995 to 31 in 1998, but only Minnesota had fewer deaths as a percentage of average daily population. Wisconsin's inmate death rate has remained stable since 1998. It was 0.11 percent in FY 1998-99, when there were 20 deaths, and 0.13 percent in FY 1999-2000, when there were 25 deaths. Data for other states are unavailable after 1998.

Table 27

Inmate Deaths in Seven States
Number and Percentage of Average Daily Population (ADP)
1995 through 1998

	1995		1996		1997		1998	
	Total Deaths	% of ADP	Total Deaths	% of ADP	Total Deaths	% of ADP	Total Deaths	% of ADP
Tennessee	71	0.55%	56	0.41%	64	0.44%	48	0.31%
Colorado	25	0.32	22	0.26	33	0.38	26	0.27
Arizona	58	0.28	64	0.29	62	0.27	65	0.26
Illinois	103	0.27	96	0.25	101	0.25	96	0.23
Michigan	97	0.25	125	0.32	87	0.20	96	0.22
Wisconsin	12	0.11	17	0.14	21	0.16	31	0.19
Minnesota	9	0.19	10	0.20	6	0.11	8	0.14

Source: Criminal Justice Institute, *The Corrections Yearbook,* 1995-1999.

The Department has reviewed inmate deaths since 1994, and in 2001 it developed a new inmate death review committee, which includes some members from outside the Department. It should be noted that 2001 Assembly Bill 170 would establish a mortality review committee composed of medical professionals. The committee would meet quarterly to review and investigate all inmate deaths.

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The correctional environment poses challenges to providing quality health care.

Correctional health care staff must continually balance the legitimate health needs of their patients with the security mission of the Department. For example, because of security concerns, inmates who require injections of insulin to control their diabetes are not allowed to have hypodermic needles in their cells. Similarly, inmates who require psychotropic medications to control their mental illness are not allowed to keep their medications in their cells because of the risk of misuse. Consequently, health care staff are often unable to provide services in the same manner as they would in a community setting.

Inmates may also exhibit manipulative behavior toward health care staff. For example, we were told of one inmate who refused to follow medical advice on seven separate occasions, five of which involved refusing surgery after being transported to Milwaukee or Madison. Health care staff indicated that they continued to schedule the surgery because they believed it was medically necessary and because they feared legal ramifications if the inmate claimed care had been denied or if his condition worsened. In addition, health care staff note that inmates may demonstrate drug-seeking behavior or claim illness in an attempt to receive unneeded lower bunk assignments or non-standard footwear.

Finally, health care staff sometimes need to make health assessments without direct patient contact. When emergency or urgent medical situations arise, they must rely on correctional officers who are stationed with the inmates to relay the initial information about the nature of the problem over the telephone.

Despite these challenges, the Department is charged with providing inmate health care in the most efficient manner possible. The Governor's 2001-2003 Biennial Budget Proposal contains a number of measures to enhance health care in the adult institutions, which we reviewed.

Governor's 2001-03 Prison Health Care Budget Proposal

The Governor's 2001-03 Biennial Budget Proposal includes $37.6 million in additional funding for prison health care.

The Governor's proposed budget seeks $37.6 million in additional GPR funding, and authority for 157.5 FTE new positions related to prison health care. That amount includes $18.0 million for pharmaceuticals, professional medical services, other variable health costs, and other initiatives. Most of the remaining funding—$17.3 million—and 118.0 FTE positions have been proposed for new institutions and facility expansion. However, the 2001-03 Biennial

Budget Proposal also includes $2.3 million for 39.5 FTE positions to increase health care staffing levels at existing institutions. Major provisions to increase health care staffing for existing institutions include:

- 16.0 FTE registered nurses, 2.0 FTE licensed practical nurses, and 2.0 FTE medical assistants to increase staffing ratios and reduce overtime costs at 11 institutions;

- 10.0 FTE for Dodge and Racine to adjust for increases in population related to the return of inmates from out-of-state contract beds, including 6.0 FTE registered nurses, 2.0 FTE dental hygienists, and 2.0 FTE health information technicians;

- 5.75 FTE registered nurses to provide 24-hour nursing care at Columbia, Oakhill, and Taycheedah;

- 1.0 FTE hemodialysis technician and 0.75 FTE registered nurses to assist with hemodialysis treatment at Dodge; and

- 1.0 FTE physician to increase the level of physician services at Racine, and 1.0 FTE physician at Dodge to provide coverage for other institutions with physician vacancies.

It should be noted that the Governor's proposal also includes a 300-bed facility in Chippewa Falls to provide specialized health care to geriatric inmates, as well as funding for the new institution in Stanley and for contracted health care services at the new institutions located in Milwaukee, Sturtevant, and New Lisbon. We did not review these items. Other proposals for expansion include 6.0 FTE positions for facility expansion at Taycheedah, including a new segregation unit, a 64-bed special management unit, and additional general prison beds.

Registered Nurse Staffing Increase

The Department has traditionally used a post-shift ratio to determine its correctional officer staffing needs. The Governor's proposal for 16.0 FTE additional registered nurse positions is based on a post-shift formula as well and is designed to improve staffing ratios at selected institutions. The Department indicates that nursing positions were originally created using 1.0 FTE position for each 40-hour weekly shift, or "post." However, overtime, LTE, and contracted staff are used to provide coverage when employees are absent from their posts because

of sick leave, off-site training, and vacation time. Therefore, the Department has based its current request on a post-shift ratio of 1.19 FTE positions per 40-hour shift. That ratio is less than those used by three other states that reported this staffing strategy, as shown in Table 28.

Table 28

Post-Shift Ratio Comparisons for Nursing Staff
Fall 2000

State	FTE Positions per 40-Hour Post
Arizona	1.50
Michigan	1.40
Minnesota	1.40
Wisconsin	1.19

It is not clear how the Department will fund the requested positions, because no funding is included for them in the Governor's budget proposal. The Governor's budget assumes that the Department will be able to fund these positions by internally reallocating funds currently being used for professional medical services. As noted, $3.9 million was spent for those services in FY 1999-2000.

It does not appear that the addition of 16.0 FTE registered nurses will result in the Department having a higher ratio of nursing staff to inmates than in some neighboring and comparable states. If these positions had been in place in FY 1999-2000, the staffing ratio would have been 1 registered nurse for each 132 inmates, which would still be lower than the ratios in Minnesota, Colorado, Arizona, and Michigan that were shown in Table 12.

Other Health Care Staff to Support Return of Out-of-State Inmates

The Governor's 2001-03 Biennial Budget Proposal also includes 10.0 FTE positions for additional health care staff at the Dodge and Racine Correctional Institutions. Although these staff are intended to support the return of inmates to these institutions from out of state, the

proposed positions include staff that had originally been requested by the Department to:

- increase the number of registered nurses assigned to current operations;
- increase the number of dental staff at Racine; and
- increase the number of medical records staff at six institutions.

The Governor's proposal, however, would assign 3.0 FTE registered nurses, 1.0 FTE medical record technicians, and 1.0 FTE dental hygienists each to Dodge and Racine.

24-Hour Nursing Coverage

The Department believes that having health care staff available overnight at selected institutions will better serve the needs of inmates with chronic conditions, provide timely response to emergencies, and enable staff to complete administrative tasks that may not have been accomplished during the day shifts. The Governor's 2001-03 Biennial Budget Proposal includes a total of $713,900 in GPR over the biennium for 24-hour nursing coverage at Columbia, Oakhill, and Taycheedah.

Currently, three institutions have 24-hour nursing coverage.

Currently, three other institutions have 24-hour nursing staff coverage:

- Dodge has registered nurses who cover the night shift in the infirmary and respond to emergency situations anywhere in the institution;
- Supermax is required by contract to have licensed practical nurses to cover the night shift seven days a week; and
- beginning in March 2001, the Department internally reallocated positions to provide 24-hour coverage at Taycheedah.

Of the 11 institutions that do not have 24-hour care, 10 have at least 16-hour coverage by registered nurses on weekdays. Oakhill currently has 8-hour coverage on weekdays.

At this time, inmates with serious chronic care needs are placed in the infirmary at Dodge. However, if staffing for 24-hour health care is approved, the Department indicates that inmates with serious chronic care needs may be placed at one of the other institutions with 24-hour

health care, which may reduce the number of inmates transferred to the infirmary at Dodge. Two of the institutions selected for 24-hour coverage, Taycheedah and Columbia, have the highest percentages of chronically ill inmates: in fall 2000, 72.1 percent and 45.3 percent of their respective populations were chronically ill. Oakhill was selected for 24-hour coverage so that one minimum-security facility would have 24-hour coverage. The Department assigns male inmates who need health services to this institution.

