# DOES SANTA CLARA COUNTY PAY TOO MUCH FOR ADULT INMATE HEALTHCARE?

## Summary

Based on a citizen's complaint noting that inmate healthcare costs in Santa Clara County (County) were relatively high in comparison with those in several other California counties, the 2004-2005 Santa Clara County Civil Grand Jury (Grand Jury) conducted an inquiry into the costs of adult inmate healthcare in the County. The inquiry included reviews of previous studies of inmate healthcare costs published in the press and those performed by consultants to the County. The inquiry also included interviews with relevant County government and management officials and with personnel in the Department of Correction (DOC) and the Santa Clara Valley Health and Hospital System (SCVHHS). The Grand Jury performed independent analyses of information obtained from County offices in an attempt to evaluate the rationale for inmate healthcare costs and their justification.

The Grand Jury has serious concerns about the justification for the current level of adult inmate healthcare costs in the County and has made four findings summarized here and explained in more detail in the *Findings and Recommendations* section of this report:

- The quality of adult inmate healthcare in the County appears to be very good and to exceed the requirements of Title 15 of the California Code of Regulations;
- The cost of adult inmate healthcare in the County for FY 2004-2005, about $38.3 million per year, is high by a number of measures. This cost is as much as $16.4 million above the cost of fully paid healthcare benefits provided to a comparable number of County employees. Although this is not a perfect comparison, no other quantitative information was available from County officials as they have not done any comparison of their costs against other similar entities. County managers responsible for these services do not have any satisfactory, quantitative justification for these cost differences;
- SCVHHS reports to the County Executive (CE) and DOC reports to the Board of Supervisors (BOS); hence, the lines of responsibility, accountability, and reporting for the organizations in charge of adult inmate healthcare (DOC and SCVHHS) are independent. As a result, it is difficult to assess and manage on-going inmate healthcare costs, and there appear to be no clear incentives for either SCVHHS or DOC to lower these costs; and
- Current record management and information technology (IT) systems in DOC and SCVHHS are wholly inadequate to provide necessary information to properly assess and manage inmate healthcare delivery and its associated costs. The systems are largely manual and uncoordinated. The SCVHHS Pharmacy

Services group is an exception to this finding and serves as an example of what can be accomplished with appropriate and professionally implemented information services.

# Background

The County system of correctional facilities and associated adult inmate healthcare services is complex. In order to discuss the nature of the costs involved and the indicators used to assess reasonability and cost-effectiveness of the system, a range of background materials is presented reflecting the key aspects of the system. To set this stage, brief overviews of the following topics are given in the following sections:

- The County correctional system and relevant demographics of inmates;
- The legal basis and obligation for inmate healthcare;
- How Santa Clara County organizes and delivers inmate healthcare; and
- Some statistics about the types of healthcare interventions delivered.

### CORRECTIONAL SYSTEM SUMMARY AND INMATE DEMOGRAPHICS

Until 1987, County correctional facilities were operated under the Sheriff's Office. In 1987, a separate Department of Correction was established by the BOS with the approval of voters. Under the DOC, the County operates an extensive correctional detention system. Adult inmates are held in either the Main Jail or in the medium- and minimum-security Elmwood Correctional Facility, which includes the Elmwood Women's Facility (formerly known as the Correctional Center for Women – CCW). Note that the County also operates juvenile detention facilities but these are not the responsibility of DOC and are not included in the scope of this report.

The overall DOC system holds an average of 4,200 adult inmates and is the sixth largest jail system in California. The inmate population of the Main Jail numbers about 1,200 and that of the Elmwood Facility 3,000 (2,500 males and 500 females).

These facilities are used to hold inmates who are still in process in the judicial system and have not been sentenced, those who have been detained for psychiatric evaluation under California Welfare and Institutions Code Sections 5150 (72-hour holds) and 5250 (14-day certifications) or Section 5332 (capacity to refuse psychiatric medications – Riese hearings), those who have misdemeanor or short felony sentences, and those who are committed to a work furlough program. The average length of stay for inmates in the system is about 100 days. The average length of stay varies from a low of about 30 days for those awaiting sentencing for misdemeanors to about 130 days for those awaiting sentencing for felonies. All long-term (sentences greater than 1 year) felony prisoners are housed in the state prison system. The County also houses a small number of inmates from federal, state, and other county jurisdictions under contract arrangements approved by the BOS.

