Memorandum

MIAMI-DADE COUNTY

DATE: May 17, 2007

HPSC
Agenda Item No. 7(A)

TO: Honorable Chairperson Bruno A. Barreiro and Members, Board of County Commissioners

FROM: George M. Burgess
County Manager

SUBJECT: Report on Inmate Healthcare Services

Resolution R-458-06, sponsored by Commissioner Rebeca Sosa, directed the County Manager to evaluate potential sources for healthcare services for individuals in the custody of Miami-Dade Corrections and Rehabilitative Department (MDCR). The following report was prepared with input from MDCR, the Public Health Trust (PHT), Department of Procurement Management, Office of Healthcare Planning (OCHP) and the Office of Strategic Business Management. It addresses current inmate medical services, comparative expenditures, pricing models, contracting considerations, best practices and recommendations from County staff. In addition, the report includes research on inmate healthcare from other jurisdictions, identified third party vendors that offer these services and the associated costs.

In summary, the research and input provided by the County agencies, indicate the need to conduct an independent in-depth analysis of the current level of services administered by PHT against national standards, evaluate areas where potential cost efficiencies can be realized and recommend necessary program realignments. Pending completion of the analysis, PHT will continue to provide inmate medical services. In addition, on-going discussions between Jackson Health System (JHS) and MDCR will continue in order to identify ways to further improve services and amend the existing contract, as needed.

CURRENT SERVICES PROVIDED FOR INMATE HEALTHCARE

Currently, inmate medical services are delivered by Jackson Health System (JHS), Corrections Health Services (CHS), under a contract between MDCR and the PHT. The total annual cost to JHS for inmate medical services is approximately $24 million of which MDCR pays $4.9 million and the balance is paid by PHT (Attachment A). The FY 2006-07 Adopted Budget includes $645,000 in additional funding to increase the number of mental health professionals assigned to the jails. Additionally, the County reimburses approximately $1.3 million to other providers where inmates may be transferred for emergency services.

MDCR operates six jails with an average daily inmate population of almost 7,000. Corrections Health Services (CHS) include both in-jail clinical services and in-patient hospital services. Treatment statistics for FY 2005-06 are listed in Attachment B.

- ***In-Jail Clinical Services***
  JHS provides primary care, dental, mental health and pharmacy services 24 hours a day, seven days per week. Patients are medically screened to determine specific medical needs. At any time during incarceration, inmates can request to be seen by health staff. A small number of inmates are referred for community services/follow-up upon release. When medically indicated, patients are sent to Jackson Memorial Hospital's (JMH) Ward D for hospitalization. In cases of emergency, inmates may be taken to the closest available hospital, and transported to JMH when determined stable. Inmates are also sent from MDCR jail facilities to JMH for diagnostic services and/or specialty physician clinic visits.

- ***In-patient Hospital Services***
  Ward D is a lockdown unit located at JMH staffed with medical personnel from JMS and MDCR correctional officers 24 hours a day, seven days per week. The unit operates a separate emergency/triage area where inmates are screened as they come in to determine if an inmate has a general medical condition that can be treated at the unit. The unit cannot handle obstetrics, rape victims, cardiac conditions that require monitoring, intensive care, trauma, or vision problems. Inmates with these conditions are stabilized and transferred to other areas of the hospital that treat these specific conditions. Psychiatric patients are stabilized and returned to the psychiatric floor of the main jail.

Inmates are accompanied by MDCR correctional officers at all times, regardless of the location where they are assigned to receive necessary medical services. MDCR estimates the annual cost of providing these security services is approximately $10 million.

MDCR (Inmate Safety/Guarding)

Expenditures	
WARD-D	6,816
NON-JMH	3,415
Total Expenditures	**10,231**
Staffing	
Regular	55
Overtime (Ward D)	14
Overtime (others)	36
Total FTEs	**105**

PRICING MODELS FOR PRIVATE HEALTHCARE PROVIDERS

Research findings and feedback from private healthcare providers indicate there are several models for structuring inmate medical care contracts, and each approach involves varying degrees of risk. Inmate medical services costs are typically positively correlated with the increase in actual and perceived risks assumed by the healthcare provider. Some contract pricing models are outlined below. These contracting models apply to both private and public sector providers. Providers have also indicated a willingness to develop customized approaches for each client.