Wisconsin provides 24-hour coverage at fewer institutions than our comparison states and the federal prison system do. With the exception of Minnesota and the federal Bureau of Prisons, all other states we contacted reported 24-hour health care staff coverage at all adult institutions. Minnesota provides 24-hour care in five of its eight institutions, and the federal Bureau of Prisons provides 24-hour health care in two-thirds of its institutions.

LTEs costs for health care are increasing.

The Department believes the budget request for 24-hour nursing coverage will help reduce overtime and LTE costs, which, as shown in Table 29, have increased in each year from FY 1995-96 through FY 1999-2000.

Table 29

Health Care Expenditures for Overtime and LTEs at Adult Institutions
FY1995-1996 through FY1999-2000
(in millions)

	1995-96	1996-97	1997-98	1998-99	1999-2000	Percentage Change
Overtime	$0.2	$0.3	$0.4	$0.4	$0.5	150.0%
LTE Costs	0.4	0.9	1.2	1.4	1.5	275.0
Total	$0.6	$1.2	$1.6	$1.8	$2.0	233.3%

It should be noted that the majority of LTE expenditures are for medical consultants, such as physicians and psychiatrists. In FY 1999-2000, LTE costs for medical consultants were $1.1 million. In contrast LTE costs for registered nurses were approximately $114,000. In the same year, overtime costs for registered nurses totaled approximately $286,000, and approximately $214,000 was spent on overtime for other health care staff.

The Department has expressed concern about insufficient staffing in the infirmary at Dodge, including the need for registered nurses to work overtime to complete their duties and to cover shifts for staff on sick leave, vacation, or attending training. The Department is also concerned that the infirmary may not be staffed sufficiently on the night shift, because night shift nurses are also responsible for responding to any medical emergency at Dodge. When a night shift nurse leaves the infirmary, there is only one nurse left to care for up to 64 seriously ill inmates.

In FY 1999-2000, the infirmary had an average daily population of 48.8 inmates and expenditures of $3,422,680, including administrative and pharmaceutical costs. Therefore, the infirmary spent an average of $69,851 per inmate in FY 1999-2000. Although the Department does not maintain historical data on health conditions of inmates in the infirmary, on January 16, 2001, the 48 inmates in the infirmary had one or more of the following conditions: cancer, end-stage liver disease, quadriplegia, vascular disease, cardiac disease, chronic renal failure, lung disease, gun shot wounds, multiple sclerosis, HIV, blindness, and dementia.

Additional Physicians

The Governor's 2001-2003 Biennial Budget Proposal includes 1.0 additional FTE physician at Racine, at a cost of $290,400 for the biennium. According to our analysis, if this request is approved, 10 of the 14 institutions will have inmate-to-physician ratios that comply with the NCCHC standard for physician staffing, which is the equivalent of 1,143 inmates per physician, excluding time for administrative duties. Inmate-to-physician ratios at Kettle Moraine, Oshkosh, Taycheedah, and Waupun will continue to be out of compliance with NCCHC standards.

As shown in Table 30, Racine had 1,414 inmates per physician in FY 1999-2000. Adding a physician at Racine would reduce the number of inmates per physician to 707.

Table 30

Ratio of Inmates to Physicians
FY 1999-2000

Institution Name	Number of Inmates per Physician
Columbia	808
Dodge	495
Fox Lake	1,112
Green Bay	1,002
Jackson	971
Kettle Moraine	2,466
Oakhill	1,128
Oshkosh	1,859
Prairie du Chien	1,188
Racine	1,414
Racine Youthful Offender	790
Supermax	1,010
Taycheedah	1,288
Waupun	1,225
System-wide Ratio	1,062

The Governor's 2001-03 Biennial Budget Proposal also includes a request for 1.0 FTE "pool" physician, at a cost of $290,400 over the biennium, who would travel among the institutions to fill short-term physician vacancies such as for sick leave and vacations. This physician would assist health services unit staff at Dodge when not covering vacancies.

Alternatives to Reduce Prison Health Care Costs

We reviewed five alternatives for management improvements or other changes that could offset costs associated with additional prison health care staff:

- improving contract management;
- applying for Medical Assistance eligibility for some inmates;

- improving the process for transporting inmates to medical appointments;
- increasing the use of telemedicine; and
- increasing the co-payment fee for inmate-initiated visits to the health services unit.

We also compared per inmate health care expenditures among the institutions to identify trends in operating costs for health services units. Expenditures vary significantly by institution, as shown in Table 31. For example:

- Taycheedah, which houses the majority of the state's female inmates, had the highest annual expenditure rate at $6,805 per inmate in FY 1999-2000. The Department believes that it is more expensive to provide health care to female inmates because of women's unique health needs.
- The lowest annual cost per inmate was at Jackson, which spent $1,540 per inmate on health care in FY 1999-2000. Jackson does not have any specialized health care functions.
- Dodge, which houses the infirmary unit for inmates with serious chronic illnesses and is also responsible for all initial health assessments, spent an average of $5,507 per inmate in FY 1999-2000.

It is not clear that contracting for operation of health services units is less expensive than hiring state employees.

Some suggest that contracting for services allows for greater cost efficiency, but the Department's experience does not provide clear evidence to support such a claim. FY 1999-2000 expenditure data show that Supermax, where health services are provided by a contractor, had higher per inmate health costs than any other institution housing male inmates; however, Supermax contract costs were allocated over less than 12 months in FY 1999-2000. Other unique features of Supermax, such as more frequent contact between health staff and inmates than at other maximum-security prisons, also likely create higher per inmate health care costs. In contrast, at Prairie du Chien, where health care services are also contracted, per inmate costs appear to be slightly lower than at the Racine Youthful Offender Facility, which is operated by the Department's staff. Both Prairie du Chien and the Racine Youthful Offender Facility are medium-security institutions that house younger offenders, who typically require fewer health care services.

Table 31

Health Care Expenditures by Institution
FY 1999-2000
(in millions of dollars)

Institution	Health Care Expenditures	Expenditure per Inmate
Taycheedah	$4.4	$6,805
Supermax*	0.6	6,211
Dodge	8.2	5,507
Racine Youthful Offender	1.1	2,682
Prairie du Chien*	0.7	2,523
Oakhill	1.4	2,492
Waupun	2.7	2,181
Columbia	1.7	2,129
Correctional Centers**	3.8	2,107
Kettle Moraine	2.2	1,765
Oshkosh	3.2	1,708
Racine	2.3	1,664
Fox Lake	1.8	1,663
Green Bay	1.6	1,569
Jackson	1.5	1,540
Total/Average	$37.2	2,495

* Health care services are provided by a contractor, and the Supermax amount reflects only seven months of operation.

** Includes health care services provided at 17 facilities in FY 1999-2000.

Improved Contract Management

The Department paid $1.2 million in FY 1999-2000 for health care services at Prairie du Chien and Supermax.

State law permits the Department to contract for any care or services it would otherwise provide itself, including health care. In FY 1999-2000, the Department paid $1.2 million to a private vendor to operate the health services units at Prairie du Chien and Supermax. Contract expenditures for the Redgranite Correctional Institution will be incurred beginning in FY 2000-2001.

The Department has made an ongoing effort to oversee the vendor's performance at Prairie du Chien and Supermax, although improvements are needed to avoid unnecessary costs and improve accountability. In

FY 1999-2000, the Department employed 1.0 FTE contract monitor to complete regular site visits at Prairie du Chien and Supermax and report any contract violations to the Department. The monitor also reviewed monthly reports provided by the vendor in order to determine whether contract staff worked the number of hours specified in the contract.

The Department reclaimed $35,853 from the Supermax and Prairie du Chien health services vendor in FY 1999-2000.

The Department has sought and received reimbursement for discrepancies in the number of hours worked and in the rates being charged by the vendor. In FY 1999-2000, it reclaimed $8,262 from the vendor as reimbursement for hours not worked because of a vacancy in the Health Services Administrator position. Further, the Department sought and received reimbursement for overcharges associated with contract-specified rate increases that amounted to $27,591 over two years. The Department has not, however, sought reimbursement for some overcharges and has failed to require staffing information needed to fully assess contract compliance. For example, in January and February 2000, the Department was overcharged approximately $11,700 for nursing hours during day shifts at Supermax, yet no reimbursement was sought.

The Department did not seek reimbursement for these and other costs because, in part, of restrictive language in its agreements with the vendor. Agreements for both Supermax and Prairie du Chien identify required staffing levels but restrict the Department from claiming reimbursements for staffing vacancies unless a position has been vacant for 30 days or more. However, during all of calendar year 2000, the vendor's staffing reports were not complete, and the Department was unable to determine whether the vendor was fulfilling the contract terms for nursing staff. For example, vendor staffing reports did not include data documenting the number of hours nursing staff had worked during the second and third shifts at Supermax. Further, the information contained in the reports was insufficient to identify whether a position was vacant for 30 days. In spite of these problems, the Department did not require the vendor to report the necessary data.