This relatively short length of stay means there is a high traffic in prisoner bookings and releases through the system. Each year, 65,000 persons are processed at the Main Jail. The majority are cited and released or post bail on their charges. The remaining are

classified by their offense, their behavior and health status, the potential threat they pose to themselves and/or others, and other parameters to determine where they will be held as they enter the system.

## LEGAL BASIS FOR INMATE HEALTHCARE

In addition to providing for public safety and jail security, the County is responsible for the humane treatment, feeding, well-being, and healthcare of its inmate population. Because inmates have no ability to seek care on their own for injuries or illnesses, healthcare is mandated under California Penal Code Section 6030 et seq. (see Appendix A):

> "The Board of Corrections shall establish minimum standards for local detention facilities… The standards shall include, but not be limited to, the following: health and sanitary conditions… The standards shall also include requirements relating to the acquisition, storage, labeling, packaging, and dispensing of drugs… In establishing minimum standards, the Board of Corrections shall seek the advice of the following:… (1) For health and sanitary conditions:… The State Department of Health Services, physicians, psychiatrists, local public health officials, and other interested persons… For the purpose of this title, "local detention facility" means any city, county, city and county, or regional facility used for the confinement for more than 24 hours of adults…".

This responsibility is further elaborated under California Code of Regulations, Title 15, Division 1, Chapter 1, Subchapter 4, *Minimum Standards for Local Detention Facilities* (Section 1200 et seq.):

> "… (a) In Type I, II, III and IV facilities, the facility administrator shall have the responsibility to ensure provision of emergency and basic health care services to all inmates. Medical, dental, and mental health matters involving clinical judgments are the sole province of the responsible physician, dentist, and psychiatrist or psychologist respectively; however, security regulations applicable to facility personnel also apply to health personnel… Each facility shall have at least one physician available to treat physical disorders… (b) In court holding and temporary holding facilities, the facility administrator shall have the responsibility to develop written policies and procedures which ensure provision of emergency health care services to all inmates…".

Incarcerated persons are among the very few members of our society who are entitled to a "reasonable" level of healthcare by law. Much of this report will focus on discussing what constitutes "reasonable healthcare".

## SANTA CLARA COUNTY ORGANIZATION AND DELIVERY OF INMATE HEALTHCARE

In Santa Clara County the responsibility for adult inmate healthcare rests with DOC and is split operationally between DOC, which provides detention facilities and security for incarcerated persons, and SCVHHS, which provides professional healthcare personnel, prescribed drugs, and services for routine and acute or emergency care to inmates. A Memorandum of Understanding (MOU) governs the coordination between DOC and

SCVHHS for inmate healthcare. The most recent draft of this MOU, dated December 2004, is shown in Appendix B. The introduction of the MOU states:

> "Department of Correction facility administrator (Chief, DOC) shall have the responsibility to ensure provision of emergency and basic health care services to all inmates. The Department of Correction, as the Agency responsible for the management of inmates remanded to the custody of the Santa Clara County Jail facilities, and Santa Clara Valley Health and Hospital System, as the agency responsible for medical, dental and mental health matters involving clinical judgments, agree to the following conditions in respect to the delivery of medical and mental health services to incarcerated individuals within the jail facilities, the ambulatory clinics and inpatient units of Santa Clara Valley Medical Center."

Furthermore, the *Philosophy of Health Care* section of the MOU states:

> "The provision of health care will focus on the prevention of illness, the control of pre-existing pathologies, and the restoration to health once the inmate becomes compromised by illness.
>
> The care will be offered in an objective, non-judgmental environment and will meet or exceed Title XV regulations."

This MOU is especially important to coordinate efforts between DOC and SCVHHS because of the independent reporting lines of the two organizations shown in Figure 1, as established by the County of Santa Clara Charter and Ordinance Code. As discussed later, this reporting structure introduces certain complexities into matters such as the negotiation of departmental budgets and the coordination of joint responsibilities and accountability for inmate healthcare between the departments.