- ***Staffing with Claims Adjudication Model***
  The vendor provides staffing for inmate services and has the sole authority to render decisions all off-site claims. By having the authority to adjudicate claims without participation of the using jurisdiction, the vendor expects to minimize costs. The user jurisdiction avoids the price increase that would otherwise be included in the bid price since vendors would be obligated to include a risk premium in their price proposal. This premium would compensate for the inability of the jurisdiction to manage claims adjudication. This model is the least expensive.

- ***Aggregate Limits Model***
  The vendor is responsible for all on-site and off-site care and costs up to a fixed limit. The vendor's responsibility for off-site and pharmacy costs would be limited to a fixed annual aggregate cost. For example, a vendor could agree to pay off-site and pharmacy costs up to $1 million per year. If the total cost for the year is less that the agreed sum, the savings are returned to the jurisdiction. If costs exceed the value up to a certain predetermined limit (Tier 2) the jurisdiction and the vendor would share the added cost based on some predetermined ratio. Expenses in excess of the Tier 2 limit would be the sole responsibility of the client.

- ***Per Inmate Aggregate Limits Model***
  Typically, this option is more expensive than the aggregate limits model. In this model, the vendor provides all care and pays for all off-site care up to a fixed amount for each inmate over a one year period. Unless the per inmate aggregate limit is fairly low (approximately $5,000 – $10,000), the associated risk (real and perceived) assumed by the vendor is high and may not yield significant economies. Additionally, this model may not be attractive to many vendors, but provides significant advantages to the using jurisdiction.

- ***Full Risk Model***
  The vendor provides and pays for all inmate healthcare costs based on a proposed/bid price. This model allows the using jurisdiction to benefit from a fixed healthcare budget. The bid price typically includes a significant risk premium because the type, number and severity of illnesses are unknown.

A review of the contracts and requests for proposals advertised by various jurisdictions show that healthcare providers are required to provide a variety of services and to assume a myriad of responsibilities and associated risks. These include responsibility for coordination of care, providing initial health screening at intake, in-patient and out-patient care, infirmary and hospitalization care, mental health services, crisis stabilization, psychiatric care and psychological evaluations and referrals. In all the cases reviewed, the jurisdiction provided facilities space, security, and where applicable, allowed the healthcare provider to utilize existing medical equipment owned by the jurisdiction.

The research also indicates that there are several additional operating and contracting issues that should be taken into account in the provision of inmate healthcare. These include:

- Service delivery in accordance with the standards of National Correctional Healthcare and the American Correctional Association
- Employment of qualified medical staff to include thorough background checks
- Development and improvement of in-house infirmaries
- Implementation of pricing control mechanisms to control pharmacy costs, laboratory analyses and other cost escalations
- Implementation of secure inmate medical record management tracking system
- Regularly scheduled audits
- Inclusion of general prison population, allied facilities, road prisons, work camps and release centers

The research has indicated that in those communities where correctional health is privatized, contracts should be extensively detailed and should be managed by a public health provider. Additionally, some national data indicates that privatizing correctional health has only averaged a savings of five percent annually. Contracting with private entities for correctional health has proven most effective for facilities in smaller communities where recruiting medical personnel is difficult. National correctional healthcare experts have expressed concerns due to the historically unsuccessful ability to effectively offer incentives to private providers to deliver comprehensive, quality health services within such a complex population.

COMPARATIVE MODELS FOR INMATE HEALTHCARE

The City of Jacksonville and Polk County Sheriff's Office purchase inmate healthcare services through Correctional Medical Services, Inc. (CMS). CMS provides medical, dental and mental healthcare services, substance abuse care, and performs a comprehensive health evaluation of each inmate taken into custody. Additionally, CMS provides emergency services, inmate transportation, hospitalization services and both off-site and on-site specialty services.

The Florida Department of Corrections contracts with Prison Health Services, Inc. to provide inmate healthcare services. The contractor is responsible for all costs associated with the provision of comprehensive healthcare services including the costs of pharmaceuticals, medical, dental and mental health services. The contract includes the general prison population, allied facilities, road prisons, work camps and release programs.