Differences in the requirements included in the request for proposals (RFP) and the vendor's proposal for operating the health services unit at Prairie du Chien have also led to confusion about whether the vendor is meeting the terms of the contract. The Department does not use a formal contract to specify the terms of its agreement with the vendor at Prairie du Chien. Instead, as permitted by Department of Administration procurement procedures, it uses the RFP, the proposal submitted by the vendor, and the annual purchase order between these entities to serve as the binding contract.

The Department anticipated, but did not require, that the vendor would hire a physician to provide medical care to inmates at Prairie du Chien. The vendor's proposal indicated that it would hire a "medical director" to provide care to inmates. However, the physician hired by the vendor

did not always work the full ten hours per week specified in the vendor's proposal, and the vendor used a physician assistant to cover for the physician's duties, including completing most medical appointments. For example, during a five-week period in February and March 2000, the physician worked 4.75 of the 50 hours specified in the vendor's proposal. During that time, the Department's contract monitor believed that some of the duties performed required a physician and not a physician assistant. Nevertheless, the Department has indicated that because of the differences in the RFP and the vendor's proposal and because of the 30-day vacancy clause, it cannot seek reimbursement for the hours not worked by the physician.

Our review of vendor staffing reports for Prairie du Chien and Supermax, which were summarized by the Department, indicates that the vendor did not fulfill the staffing requirements at either institution. However, we were unable to determine precisely how much reimbursement the Department could claim for staff vacancies because of a lack of information regarding staffing coverage for periods exceeding 30 days. We estimate that the vendor failed to provide staffing coverage for as many as 5,845 hours with a value of $124,754 between October 1999 and December 2000. It should be noted that the vendor did make an attempt to cover staff vacancies by re-assigning staff of equal or greater professional training. For example, in FY 1999-2000, the vendor's physician at Supermax worked an additional 208 hours to cover for vacant physician assistant and registered nurse positions.

Because the Department paid a vendor for health care services that were not provided, *we recommend the Department of Corrections seek reimbursement from the vendor operating the health services units at Prairie du Chien and Supermax for the full amount allowable under the contracts*.

Although a signed formal contract could remove ambiguity and allow the Department to more aggressively seek reimbursement for any violations identified by contract monitors, the Department has been reluctant to negotiate a contract for Prairie du Chien because it believes contract negotiations could lead to the vendor receiving a higher monthly rate. However, the Department does not appear to have prevented rate increases by avoiding renegotiations: the vendor has received annual increases to the monthly rate over the past three fiscal years.

To ensure it has adequate information to monitor the delivery of services provided by vendors, *we recommend the Department of Corrections prepare written contracts for health care vendors, basing the contract on language included in its request for proposals and on vendor proposals, and that it ensure clarity in these contracts regarding reimbursements for staffing vacancies*.

Medical Assistance Funding for Eligible Inmates

The Department could potentially achieve additional cost savings by applying for Medical Assistance eligibility for certain inmates. Section 1905(a)(A) of the federal Social Security Act and s. 49.47(6)(c)3, Wis. Stats, state that Medical Assistance funding is generally not available to inmates but can be claimed if an inmate is a patient in a medical institution, which includes receiving inpatient services at a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility for individuals who are mentally retarded. This means the Department could not apply for Medical Assistance eligibility for inmates who are housed at the infirmary at Dodge, or for the inmates who will be housed at the proposed Highview facility for aging inmates. It should also be noted that Medical Assistance funding would be available only for those costs and services normally covered under the Medical Assistance program.

The Department has never claimed Medical Assistance funding for inmate hospital costs, and at least three questions would need to be resolved before doing so:

- whether matching funds for Medical Assistance funding would be appropriated, and if so, whether they would be included in the Department of Health and Family Services' Medical Assistance budget;
- whether responsibility for submitting applications and determining eligibility for Medical Assistance would be placed with the Department of Corrections or the Department of Health and Family Services; and
- whether administrative code would need to be changed to allow for Medical Assistance payments for eligible inmates, consistent with federal and state statutes and the state Medical Assistance plan that currently allow such payments.

The Department of Corrections' contract with the UWHC contains a clause that specifies that it will seek, and UWHC will accept, Medical Assistance funding for eligible inmates. Although the Department has successfully negotiated with UWHC to accept Medical Assistance funding as full reimbursement for hospital services, it has not yet negotiated such agreements with other local hospitals, such as Agnesian Healthcare or Waupun Memorial Hospital.

We were not able to estimate potential cost savings, because we were unable to determine the number of inmates who meet Medical Assistance eligibility criteria or the additional cost of determining

eligibility. However, inmates who are eligible for this funding include those who meet income and asset limitations and who are:

- female inmates who receive inpatient prenatal care and childbirth services;
- disabled inmates who receive inpatient services; and
- inmates younger than 19 or 65 and older who receive inpatient services.

In December 2000, excluding out-of-state inmates, 470 inmates were either younger than 19 or 65 and older. During 2000, the Department reported a total of 41 births to female inmates.

Despite challenges to implementing this provision, the availability of Medical Assistance funding would allow for 60 percent federal reimbursement for some inmate health care costs that are now funded entirely by GPR. *Therefore, we recommend the Legislature:*

- *require the Department of Corrections to negotiate in all of its future contracts with hospitals that provide inpatient care for inmates the willingness to accept Medical Assistance rates for those who are eligible; and*
- *require the Department of Corrections to work with the Department of Health and Family Services to explore options for determining Medical Assistance eligibility for certain inmates.*

Improvements in the Transportation of Inmates

Despite the identification of a possible $172,000 in annual savings, the Department has not implemented a centralized medical transportation unit.

Our 1995 evaluation of inmate transportation (report 95- 21) found that the Department could reduce inmate transportation costs by coordinating scheduling and transportation for off-site medical appointments. In January 1996, the Department reported to the Joint Legislative Audit Committee that within a year, it would follow our recommendation to establish a medical transportation unit that would coordinate inmate transportation for four institutions. In March 1999, the Department conducted a three-month pilot project at the Dodge, Fox Lake, Oshkosh and Waupun correctional institutions. This pilot project saved more than $43,000 in overtime costs, which represents annual estimated savings of $172,000 in overtime at these institutions and is also likely to have generated transportation cost savings at these institutions.

Nevertheless, the Department has not implemented our recommendation, in part because it has identified some challenges in doing so. For example, Oshkosh was dropped from the pilot study when the distance between it and the other three institutions proved too great to coordinate trips. Additionally, the Department found that more inmate trips were cancelled because of inter-facility transfers or segregation holds than had been anticipated in the audit, and savings were reduced as a result. Finally, the Department identified a need for better communication with UWHC regarding scheduling than is currently the case. Nevertheless, the Department has demonstrated that a coordinated medical transportation system could achieve significant savings, particularly by reducing overtime costs for medical trips.

Although the Department does not maintain data on correctional officers' overtime hours to complete inmate medical trips, indirect evidence suggests that overtime related to medical transportation occurs frequently and is caused by several factors. For example, the Department indicates that UWHC often schedules medical appointments early or late in the day, which requires correctional officers to begin or finish trips outside of their regularly scheduled hours. In addition, the Department indicates that UWHC frequently reschedules an appointment after the inmate arrives. Furthermore, for some facilities, such as the Jackson Correctional Institution located near Black River Falls, the distance to be traveled requires that correctional officers arrive for their shifts several hours early in order to reach Madison in time for morning appointments. Overtime costs are multiplied in these cases if the inmate requires more than one escort. For example, a maximum-security inmate may require two guards for an off-site medical visit.

In FY 1999-2000, correctional officers at Jackson were paid $67,706 in overtime for all types of trips. Assuming that no major changes have been made to the procedures for transporting inmates since our 1995 audit, as much as 48 percent of these overtime costs may have been for transporting inmates to medical appointments. In FY 1999-2000, 14.2 percent of correctional officer overtime costs at Jackson was for trips, which was higher than at any other institution in the state.

The Department could also consider identifying methods to increase coordination of inmate medical transportation and trip scheduling to produce savings. For example, it could consider developing transportation hubs for institutions and correctional centers located in southeastern and northern Wisconsin. Our 1995 audit recommended establishing a transportation hub system, which the Department made efforts to do at Dodge. The Department should assess whether it is feasible to implement this concept in other areas of the state.

Because scheduling problems continue to occur and are currently being addressed by each institution separately, and because cost savings could be realized from a reduction in overtime for correctional officers if the

centralized medical transportation unit at Dodge were permanently implemented, *we recommend the Department of Corrections:*

- *implement a central medical transportation unit at Dodge;*
- *monitor overtime for medical trips and scheduling conflicts with University of Wisconsin Hospitals and Clinics for all facilities; and*
- *work with University of Wisconsin Hospitals and Clinics staff to schedule appointments during hours that would reduce the amount of overtime required for correctional officers.*

Increased Use of Telemedicine

The Department spent $941,000 on telemedicine equipment, which is rarely used for its intended purpose.