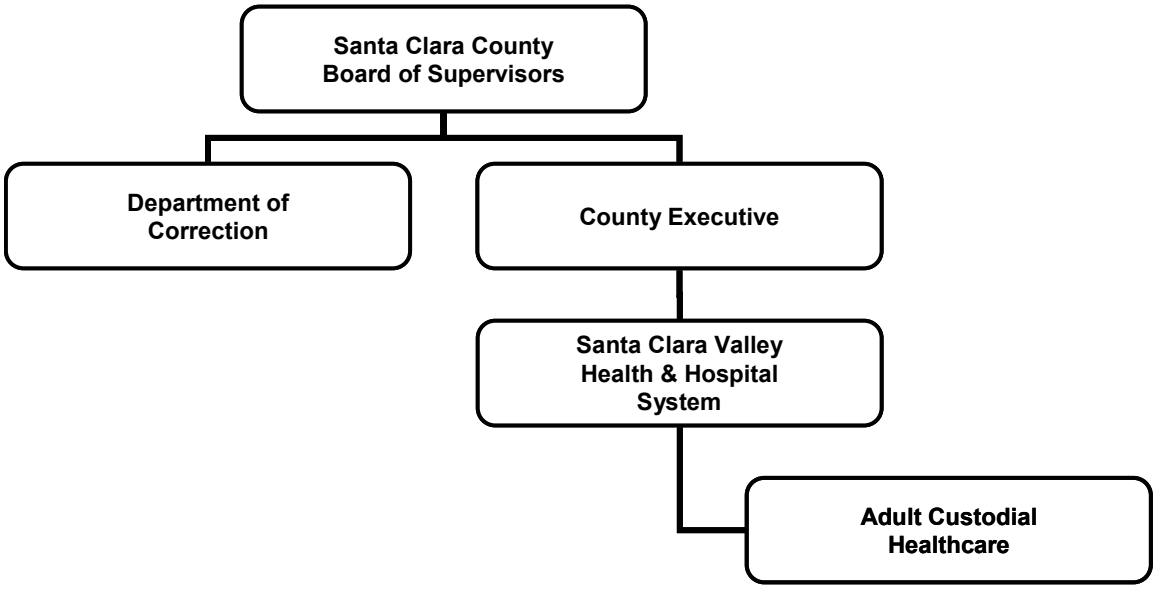


Figure 1: Organization Chart for DOC and SCVHHS Reporting Lines

The geographic locations of the institutions involved introduce additional complicating logistical factors. The Elmwood Facility is located in Milpitas, the Main Jail is located north of downtown San Jose (near the main County administrative offices), and the Santa Clara Valley Medical Center (SCVMC or simply VMC) is located on South Bascom Avenue in San Jose. The interfacility distances are between 3 and 8 miles.

This is important because only certain medical services are provided on-site, such as:

- Tuberculosis prophylaxis;
- Diagnosis and treatment of common chronic and acute medical conditions;
- Screening and counseling for Sexually Transmitted Diseases (STDs)/HIV/hepatitis;
- Diagnosis and treatment of chronic and acute musculoskeletal conditions;
- Mental health diagnosis and treatment; and
- Dental diagnosis and treatment.

Specialty clinic and other services not available on-site at the correctional facilities are provided off-site at the VMC and include:

- Ear/Nose/Throat Clinic;
- Orthopedic Clinic;
- Treatment of newly diagnosed HIV patients;
- General surgery;
- Dermatology Clinic; and
- Emergency Department services.

In general, inmates must be escorted by DOC officers for any healthcare visits, whether inside or outside the correctional facility. Off-site visits are considerably more time-consuming to DOC staff because of the complex logistics and transportation services involved.

## STATISTICS ABOUT HEALTHCARE INTERVENTIONS

Even though the inmate population in County correctional facilities is mostly young to middle-aged, as seen in Figure 2, it can be expected, according to SCVHHS custodial healthcare officials, that inmates will have a different cross-section of medical conditions than the typical ambulatory population seen by medical clinics such as those run by the SCVHHS. Anecdotally, the incidence of drug abuse, infectious diseases (e.g., hepatitis, HIV, and STDs), and mental health problems is stated by SCVHHS management to be higher in the inmate population. The Grand Jury was not able to obtain comparative occurrence rate statistics to document quantitatively such cited differences for the areas served by the County DOC/SCVHHS facilities.