The Kentucky Corrections Healthcare Services Network (KCHSN) is a collaboration of agencies that manages and delivers healthcare to 13 prisons and 75 jails across the state. The partnership includes the Kentucky Department of Corrections, the University of Kentucky and CorrectCare, a private health management firm. According to the Kentucky Governor's office, the partnership has reduced the cost of inmate care by approximately $9 million or 40 percent in the first year.

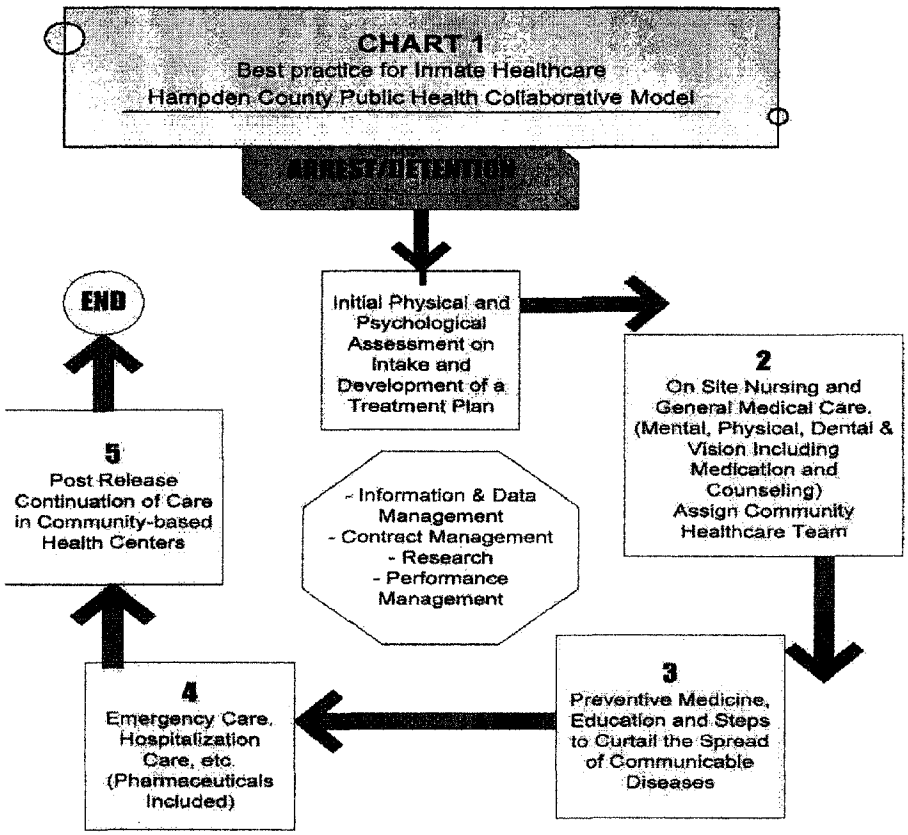
A comparative of inmate healthcare costs for other public jurisdictions is listed in Attachment C. Please note that the comparative includes both prison and jail facilities, both of whom may require different types and scope of healthcare services.

BEST PRACTICES

The Office of Countywide Healthcare Planning (OCHP) reviewed over 30 national and state informational sources on prison and jail services, as well as consulted with Dr. B.J. Anno, a nationally recognized expert in corrections health and Judy Stanley, quality management staff at the National Commission on Correctional Healthcare. Best practices in inmate healthcare indicate that jurisdictions should provide inmate healthcare based on a continuum. Research conducted by OCHP indicates that the Hampden County Public Health Collaborative Model is the industry standard for best practices for inmate healthcare. This model provides a comprehensive spectrum of inmate health services beginning within the first days of incarceration and following their care as they re-enter society. The model emphasizes wellness, health education and prevention. It employs a proactive rather than reactive approach to quality health care and serves as a public health sentinel indicator for the community providing data that can be integrated with other community service data.

The five core elements of the model listed below. The research performed indicates that the core elements of the Hampden County Public Health Collaborative Model have been adapted in 25 state departments of corrections and some county jail systems in New York, Chicago, Philadelphia and Hampden County, MA.