Our 1995 inmate transportation audit also recommended that the Department explore increased use of telemedicine equipment as a means for reducing inmate medical transportation costs. Although the Department has taken some steps to develop its telemedicine capabilities, purchased equipment remains largely unused for its original purpose. In total, the Department has spent $941,00 since FY 1996-97 to purchase and operate the equipment at ten institutions, including the recently opened institution at Redgranite, the Department's central office, and UWHC. Although precise usage statistics are unavailable, staff report that equipment is used infrequently, and rarely for medical purposes. Nevertheless, there are several potential advantages to increased use of the existing equipment, including increased security and reduced expenditures for inmate transportation.

The Department has experienced difficulty in implementing the telemedicine program because of coordination problems with UWHC and vendor delays in installing equipment. Coordination has proved difficult because of key staff turnover at UWHC and at the Department in the early stages of the project, because of resistance from UWHC physicians, and because of equipment locations that proved inconvenient for UWHC physicians. Equipment purchased by the Department in May 1997 was not fully installed and operational until May 1999—although the Department appropriately refused payment to the vendor until after the equipment was functional.

Other states have experienced cost savings and security benefits from using telemedicine.

Other states use telemedicine equipment with varying degrees of success, and those most active in its use have experienced some cost savings, as well as improved security from a reduced number of inmates traveling off-site. We found that Arizona, Colorado, Illinois, Michigan, and Tennessee use telemedicine equipment, although usage data were

generally not available. Arizona reported that in FY 1999-2000, its average telemedicine visit cost $122, or $79 less than its average off-site visit cost of $201. Ohio also reported significant use of telemedicine equipment in its correctional system: it has the equivalent of five full-time staff working on telemedicine and teleconferencing equipment at 56 sites and completed 5,910 consultations in 1999. Ohio reported that its correctional and hospital staff were committed to using the equipment.

Only two institutions report using the equipment for medical consultations during FY 1999-2000.

The Department's telemedicine equipment is currently used primarily for non-medical purposes. Only four institutions reported using the equipment, and only two of these used it for medical consultations during FY 1999-2000. Health services unit staff reported in our survey that they have used the equipment to conduct meetings between health service professionals in different locations. Additionally, central office staff reported that institutions have used the equipment for:

- immigration and naturalization hearings with a judge in Chicago;
- quarterly budget meetings; and
- inmate court appointments.

Central office staff also report that the minimum-security correctional centers are using the equipment for visits between inmates and parole officers who are in different counties.

The Department faces several challenges to increase the use of its telemedicine equipment for medical purposes. For example, it reports that coordination with UWHC is improving, but usage by both UWHC and health services unit staff remains infrequent, in spite of an agreement with UWHC that provides $168 for each completed telemedicine appointment. No payments for completed telemedicine appointments were made to UWHC by the Department in FY 1999-2000. The Department had a contract with Ameritech for technical assistance and training in FY 1999-2000, but that contract has been allowed to lapse, and health services unit staff do not currently have access to technical assistance.

There are also continuing costs associated with keeping the equipment operational. The Department pays monthly line fees regardless of whether the equipment is used, and usage and other charges when the equipment is used. From FY 1997-1998 through FY 1999-2000, the estimated total cost for the line fees was $40,467, excluding some disputed charges at Racine Youthful Offender Facility and at Columbia.

In 2000, the Department began a review of the telemedicine program. It currently has a plan to use the telemedicine equipment for its originally intended purpose at Columbia, Waupun, and Dodge and has established a goal of doing so at these institutions 200-220 times over the course of a year. This will require overcoming several remaining challenges, including that the equipment is now several years old, equipment warranties have expired, some equipment vendors have changed, and training opportunities for the existing equipment are lacking.

Increased Medical Co-Payment Fees

Beginning in December 1995, inmates were required by statutes to make a co-payment of $2.50 for each request for medical or dental services. Co-payments are not required for emergency medical care or follow-up care scheduled by health care staff, and the Department indicates that inmates are not refused care if they do not have funds for co-payment. The intent of the medical co-payment fee is to reduce the number of unnecessary requests for health care. The Legislature could consider increasing the medical co-payment fee, which could reduce the number of routine health service requests and make additional staff time available for other activities, including better management of chronically ill inmates. It would also raise a small amount of program revenue.

The inmate co-payment fee generates over $96,000 annually.

As shown in Table 32, the Department's implementation of the medical co-payment fee has resulted in fewer inmate-initiated requests for medical service, and the fee generated over $96,000 in FY 1999-2000. Although there is not a perfect correlation between the number of inmate visits to health services units and the number of inmate-initiated requests for care, visits to health services units is the statistic that most closely mirrors the number of inmate-initiated health care requests.

Wisconsin currently charges inmates less for inmate-initiated sick call visits than several of our comparison states.

Wisconsin currently charges inmates less for inmate-initiated sick call visits than several of our comparison states. For example, Minnesota, Michigan, Arizona, and Tennessee all charge a $3.00 co-payment fee. In FY 1998-99, Illinois charged $2.00.

We could not easily document whether the co-payment fee is always applied for inmate-initiated visits to all health services units. However, assuming no change in the number of inmate-initiated visits to health services units that result in collection of a co-payment fee, increasing the fee from $2.50 to $3.00 would have generated an additional $19,273 in program revenue in FY 1999-2000.

Table 32

Inmate Medical Co-Payment Fee Revenue
FY 1994-95 through FY 1999-2000

Fiscal Year	Co-Payment Fees Collected	Percentage Change	Inmate Visits to Health Services Units	Percentage Change
1994-95	n.a.	n.a.	58,016	n.a.
1995-96	$47,589*	n.a.	44,813	-22.8%
1996-97	75,048	n.a.	37,123	-17.2
1997-98	84,556	12.7%	40,796	9.9
1998-99	88,337	4.5	37,566	-7.9
1999-2000	96,365	9.1	43,486	15.8

* The co-payment fee was initiated in December 1995; FY 1995-96 represents seven months of revenue.

It should be noted, however, that increasing the co-payment fee could reduce access to health care for some inmates. Some health services unit staff oppose increasing the co-payment fee because they believe it will increase barriers to health care. NCCHC generally opposes co-payment systems that restrict inmate access to care, which in this case would involve those inmates who choose not to request care because of the fee. Finally, the Department believes that increasing the co-payment fee when inmate wages have not been increased since 1982 could create increased security problems.

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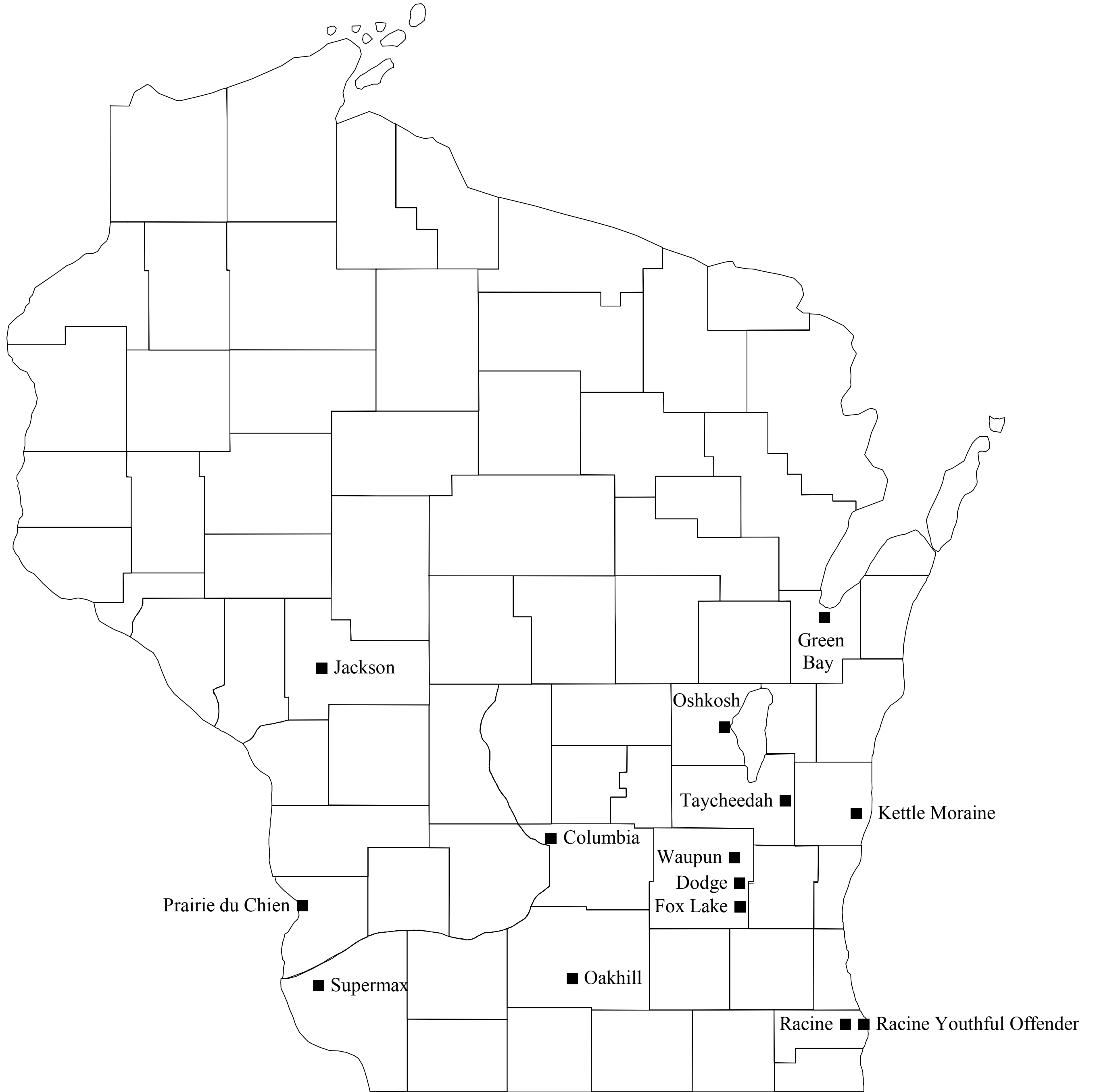
Appendix 1