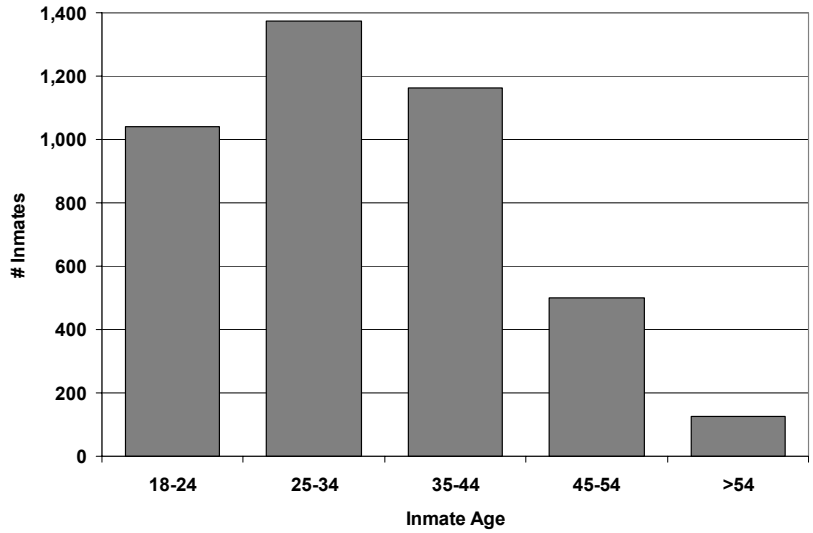


Figure 2: Age profile of adult inmates in County correctional facilities (March 2005).

As required by law, SCVHHS Adult Custody Health Services (ACHS or CHS) prepares annual reports on healthcare for both the Main Jail and the Elmwood Facility. Based on the FY 2003/2004 report, the following tables give a profile of various aspects of annual healthcare case loads for each facility:

*1) General Medical Care (FY 2003/2004)*

| | **Elmwood Facility** | **Main Jail** |
|---|---|---|
| **On-site Services** | | |
| MD/NP/PA* clinic appts | 29,218 | 5,034 |
| Inmates evaluated at Sick Call | 274,548 | 17,161 |
| X-rays | 4,581 | 2,154 |
| Active TB cases treated | 0 | 2 |
| Infirmary admissions | n/a | 909 |
| **Off-Site Services at SCVMC** | | |
| Emergency Dept Referrals | 1,226 | 494 |
| SCVMC Admissions | 205 | 133 |
| Outpatient Spec Clinic Visits | 2,762 | 1,111 |

* MD = Medical Doctor, NP = Nurse Practitioner, and PA = Physician Assistant

*2) Mental Health Care (FY 2003/2004)*

| | **Elmwood & Main Jail** |
|---|---|
| Daily Outpatient Caseload** | 447 |
| Crisis Referrals to MH for Evaluation | 29,778 |
| Acute Psychiatric Unit Admissions | 1,475 |
| Acute Psychiatric Unit ADP | 29.5 |

** Inmates with serious mental illnesses not housed in the Main Jail Acute Psychiatric Unit (8A).

The SCVHHS FY 2003/2004 annual report states that, "Santa Clara [County] Custody Facilities have not had a completed suicide in over two years." Unfortunately, this record appears to have been broken recently with two apparent suicides in the Main Jail, one in October 2004 and another in April 2005.

*3) Pharmacy (FY 2003/2004)*

| | **Elmwood Facility** | | **Main Jail** |
|---|---|---|---|
| | Male | Female | M/F |
| % on medications | 28% | 60% | 40% |
| Average # drugs per patient | 2.2 | 2.8 | 2.8 |
| # drug orders per month | 2,300 | 2,200 | 3,370 |

*4) Infectious Diseases (FY 2003/2004)*

| | **Elmwood Facility** | | **Main Jail** |
|---|---|---|---|
| | Male | Female | M/F |
| Hepatitis C | 38 | 148 | 657 |
| Hepatitis B | 5 | 6 | 50 |
| Chlamydia | 21 | 20 | 1 |
| Tuberculosis | 0 | 0 | 2 |
| Gonorrhea | 4 | 6 | 1 |
| HIV | 1 | 9 | 63 |

*5) Dental Care (FY 2003/2004)*

| | **Elmwood Facility** | | **Main Jail** |
|---|---|---|---|
| | Male | Female | M/F |
| Dental visits | 2,406 | 1,052 | 679 |

# Discussion

In the following sections the Grand Jury will summarize the results of its 6-month inquiry into adult inmate healthcare costs. As noted in the introduction, the investigation included reviews of previously conducted studies as well as reports from DOC and SCVHHS cited in the Reference section of this report. In particular, a key input to the study was the Helmuth, Obata, and Kassabaum (HOK) report entitled "Santa Clara County Adult Custody Healthcare Study; Summary of Findings & Recommendations," started in October 2003 and completed April 28, 2004, under contract to the County Executive's Office (see Appendix C for the Executive Summary). The Grand Jury's findings are also based on visits to the major County correctional facilities and extensive interviews with County Supervisors, members of the County Executive's Office, and management in DOC and SCVHHS. Finally, the Grand Jury collected diverse data from DOC, SCVHHS, and the County Employee Services Agency (ESA), and performed its own syntheses and analyses of this information to evaluate and establish a rationale and business metrics for inmate healthcare costs.