- Early assessment and detection
- Prompt and effective treatment at a community standard of care
- Disease prevention including comprehensive health education
- Continuity of care in the community upon release
- Outcome based research



While many of the following five elements are present in community correctional systems, including the system currently operated by the PHT (elements one and two), the Public Health Collaborative Model notes targeted components:

- ***Early assessment and detection***
  Initial assessment of inmate health status within 14 days of arrival to include physical, dental and mental status per accreditation standards set by the National Commission on Corrections Health Care. The establishment of a baseline for chronic physical and mental health needs of each inmate to help prioritize treatment and prevention interventions and the development of an initial treatment plan covering the conditions identified.

- ***Prompt and effective treatment at a community standard of care***
  On-site nursing clinic five days a week, daily "sick call," on-site pharmacy, group and individual disease-specific educational sessions, on-site substance abuse and mental health treatment, emergency and surgical services at local hospitals. Daily nurse and mental health clinicians serve as a triage system where services are brought directly to inmate living quarters in order to assess health status, deliver care and respond to non-emergency complaints.

- ***Disease prevention including comprehensive health education***
  Health education begins during inmate orientation and is delivered through a variety of methods such as individual/group education, chronic disease management, and wellness programs. Comprehensive inmate health education, especially for prevention of infectious and chronic diseases and substance abuse is critical.

- ***Continuity of care in the community upon release***
  Discharge planning by healthcare teams that work in the jail and the community (physicians, nurses, case managers, mental health provider, etc.) begins when the inmate is admitted. These relationships enable continuity of care from incarceration through release. Planning for release is provided by provider care teams throughout the incarceration period and includes non-medical needs such as housing, financial assistance, etc. Financial contracts with local community health centers and mental health providers, dental and optometry providers to deliver services on-site and in the community must be established.

- ***Outcome based research***
  Studies following inmate re-entry are integrated into the larger public health monitoring function in collaboration with community-based providers and academic public health institutions. Ideally, longitudinal data should be captured and analyzed for continuing baselines and treatment outcomes during incarceration and should follow inmates through re-entry.

Different variations of this model have been employed by state correctional systems and in some county jail systems including New York City, Chicago, Philadelphia and Hampden County, MA. In California, the Department of Health Services works with corrections during intake by providing HIV/AIDS, sexually transmitted disease and hepatitis testing, as well as education and prevention services. In New York City, corrections staff coordinates with community public health staff on public health strategies that reduce the communication of disease, both within the facilities and upon release. In this way, strategies for reducing the incidence of communicable diseases are consistent, if not part of the same program, with initiatives in the community. Oklahoma, Virginia and Wisconsin rely on public university hospitals for medical care, hospitalization and emergency room services, while they contract with county health departments for education and prevention services.

JMS's CORRECTIONS HEALTH SERVICES

JMS's Corrections Health Services (CHS) states that it continuously reviews alternative correctional health care providers to ensure it is providing the most cost effective service delivery system. In 1991, with an outside consultant hired by the County and again in 2003, with an in-house review of vendor cost proposals, CHS continued to be the most cost effective option. Below is CHS's fiscal track record for the last five years.

CHS ANALYSIS OF OVERALL EXPENSES & ACTIVITY
FY 2002-2006

FY	Average Daily Census	Total Actual Expenses	Cost/Inmate/Day	Inc/Dec 02-06	FTE Actual
'02	6638	$17.8 M	$7.35		209.0
'03	6687	$17.8 M	$7.31		203.7
'04	6524	$18.3M	$7.71		193.1
'05	6643	$18.0M	$7.45		183.7
'06	6637	$18.2M	$7.52	2.4%	180.8

- *The average daily census was essentially flat during this five year period since no new jail bed capacity was added and the system is consistently pushing the limits of its capacity.*
- *FTE's have been reduced by 13.5 percent over the last five years through job combinations, floating of staff among facilities and use of automation.*
- *Total actual expenses rose 2.25 percent over this five year period – despite annual cost of living adjustments in the 3-4 percent range annually, and that 82 percent of total actual expenses are labor costs.*
- *CHS total cost per inmate per day rose only 2.4 percent for the five year period despite increases in labor and drug costs.*