Locations of Adult Correctional Institutions
FY 1999-2000



Appendix 2

Institution Profiles

This appendix provides a description of the health services environment in December 2000 at the Department's 14 adult institutions; the Correctional Center System, which consists of 16 minimum-security centers operated by the Division of Community Corrections; and the Wisconsin Resource Center, which is a secure treatment facility operated by the Department of Health and Family Services. Information is provided on:

- institutional demographics, including the number of inmates with chronic illnesses and the number older than 50;
- staffing levels and expenditures for health care and mental health services; and
- estimated levels of selected chronic illnesses at each institution, ranked by order of frequency.

Staffing levels for health services include the number of full-time equivalent (FTE) physician, psychiatrist, nurse, and clerical positions. Staffing levels for mental health services include FTE psychologist, psychological services associate, crisis intervention, and clerical staff positions. Health services expenditures include salaries and fringe benefits, pharmaceuticals, and medical supplies. Mental health services expenditures include salaries and fringe benefits and other supplies and services.

The number of chronic illnesses was estimated using pharmacy data supplied by the Department, as well as survey information collected from each facility clinic. The number of diagnosed cases does not equal the number of inmates with chronic illnesses because many inmates have more than one chronic condition. Furthermore, some inmates may have chronic conditions that have not been diagnosed or are not being treated. Pharmacy data are from December 1, 2000. Some institutions completed surveys in October 2000, and others completed them in November 2000.

COLUMBIA CORRECTIONAL INSTITUTION

Institution Demographics
As of December 1, 2000

Institution population	797
Estimated number of inmates with a chronic condition	361
Percentage of inmates with a chronic condition	45.3 %
Average inmate age	32.8
Number of inmates over 50	50
Percentage of inmates over 50	6.3 %

Health Care and Mental Health Staffing and Expenditures
Fiscal Year 1999-2000

Health care positions	10.0
Mental health positions	6.0
Health care expenditures	$1,719,940
Mental health expenditures	$412,229

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses
Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Mental illness	249	31.2%
Asthma, treated with inhaler	114	14.3
Neurological	99	12.4
Cardiac	83	10.4
Asthma, treated with nebulizer	54	6.8
Gastrointestinal	29	3.6
Diabetic	24	3.0
Endocrinological	16	2.0
HIV/AIDS	9	1.1
Other	8	1.0

System Demographics
As of December 1, 2000

Institution population	1,625
Estimated number of inmates with a chronic condition	361
Percentage of inmates with a chronic condition	22.2 %
Average inmate age	32.5
Number of inmates over 50	64
Percentage of inmates over 50	3.9 %

Health Care and Mental Health Staffing and Expenditures
Fiscal Year 1999-2000

Health care positions	3.0
Mental health positions	1.0
Health care expenditures	$3,826,246
Mental health expenditures	$46,134

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses
Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Cardiac	113	7.0%
Asthma, treated with inhaler	111	6.8
Mental illness	87	5.4
Neurological	40	2.5
Estrogen replacement therapy	30	1.8
Gastrointestinal	30	1.8
Diabetic	30	1.8
Endocrinological	12	0.7
Hematological	12	0.7
Other	41	2.5

Institution Demographics

As of December 1, 2000

Institution population	1,464
Estimated number of inmates with a chronic condition	474
Percentage of inmates with a chronic condition	32.4 %
Average inmate age	33.1
Number of inmates over 50	118
Percentage of inmates over 50	8.1 %

Health Care and Mental Health Staffing and Expenditures

Fiscal Year 1999-2000

Health care positions	68.5
Mental health positions	11.5
Health care expenditures	$8,177,407
Mental health expenditures	$535,673

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses

Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Mental illness	230	15.7%
Cardiac	158	10.8
Asthma, treated with inhaler	115	7.9
Neurological	72	4.9
Diabetic	43	2.9
Hematological	42	2.9
Gastrointestinal	35	2.4
Endocrinological	12	0.8
Dialysis	10	0.7
Other	31	2.1

Institution Demographics
As of December 1, 2000

Institution population	1,327
Estimated number of inmates with a chronic condition	341
Percentage of inmates with a chronic condition	25.7 %
Average inmate age	33.2
Number of inmates over 50	80
Percentage of inmates over 50	6.0 %

Health Care and Mental Health Staffing and Expenditures
Fiscal Year 1999-2000

Health care positions	9.0
Mental health positions	4.0
Health care expenditures	$1,848,821
Mental health expenditures	$227,843

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses
Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Cardiac	135	10.2%
Mental illness	110	8.3
Asthma, treated with inhaler	81	6.1
Diabetic	36	2.7
Neurological	33	2.5
Gastrointestinal	21	1.6
Endocrinological	13	1.0
HIV/AIDS	11	0.8
Hematological	5	0.4
Other	15	1.1

Institution Demographics
As of December 1, 2000

Institution population	1,008
Estimated number of inmates with a chronic condition	278
Percentage of inmates with a chronic condition	27.6 %
Average inmate age	28.8
Number of inmates over 50	29
Percentage of inmates over 50	2.9 %

Health Care and Mental Health Staffing and Expenditures
Fiscal Year 1999-2000

Health care positions	10.0
Mental health positions	4.2
Health care expenditures	$1,572,126
Mental health expenditures	$216,967

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses
Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Mental illness	177	17.6%
Cardiac	71	7.0
Asthma, treated with inhaler	49	4.9
Neurological	37	3.7
Diabetic	13	1.3
HIV/AIDS	10	1.0
Gastrointestinal	7	0.7
Endocrinological	2	0.2
Cancer	1	0.1
Other	2	0.2

Institution Demographics
As of December 1, 2000

Institution population	964
Estimated number of inmates with a chronic condition	261
Percentage of inmates with a chronic condition	27.1 %
Average inmate age	32.6
Number of inmates over 50	58
Percentage of inmates over 50	6.0 %

Health Care and Mental Health Staffing and Expenditures
Fiscal Year 1999-2000

Health care positions	11.0
Mental health positions	6.0
Health care expenditures	$1,495,635
Mental health expenditures	$359,314

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses
Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Cardiac	97	10.1%
Mental illness	82	8.5
Asthma, treated with inhaler	73	7.6
Gastrointestinal	43	4.5
Neurological	32	3.3
Diabetic	23	2.4
HIV/AIDS	9	0.9
Endocrinological	8	0.8
Hematological	8	0.8
Other	22	2.3

KETTLE MORAINE CORRECTIONAL INSTITUTION

Institution Demographics
As of December 1, 2000

Institution population	1,206
Estimated number of inmates with a chronic condition	383
Percentage of inmates with a chronic condition	31.8 %
Average inmate age	32.2
Number of inmates over 50	45
Percentage of inmates over 50	3.7 %

Health Care and Mental Health Staffing and Expenditures
Fiscal Year 1999-2000

Health care positions	11.9
Mental health positions	4.5
Health care expenditures	$2,175,992
Mental health expenditures	$284,231

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses
Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Mental illness	165	13.7%
Cardiac	146	12.1
Asthma, treated with inhaler	80	6.6
Neurological	59	4.9
Diabetic	40	3.3
Gastrointestinal	32	2.7
HIV/AIDS	18	1.5
Hematological	11	0.9
Orthopedic	6	0.5
Other	20	1.7

Institution Demographics
As of December 1, 2000

Institution population	545
Estimated number of inmates with a chronic condition	162
Percentage of inmates with a chronic condition	29.7 %
Average inmate age	35.9
Number of inmates over 50	55
Percentage of inmates over 50	10.1 %