In this discussion, the costs of adult inmate healthcare within the County and their reasonableness from various perspectives are examined. Much of this discussion will have a business orientation – i.e., asking questions like, "How much is the County investing in inmate healthcare and where does the money go?", "How does this compare to investments in other aspects of healthcare for County residents?", "Can we justify these investments quantitatively in actuarial terms and through demonstrated cost-effectiveness and outcomes measures?", and "Is the incarceration of people on the margin of society and the investment in custodial healthcare the most effective way to improve their situation?"

This inquiry is important because there is an unexplained gap of $16.4 million per year between the almost $40 million the County spends on adult inmate healthcare and the smaller amount the County spends on healthcare benefits for a comparable number of County employees. This $16.4 million gap is almost 14% of the projected County budget deficit for FY 2005/2006 ($120 million). Ultimately, the tradeoffs involved in inmate healthcare versus other aspects of County services come down to Board of Supervisors policy decisions, but the Grand Jury believes these tradeoffs and evaluations are best made in an information-driven, objective, and business-like manner.

Despite concerns about justifications for the cost of inmate healthcare, the Grand Jury would like to emphasize that it is not making any finding about shortcomings in the *quality* of inmate healthcare delivered by DOC and SCVHHS. Quite the contrary, the current standard of care appears to be excellent. According to the HOK study, County inmate healthcare "meets and often exceeds the standards required by the California Code of Regulations Title 15". The Grand Jury has also heard supporting anecdotal comments in the course of its inquiry from healthcare workers in the facilities visited that the "inmates are receiving better care than their own families do".

In the following sections, the discussion will, in turn, address a number of questions to which our inquiry has led:

- How much does adult inmate healthcare cost and where are those costs allocated?
- How does what the County spends on adult inmate healthcare measure up against relevant metrics for spending elsewhere?
- Can the County adequately and convincingly explain the cost differences between adult inmate healthcare and care the County provides to other groups?
- Have County correctional facilities become a point of healthcare delivery for County indigent and mentally ill populations and is there a more cost-effective alternative?
- Does the current DOC/SCVHHS management structure help or hinder effective budget negotiations and oversight and where are the incentives to make inmate healthcare delivery more cost-effective?
- How well do existing information systems and data resources support the analysis of the business case for inmate healthcare cost trade-offs? What additional information technology services would be desirable and prudent?

## CURRENT ADULT CUSTODIAL HEALTHCARE COSTS AND THEIR ALLOCATION

The DOC/SCVHHS FY 2004/2005 budget for adult inmate healthcare is complex and the Grand Jury only presents an overview to give an indication of how much money is involved, where it is spent among the correctional facilities, and how the costs are divided among various categories of personnel and services. It must be emphasized that in these and in later discussions of cost figures, *none of the costs for DOC officers to accompany and maintain security for inmates during treatment are included*. The data shown in the following are derived from detailed budget spreadsheets received by the Grand Jury from the Chief Financial Officer of SCVHHS, with additional information from the previous HOK study.

Figure 3 shows the breakdown of costs by detention facility and a category of costs labeled “Unreimbursed VMC Services”. In this illustration the allocations for juvenile and children’s healthcare are included, just to show that only about 10% of the overall Custody Health Service budget ($42.6 million in FY 2004/2005) goes for these purposes. The rest is divided among the Main Jail (48% total), Elmwood (24%) and Unreimbursed VMC Services (18%). Unreimbursed VMC Services (about $7.8 million) are an allocation from the VMC “General Fund Subsidy” for inmate healthcare and include services provided at VMC when required care cannot be provided on-site at a detention facility. Such services include Emergency Department, specialty clinics, and surgery. These unreimbursed costs do not appear as line items in either the DOC or SCVHHS custodial healthcare budgets for unknown reasons, but they are a significant and integral part of providing care. One other aspect of these off-site Unreimbursed VMC Service costs is that they must be augmented with larger costs for DOC officers to transport and accompany inmates between their detention facility and the off-site VMC facility, as well as guard the inmate during care at VMC (possibly for days during an inpatient stay). This cost is discussed further in relation to Figure 6.