CHS ANALYSIS DRUG EXPENSE FY 2002-2006			
FY	COST OF DRUGS	AVERAGE DAILY CENSUS	COST/INMATE/DAY
'02	$3,771,233	6638	$1.55
'03	$3,245,178	6687	$1.33
'04	$3,143,876	6524	$1.32
'05	$3,130,845	6643	$1.29
'06	$2,791,582	6637	$1.15

- *CHS pharmacy was the second correctional healthcare provider in the nation to receive approval for 340B drug pricing. Only VA hospitals receive a lower pricing plan from the drug wholesalers. CHS is able to purchase drugs from a wholesaler at lower costs than JMH. Savings with 340b pricing is 30 percent compared to previous pricing.*
- *CHS drug cost per inmate per day has decreased by 25 percent over the last five years. At the same time, there has been a dramatic increase in the number of mental health inmates requiring medication. This is also due to prescriber education programs initiated by the CHS wherein adherence to formulary, disease management, and adherence to prescribing algorithms are stressed.*

RECOMMENDATIONS

In order to adopt a comprehensive cost-effective system of inmate healthcare that utilizes industry best practices and ensures the health of the inmate population, in recognition to the contribution that lack of such practices may be detrimental to the Miami-Dade community public health, the following actions are recommended:

- Continue to provide inmate medical services under the current contract with PHT.
- Continue discussions between CHS and MDCR to identify ways to further improve services and amend the existing contract, as needed.
- Employ the services of an independent inmate healthcare professional to conduct a comparative analysis of the current services, as administered by CHS to current best practices in the industry, evaluate areas for cost efficiencies and recommend necessary program realignments.

Upon the conclusion of this recommended analysis, a follow-up report will be provided to the Board.

Susanne M. Torriente
Assistant County Manager

ATTACHMENT A

COST OF INMATE MEDICAL SERVICES
FY 2005-06 ACTUAL ($1,000'S)

Revenues	PHT (inpatient and outpatient services)	GG (emergency and other inpatient)	TOTAL Inmate medical cost and staffing
COUNTYWIDE GENERAL FUND		1,271	1,271
MDCR	4,900		4,900
PHT REVENUES	19,276		19,276
Total Revenues	24,176	1,271	25,447
Expenditures			
IN-JAIL	19,464		19,464
WARD-D	4,712		4,712
NON-JMH		1,271	1,271
Total Expenditures	**24,176**	**1,271**	**25,447**
Staffing			
In-Jail	189	0	189
Ward-D	26	0	26
Total FTEs	**215**	**-**	**215**

-Total expenses for In-Jail Corrections Health Services (CHS) were $19.464 million ($18.21 million direct expenses plus indirect costs of$1.254 million). Ward Expenses were $2.952 million $1.760
*-Total expenses for Ward-D*were $4.712 million ($2.952 million direct expenses plus indirect costs of$1.76 million).*

ATTACHMENT B

TREATMENT STATISTICS IN-JAIL SERVICES
FY 2005-06

Inmate contacts with healthcare staff	405,500
Inmates screened for immediate medical need during intake	101,296
Inmate health appraisals (detailed health history, physical, TB and STD testing)	28,284
Total "visits"	**535,080**

**Difference in numbers relates to the number of inmates who stay 14 days or longer*

TREATMENT STATISTICS WARD-D
FY 2005-06

Total number of beds	31
Average number of beds that are staffed	14
Average daily census in beds	10.2
Historical high occupancy	18-20
Average length of stay (in days)	10
Number of Ward D emergency room visits	4,537
Number of inpatient admissions	360
Patient days	3,657