Health Care and Mental Health Staffing and Expenditures
Fiscal Year 1999-2000

Health care positions	8.5
Mental health positions	2.5
Health care expenditures	$1,405,692
Mental health expenditures	$162,862

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses
Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Cardiac	73	13.4%
Asthma, treated with inhaler	45	8.3
Mental illness	33	6.1
Diabetic	20	3.7
Neurological	18	3.3
HIV/AIDS	15	2.8
Gastrointestinal	10	1.8
Hematological	7	1.3
Endocrinological	5	0.9
Other	17	3.1

Institution Demographics
As of December 1, 2000

Institution population	1,879
Estimated number of inmates with a chronic condition	735
Percentage of inmates with a chronic condition	39.1 %
Average inmate age	35.8
Number of inmates over 50	185
Percentage of inmates over 50	9.8 %

Health Care and Mental Health Staffing and Expenditures
Fiscal Year 1999-2000

Health care positions	17.0
Mental health positions	4.5
Health care expenditures	$3,174,580
Mental health expenditures	$346,058

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses
Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Mental illness	386	20.5%
Cardiac	305	16.2
Neurological	122	6.5
Asthma, treated with inhaler	119	6.3
Diabetic	75	4.0
Endocrinological	32	1.7
Gastrointestinal	22	1.2
HIV/AIDS	22	1.2
Hematological	20	1.1
Other	58	3.1

PRAIRIE DU CHIEN CORRECTIONAL INSTITUTION

Institution Demographics
As of December 1, 2000

Institution population	293
Estimated number of inmates with a chronic condition	54
Percentage of inmates with a chronic condition	18.4 %
Average inmate age	20.1
Number of inmates over 50	0
Percentage of inmates over 50	0.0 %

Health Care and Mental Health Staffing and Expenditures
Fiscal Year 1999-2000

Health care positions	7.6
Mental health positions	2.0
Health care expenditures	$749,411
Mental health expenditures	$124,907

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses
Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Mental illness	27	9.2%
Asthma, treated with inhaler	24	8.2
Cardiac	5	1.7
Neurological	3	1.0
Diabetic	1	0.3
Orthopedic	1	0.3
Sickle Cell Anemia	1	0.3

Institution Demographics
As of December 1, 2000

Institution population	1,447
Estimated number of inmates with a chronic condition	391
Percentage of inmates with a chronic condition	27.0%
Average inmate age	33.9
Number of inmates over 50	67
Percentage of inmates over 50	4.6%

Health Care and Mental Health Staffing and Expenditures
Fiscal Year 1999-2000

Health care positions	14.0
Mental health positions	6.0
Health care expenditures	$2,353,500
Mental health expenditures	$370,432

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses
Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Mental illness	189	13.1%
Cardiac	150	10.4
Asthma, treated with inhaler	73	5.0
Neurological	57	3.9
Diabetic	44	3.0
Endocrinological	9	0.6
HIV/AIDS	9	0.6
Gastrointestinal	6	0.4
Hematological	6	0.4
Other	14	1.0

Institution Demographics
As of December 1, 2000

Institution population	392
Estimated number of inmates with a chronic condition	89
Percentage of inmates with a chronic condition	22.7 %
Average inmate age	20.1
Number of inmates over 50	0
Percentage of inmates over 50	0.0 %

Health Care and Mental Health Staffing and Expenditures
Fiscal Year 1999-2000

Health care positions	7.5
Mental health positions	6.0
Health care expenditures	$1,059,562
Mental health expenditures	$347,947

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses
Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Mental illness	60	15.3%
Asthma, treated with inhaler	30	7.7
Neurological	13	3.3
Cardiac	3	0.8
Gastointestinal	2	0.5
Orthopedic	1	0.3

Institution Demographics
As of December 1, 2000

Institution population	314
Estimated number of inmates with a chronic condition	86
Percentage of inmates with a chronic condition	27.4 %
Average inmate age	31.5
Number of inmates over 50	16
Percentage of inmates over 50	5.1 %

Health Care and Mental Health Staffing and Expenditures
Fiscal Year 1999-2000

Health care positions	7.6
Mental health positions	3.0
Health care expenditures	$627,357
Mental health expenditures	$21,252

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses
Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Mental illness	48	15.3%
Asthma, treated with inhaler	26	8.3
Cardiac	13	4.1
Neurological	6	1.9
Diabetic	4	1.3
HIV/AIDS	2	0.6
Asthma, treated with nebulizer	1	0.3
Orthopedic	1	0.3
Paraplegia or quadriplegia	1	0.3

Institution Demographics
As of December 1, 2000

Institution population	645
Estimated number of inmates with a chronic condition	465
Percentage of inmates with a chronic condition	72.1 %
Average inmate age	35.4
Number of inmates over 50	43
Percentage of inmates over 50	6.7 %

Health Care and Mental Health Staffing and Expenditures
Fiscal Year 1999-2000

Health care positions	12.2
Mental health positions	2.5
Health care expenditures	$4,382,130
Mental health expenditures	$178,146

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses
Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Mental illness	330	51.2%
Neurological	144	22.3
Cardiac	108	16.7
Asthma, treated with inhaler	90	14.0
Estrogen replacement therapy	62	9.6
Gastrointestinal	42	6.5
Hematological	38	5.9
Endocrinological	25	3.9
Irregular Pap Test Results	22	3.4
Other	49	7.6

Institution Demographics
As of December 1, 2000

Institution population	1,211
Estimated number of inmates with a chronic condition	391
Percentage of inmates with a chronic condition	32.3 %
Average inmate age	34.9
Number of inmates over 50	125
Percentage of inmates over 50	10.3 %

Health Care and Mental Health Staffing and Expenditures
Fiscal Year 1999-2000

Health care positions	15.0
Mental health positions	5.5
Health care expenditures	$2,671,872
Mental health expenditures	$301,316

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses
Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Mental illness	191	15.8%
Cardiac	140	11.6
Asthma, treated with inhaler	83	6.9
Neurological	44	3.6
Diabetic	26	2.1
Gastrointestinal	24	2.0
HIV/AIDS	19	1.6
Endocrinological	10	0.8
Respiratory illness	7	0.6
Other	27	2.2

Institution Demographics

As of December 1, 2000

Institution population	278
Estimated number of inmates with a chronic condition	278
Percentage of inmates with a chronic condition	100.0 %
Average inmate age	37.9
Number of inmates over 50	34
Percentage of inmates over 50	12.2 %

Facility Staffing and Expenditures*

Fiscal Year 1999-2000

Facility staff positions	494.5
Facility expenditures	$31,395,652

* Health care and mental health expenditures were not available separately from overall facility expenditures.

Estimated Number of Diagnosed Cases of Selected Chronic Illnesses

Fall 2000

Condition	Estimated Number of Cases	Percentage of Population
Mental illness	278	100.0%
Cardiac	36	12.9
Asthma, treated with inhaler	26	9.4
Neurological	26	9.4
Gastrointestinal	14	5.0
Diabetic	9	3.2
Endocrinological	7	2.5
HIV/AIDS	5	1.8
Blindness	2	0.7
Other	5	1.8

Appendix 3

NCCHC Standards

The National Commission on Correctional Health Care (NCCHC) is an accrediting organization that assesses adult institutions based on its “Standards for Health Care in Prisons.” These standards are revisions of standards that were first published in 1977 by the American Medical Association.

NCCHC standards represent recommended minimum requirements for the management of correctional health care covering the general areas of administration, managing a safe and healthy environment, personnel and training, care and treatment, health promotion and disease prevention, special needs and services, health records, health care services support, and medical-legal issues. There are 37 “essential” NCCHC standards, which relate to the health, safety, and welfare of prison inmates and address inmate access to health care, institution emergency plans, and daily requests for routine care. There are also 35 “important” standards, which represent recognized, acceptable practices for health care providers and include physician peer review of clinical care, transfer of health records, and inmates’ right to refuse treatment.

To achieve NCCHC accreditation, institutions must be compliant with all of the essential standards that are applicable to them, and 85 percent of the applicable important standards. Standards that are not applicable to all institutions include, for example, perinatal care. Accredited institutions are reevaluated by NCCHC through annual written reports submitted by the institutions and through site visits conducted by NCCHC every three years.

NCCHC "Essential" Standards for Health Care in Prisons	
NCCHC "Essential" Standard	Description
P-01 Access to Care	Inmates, including those in segregated custody, must have access to health care to meet their serious medical, dental, and mental health needs; interfering with the delivery of inmate requests for care must be avoided.
P-02 Accountable Health Authority	Each institution must have a health care professional or health administrator on site who is responsible for health care services.
P-03 Medical Autonomy	Health staff must have exclusive responsibility for clinical decisions.
P-04 Administrative Meetings and Reports	Quarterly administrative meetings about health care services are required, and health care staff must meet monthly.
P-05 Policies and Procedures at All Institutions	There must be a manual of health care policies and procedures that is approved by the health authority and the responsible physician. Each policy must be reviewed annually.
P-06 Quality Improvement Program	A comprehensive quality improvement program that includes regular medical chart review by physicians is required, along with quality improvement committees at each institution with more than 500 inmates.
P-07 Emergency Plan	Health care services must have an emergency plan that is documented, practiced, and critiqued at least annually.
P-08 Communication on Special Needs Patients	Communication is required between administrators and physicians regarding disciplinary measures and housing, work, and program assignments for inmates with special needs such as chronic illnesses and serious mental health needs.
P-14 Infection Control Program	A program that includes infection policies, immunizations, treatment, decontamination, and adherence to universal precautions is required.
P-15 Safe and Sanitary Environment	Environment must be safe and sanitary, and the following must be inspected monthly: inmate housing, laundry services, housekeeping, risk exposures such as electrical outlets, heavy equipment, and operating systems.
P-18 Staff Credentials	Health care staff must be licensed, certified, or registered according to state laws.
P-19 Continuing Education for Health Professionals	Health care staff must receive 12 hours of continuing education or staff development annually, and training must be documented.
P-20 Training for Correctional Officers	Correctional officers must receive health-related training, including biannual CPR training.

NCCHC "Essential" Standard	Description
P-21 Medication Administration Training	Training on the medical and security aspects of administering medication is required.
P-22 No Inmate Health Care Workers	Inmates may not work as health staff.
P-27 Pharmaceuticals	Pharmaceutical services, including procuring, storing, prescribing, dispensing, administering, and disposing of pharmaceuticals, must be "sufficient" and meet legal requirements.
P-31 Inmate Orientation to Health Services	Institutions must notify inmates of the availability of health services within 24 hours of arrival.
P-32 Receiving Screening—Intake Unit	Inmates must receive a health screening upon admission to the prison system.
P-33 Health Screening Upon Transfer	Upon transfer, inmates must receive a health screening that includes, at a minimum, review of the medical record by health care staff within 12 hours of arrival.
P-34 Initial Health Assessment in 7 Days	A health assessment must be performed within 7 days of admission.
P-35 Mental Health Assessment	A mental health assessment must be performed within 14 days of admission, and the results must become part of the inmate's medical record.
P-36 Dental Care	Dental screenings, dental treatment, and oral hygiene education must be provided.
P-37 Handling of Routine Medical Requests	Inmates must be able to request routine medical assistance on a daily basis, and their requests are to be documented.
P-38 Sick Call	Sick call must be conducted 5 days per week by health care staff, and a physician must be on site seeing inmates a minimum of 3.5 hours per 100 inmates.
P-39 Daily Evaluation of Inmates in Disciplinary Segregation	Inmates in disciplinary segregation must have health evaluations to identify medical conditions contraindicating such placement and to ensure that their health does not decline while in segregation.
P-40 Direct Orders	Health treatment performed by nursing personnel must be pursuant to verbal or written orders signed by authorized personnel.
P-41 Emergency Services Available	24-hour emergency health care is required and must be outlined in policies and a written plan.
P-51 Special Needs Treatment Plans	Inmates must receive care and an individualized treatment plan for special needs such as chronic illnesses, physical disabilities, pregnancy, terminal illnesses, and serious mental health needs.

NCCHC “Essential” Standard		Description
P-52	Infirmary Care Available	Infirmary care must include 24-hour on-call physician services, nurse supervision, and admission to and discharge from an infirmary based on the decision of authorized health care professionals.
P-53	Suicide Prevention	Suicide prevention programs must be available and are to include training, evaluation, and intervention.
P-54	Intoxication and Withdrawal Treatment	Intoxication, overdose, and withdrawal services are to be provided.
P-55	Perinatal Care Available	Perinatal care is to be provided.
P-60	Health Records Format and Contents	The method of recording entries in health records must be defined by policy.
P-61	Confidentiality of Health Records	Health records and health information must be kept confidential.
P-62	Sharing of Information	Health information and confinement information may be shared between security staff and health care staff when necessary.
P-66	Therapeutic Restraints and Seclusion	Use of restraints or seclusion for mentally ill inmates must be appropriate and defined by policy.
P-67	Forced Psychotropic Medication	The use of forced psychotropic medication in an emergency situation must be defined by policy and authorized by a physician.

NCCHC “Important” Standards for Health Care in Prisons

NCCHC “Important” Standard		Description
P-09	Privacy of Care	Clinical encounters must be private.
P-10	Notification in Emergencies	An inmate’s family or legal guardian must be notified in case of emergencies.
P-11	Procedure in the Event of an Inmate Death	The medical examiner or coroner is to be notified immediately in the event of an inmate’s death, a postmortem exam is to be requested, and a mortality review is to be conducted.
P-12	Grievance Mechanism	A method for addressing inmates’ complaints about health care service is required.
P-13	Physician Peer Review	Evaluation of physician health care services through peer review is required.

NCCHC "Important" Standard		Description
P-16	Kitchen Sanitation and Food Handlers	Kitchen, dining, and food storage areas are to be kept clean and sanitary. Inmate food service workers are to be monitored for health and cleanliness.
P-17	Ectoparasite Control	Control procedures are required for communicable skin infestations.
P-23	Position Descriptions	Written position descriptions are required for health care personnel.
P-24	Staffing Levels	A written staffing plan that assures "sufficient" staff is required.
P-25	Orientation Training for Health Services Staff	Health care staff must receive a formal orientation.
P-26	Continuing Education for Health Services Administrative and Support Staff	Health care services administrative staff must receive continuing education.
P-28	Clinic Space, Equipment, and Supplies	Space, equipment, and supplies must be available for health care services.
P-29	Diagnostic Services	Some diagnostic services must be available on-site, and off-site services must also be available.
P-30	Hospital and Specialized Ambulatory Care	Hospital and specialized care is to be available from licensed facilities.
P-42	Patient Transport	Inmates are to be transported safely and on time to medical appointments.
P-43	Assessment Protocols	Written instructions and guidelines are to specify the steps to be taken in assessing patient health status.
P-44	Continuity of Care	There must be continuity of care from prison admission to discharge.
P-45	Health Evaluation of Inmates in Administrative Segregation	Inmates in administrative segregation must have access to health care services and must be checked by health care staff at least 3 times per week.
P-46	Health Education and Promotion	The institution is to offer health education and promote self-care.
P-47	Diet	An adequate diet based on national food guidelines is to be offered to all inmates.
P-48	Recreational Exercise	Recreational exercise, including large muscle activity, must be available.
P-49	Personal Hygiene	Bathing and laundry services must be available.
P-50	Smoke-Free Environment	Institution must be smoke-free for inmates and staff. Prevention and abatement programs must exist.
P-56	Inmates with Alcohol or Other Drug Problems	Recognition, assessment, and proper clinical management of inmates with alcohol and drug problems must be available.
P-57	Sexual Assault	Victims of sexual assault are to receive services including medical examination, medical treatment, counseling, and gathering of evidence.
P-58	Pregnancy Counseling	Counseling and assistance must be provided to pregnant inmates.

	NCCHC "Important" Standard	Description
P-59	Orthoses, Prostheses, and Other Aids to Impairment	Medical and dental aids must be supplied in cases when adverse affects are likely without them. Other aids to impairment include glasses, hearing aids, crutches, and wheelchairs.
P-63	Availability and Use of Health Records	Health records are to be available to all health care staff at each clinic visit.
P-64	Transfer of Health Records	Health records are to be transferred with inmates.
P-65	Retention of Health Records	Inactive health records are to be retained and reactivated when applicable.
P-68	Forensic Information	Health care staff may not collect forensic information.
P-69	Participation in Executions	Health care staff may not participate in inmate executions.
P-70	Informed Consent	Health care services are to be provided with informed consent by inmate or guardian.
P-71	Right to Refuse Treatment	Inmates must have the right to refuse treatment.
P-72	Medical Research	Research using inmates as subjects must be consistent with national standards for human research.

Appendix 4

Women's Health Statistics

Women's Health Demographics

As of December 1, 2000

Female inmate population*	1,148
Estimated number of inmates with a chronic condition	703
Percentage of inmates with a chronic condition	61.2%
Number of pregnant inmates	5
Number of births in calendar year 2000	41

* Includes female inmates at the Taycheedah and Dodge correctional institutions and female inmates in the Correctional Center System.