ATTACHMENT C

		Comparative Inmate Healthcare Costs			
Jurisdiction	**Average Daily Inmate Population**	**Healthcare Provider**	**Annual Cost**	**Equivalent Cost per Inmate/Year**	**Comments**
Miami-Dade County	**7,000**	**Public Health Trust (PHT) (Miami-Dade County Hospital System)**	**$19,000,000 (reported total PHT cost) $4,900,000 (MDCR reimbursement to PHT)**	**$2,714***	**Yearly billing based on agreement between MDC & PHT.* The PHT reported total inmate medical cost is $19M including the $4.9 million reimbursed by the Department of Corrections. This indicates a total inmate medical cost of $2,714 per inmate per year**
State of California Department of Corrections and Rehabilitation	170,000	Department of Corrections and Rehabilitation Healthcare Services	$1,000,000,000	$5,882	In house infirmaries and community based facilities. CA Forensic Medical Group Inc. provides medical services for some of California's counties. Inmate population includes approximately 10,000 personnel in Camps.
Broward County, FL	4,332	Armor Correctional Health Services Inc.	$22,334,350 (for up to 5,000 inmates)	$5,386	Correctional facility clinics and local hospitals are part of the program. The county issued a competitive solicitation but later awarded the contract as a bid waiver.
New York State	65,000	Department of Health, Office of Mental Health and Office of Substance Abuse Services	$303,000,000	$4,662	Includes in-house infirmaries and community based facilities. The state has a statewide network of 1,000 community based specialists that provide specialty consolations in correctional facilities. A telemedicine program is also used. For fatal diseases such as Hepatitis C, HIV/AIDS, etc. the state provides treatment through outside contractors such as Albany Medical Center and the Department of Health Aids Institute.
Hillsborough County, FL	4,799	Armor Correctional Health Services Inc.	$20,967,990	$4,369	Medical, emergency, mental health, pharmacy, laboratory, infection control are included in the contract.
Maricopa County, AZ	10,000	Correctional Health Services (CHS)	$43,000,000	$4,300	Includes in-patient psychiatric units and in-patient infirmaries in each jail. The United States Department of Health and Human Services awarded Correctional Health Services a $1.1 million grant for implementation of a telemedicine program. CHS has partnered with the Arizona Telemedicine Program which is affiliated with the University of Arizona Medical School and is recognized as a leader in telemedicine.
Florida Department of Corrections Region IV	17,484	Prison Health Services Inc.	$70,791,317	$4,049	Monthly billing based on average daily population (per inmate per diem). Medical, emergency, mental health, dental, pharmacy, laboratory, radiology and health education are included in the contract.

City of Jacksonville	3,420	Correctional Medical Services	$8,858,576	$2,590	Monthly billing based on average daily population (per inmate per diem) Medical, emergency, mental health, dental, pharmacy, laboratory, radiology and health education are included in the contract.
Los Angeles County, CA	21,000	Medical Service Bureau	$52,300,000	$2,490	In house infirmaries and community based facilities. In-house jail pharmacy system, records system, disease control, mental health, etc. are included.
Frankfort, KY	18,000	Kentucky Corrections Health Services Network (KCHSN), CorrectCare	$25,000,000	$1,389	Includes correctional facility clinics and local hospitals. The Kentucky Corrections Health Services Network (KCHSN) is a collaboration among the Kentucky Department of Corrections, the University of Kentucky and a private sector health management firm based in Lexington, CorrectCare. KCHSN is a statewide health network that provides for the hospital and specialty care for more than 18,000 state inmates across the state.
New York City	13,750	Prison Health Services Inc. (PHS)	N/A		Seriously ill inmates and those requiring intensive psychiatric observation are held in prison wards that the department operates in Elmhurst General Hospital, Kings County Hospital and Bellevue Hospital The North Infirmary Command on Rikers Island houses detainees with less serious medical problems and persons with AIDS not requiring hospitalization, as well as high security inmates. Services provided by PHS.
Orange County, CA	5,000	Correctional Medical Services (CMS)	N/A		CMS has a written agreement with local hospitals to provide medical services for inmates in the Orange County Jail system. These services include specialty consultations, treatment services and in-patient care. Inmates are referred to these facilities when appropriate. CMS Partners with the Orange County Sheriff's Office and Orange County Health Care Agency
State of Georgia	42,000	Georgia Correctional Healthcare (GCHC)	N/A		Correctional Facility clinics and local hospitals a re part of the program. Georgia Correctional HealthCare (GCHC) is the division of the Medical College of Georgia that provides health care to over 80 facilities throughout the State for the Georgia Department of Corrections. GCHC manages the healthcare units at 40 state prisons, 1 Boot Camp, 21 Probation Detention Centers, and 6 Transition Centers. Regional infirmaries provide 24 hour, 7 days per week primary healthcare services at 14 of these sites.