Estimated Number of Diagnosed Chronic Illnesses

Fall 2000

Condition	Estimated Number of Cases	Percentage of Female Population
Mental Illness	435	37.9%
Neurological	183	15.9
Cardiac	161	14.0
Asthma	156	13.6
Estrogen Replacement Therapy	95	8.3
Hematological	64	5.6
Gastrointestinal	61	5.3
Diabetic	42	3.7
Endocrinological	38	3.3
Irregular Pap Test Results	33	2.9
Pending Hysterectomy	2	0.2
Other	25	2.2

Appendix 5

Results of Self-Evaluation of Compliance with NCCHC "Essential" Standards

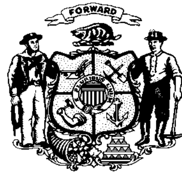
NCCHC "Essential" Standard		Met/ Not Met	Type of Change Needed for Standard to Be Met	Bureau of Health Services Comments
P-01	Access to Care	Not Met	Minimal procedural or policy changes	It is questionable whether NCCHC would allow correctional officers to deliver health services request forms, as they do at some institutions, and whether segregated inmates have adequate access to care.
P-02	Accountable Health Authority	Met		
P-03	Medical Autonomy	Met		
P-04	Administrative Meetings and Reports	Met		
P-05	Policies and Procedures at All Institutions	Not Met	Minimal procedural or policy changes	Required policies are not in place at some institutions; at others, they have not been signed. Work is currently in progress to meet this standard.
P-06	Quality Improvement Program	Not Met	Additional review and/or resources	In FY 1999-2000, 4 of 11 institutions with more than 500 inmates lacked quality improvement committees, and physicians do not review health care records and health care delivery at all institutions.
P-07	Emergency Plan	Not Met	Additional review and/or resources	Most institutions do not practice plans annually.
P-08	Communication on Special Needs Patients	Not Met	Minimal procedural or policy changes	The Security Condition Report, the Department's form for health staff to notify security staff of inmate health conditions that make particular disciplinary measures inadvisable, must be in full use by all staff.
P-14	Infection Control Program	Not Met	Minimal procedural or policy changes	A policy ensuring that communicable diseases are reported to the proper authorities is needed.
P-15	Safe and Sanitary Environment	Not Met	Additional review and/or resources	Timely inspection of institutions is needed.

NCCHC "Essential" Standard		Met/ Not Met	Type of Change Needed for Standard to Be Met	Bureau of Health Services Comments
P-18	Staff Credentials	Met		
P-19	Continuing Education for Health Professionals	Not Met	Minimal procedural or policy changes	Continuing education is not properly documented at all institutions, and some staff might not receive the number of required hours annually.
P-20	Training for Correctional Officers	Not Met	Additional review and/or resources	Many correctional officers received CPR training only at the time they entered employment.
P-21	Medication Administration Training	Not Met	Additional review and/or resources	Training does not include common side effects of certain medications.
P-22	No Inmate Health Care Workers	Met		
P-27	Pharmaceuticals	Not Met	Additional review and/or resources	Further review is necessary.
P-31	Inmate Orientation to Health Services	Not Met	Minimal procedural or policy changes	Some institutions have difficulty meeting this standard because of the extent to which inmates move in and out.
P-32	Receiving Screening—Intake Unit	Not Met	Minimal procedural or policy changes	Certain inmates who are held for a short time at Dodge might not always receive screenings.
P-33	Health Screening Upon Transfer	Not Met	Additional review and/or resources	When inmates transfer at night, on weekends, or for short-term stays such as for parole violations, health care staff do not consistently review the health records within 12 hours.
P-34	Initial Health Assessment in 7 Days	Not Met	Additional review and/or resources	Department policy requires that assessments be completed within 14 days.
P-35	Mental Health Assessment	Not Met	Additional review and/or resources	Clinical records are kept separately from medical records, and the timeliness and completeness of assessments might not meet the standard.
P-36	Dental Care	Not Met	Additional review and/or resources	Dental assessments might be delayed at some institutions, and oral hygiene education is not provided at all.
P-37	Handling of Routine Medical Requests	Not Met	Additional review and/or resources	Weekend and holiday requests might not be documented sufficiently.
P-38	Sick Call	Not Met	Additional review and/or resources	Some institutions do not have a physician available for at least 3.5 hours per week for every 100 inmates.

NCCHC "Essential" Standard		Met/ Not Met	Type of Change Needed for Standard to Be Met	Bureau of Health Services Comments
P-39	Daily Evaluation of Inmates in Disciplinary Segregation	Not Met	Significant staffing resources	Inmates being held in segregated custody do not receive daily visits by health care staff at all institutions due to insufficient staff.
P-40	Direct Orders	Met		
P-41	Emergency Services Available	Not Met	Minimal procedural or policy changes	Some institutions have not documented all of the necessary steps for the provision of 24-hour emergency services, although all institutions report they have 24-hour emergency care available.
P-51	Special Needs Treatment Plans	Not Met	Additional review and/or resources	Inmates with special health needs do not have individualized treatment plans because of insufficient staff.
P-52	Infirmary Care Available	Met		
P-53	Suicide Prevention	Not Met	Additional review and/or resources	Suicide prevention polices do not appear to meet the standard because they do not address training on suicide risks.
P-54	Intoxication and Withdrawal Treatment	Met		
P-55	Perinatal Care Available	Met		
P-60	Health Records Format and Contents	Met		
P-61	Confidentiality of Health Records	Met		
P-62	Sharing of Information	Met		
P-66	Therapeutic Restraints and Seclusion	Met		
P-67	Forced Psychotropic Medication	Met		

Scott McCallum
Governor

Jon E. Litscher
Secretary



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May 9, 2001

Janice Mueller, State Auditor
Legislative Audit Bureau
22 E. Mifflin Street, Suite 500
Madison, WI 53703

Dear Ms. Mueller:

Thank you for the opportunity to review and respond to the Legislative Audit Bureau's (LAB) evaluation of prison health care in the Department of Corrections. I appreciate the time and the effort that your staff invested in learning the many facets involved with inmate health care. They displayed the highest level of professionalism.

We are proud of the services being delivered by the Department's staff in the area of health care. They have risen to the challenges involved with providing care to increasing populations with limited resources. As the report documents, the Department receives as many as 1,000 requests from inmates for routine health services and responds to an average of 22 health emergencies daily. In an environment where one of every three inmates has a chronic illness, the challenges to providing health care are numerous.

The Department has taken many strides to evaluate and improve the management of the inmate health care delivery system within Wisconsin. Many of the initiatives undertaken address issues raised in the audit. Following are some highlights of the Department's ongoing efforts.

Health Service Action Plan - As the report indicates, the Department has developed a Health Services Action Plan that is designed to guide continuing internal review and improvement of health services. Included in the ongoing plan is the systematic review of standards, policy and procedures, protocols, and communication; and evaluation of resources and training needed.

Independent Consultant Review - A private, independent management consulting firm has been utilized to review the delivery of health care within the department. The consultants performed data and cost analysis, assisted with contracting and conducted a pharmacy cost and utilization analysis. They assisted the department in developing a Request For Proposals (RFP) for a variety of health services that would have awarded contracts for health care services on a regional basis. While this initiative is consistent with an LAB recommendation to "determine whether costs can be controlled by either seeking better rates with alternative vendors or consolidating contracts", it was not successful because of limited interest by vendors.

Contract Management - A Nurse Coordinator has been reassigned to monitor all professional medical service contracts and make recommendations on improving future vendor contracts. The Department has already identified savings with the implementation of improved monitoring of contract expenditures.

The Department has also focused an effort on the improvement of contract language to ensure quality services at the best possible costs. The Department is in the process of creating a full time Business Manager in the Bureau of Health Services to ensure fiscal accountability, improved contract negotiation, and budget management.

Medical Directors - The Department has appointed two part-time interim Medical Directors to provide direction in evaluating and enhancing the current health care system within the Department. These physicians have extensive experience in medical management of health care organizations and bring with them demonstrated strengths in quality improvement; case, disease, and pharmacy management; and financial decision-making.

Telemedicine - The Department and UWHC jointly have undertaken a comprehensive review of telemedicine in Wisconsin correctional health care. The DOC/ UWHC workgroup is surveying other states, looking at expanding the number of specialty clinics with telemedicine protocols, exploring cost benefits, and examining the possibilities of telemedicine for urgent care, primary care, and mental health services.

Medical Transportation - The Department did not fully implement the central medical transportation pilot recommended by the LAB because additional costs related to the re-allocation of staff and overtime negated the projected savings. In addition, the Department identified several security issues with the pilot.

The pilot, however, did result in the implementation of several other important medical transportation initiatives that have reduced transportation and overtime costs. These include the creation of a northern transportation hub at Jackson Correctional Institution in Black River Falls, inmate vigil responsibility being assigned to specific institutions, and temporary housing of inmates with significant health care issues at Dodge Correctional Institution for ease in scheduling and transporting to UWHC.

I would again like to thank you and your staff for your time and thoughtful analysis provided throughout this report. Combined with the provisions included in the Governor's budget, the recommendations will assist the Department in its efforts to ensure continuous improvement in the delivery of health care to inmates.

Sincerely,

Jon E. Litscher
Secretary of Corrections