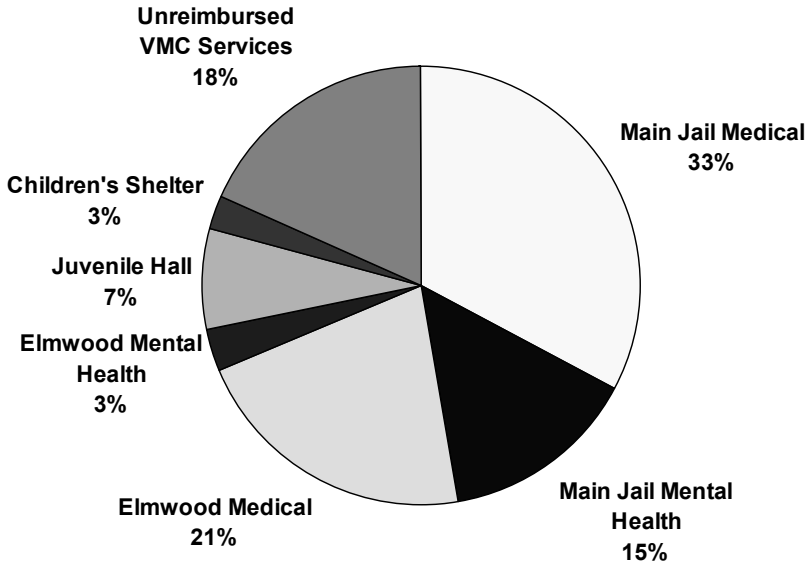


Figure 3: FY 2004-2005 SCVHHS custodial healthcare budget distribution among detention facilities ($42.6 million total).

The costs of custodial healthcare must include 9-1-1 services for urgent inmate care at sites other than VMC – for example at San Jose Medical Center (SJMC). These costs are paid out of DOC's budget and have amounted to about $1 million per year in the past. With the closing of SJMC, these services will be provided by VMC in the future, even though VMC may be more distant than SJMC was. As a result, these costs will appear under the above Unreimbursed VMC Services category in the future. They are expected to be about $650,000 per year lower in future years because of lower costs for service at the County-operated VMC.

Figure 4 shows the breakdown of the *adult* inmate healthcare portion of the budget ($38.3 million total, leaving out allocations for juvenile and children's healthcare) among personnel of various types and other services.

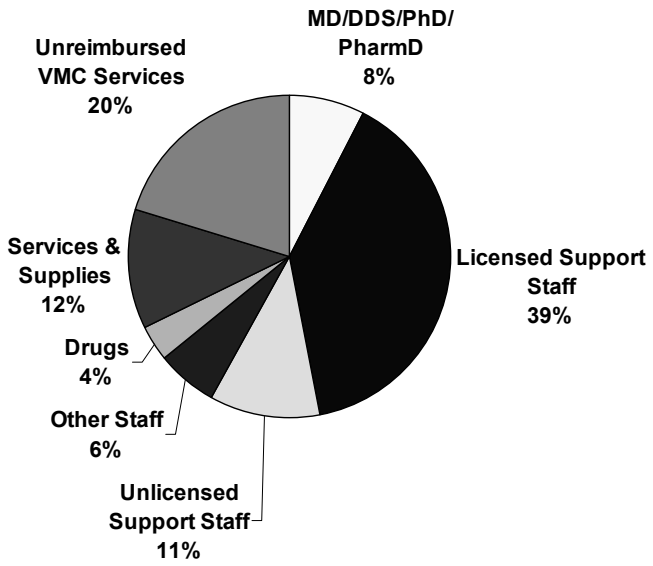


Figure 4: FY 2004-2005 SCVHHS adult-only custodial healthcare budget distribution among personnel and services ($38.3 million total).

In this Figure, the personnel category “MD/DDS/PhD/PharmD” includes all MD-, DDS-, PhD-, and PharmD-level professionals. The category “Licensed Support Staff” includes all licensed support providers such as physician assistants, nurse practitioners, registered nurses, licensed vocational nurses, licensed counselors, and licensed dental technicians. The category “Unlicensed Support Staff” includes all staff involved in patient care but who do not have any special licensed certification and authority, such as medical clerks, health information clerks, pharmacy technicians, and social workers. Finally, the category “Other Staff” includes personnel such as administrative support, information technicians, janitors, temporary employees, etc.

As can be seen from Figure 4, about 64% of total costs are related to various personnel categories. This fact must be kept in mind when considering what level of spending is reasonable for adult inmate healthcare and how savings might be achieved. The most significant economies will derive from those areas where the most money is spent.

## WAYS TO MEASURE COUNTY EXPENDITURES ON ADULT INMATE HEALTHCARE

One way of measuring the quality of inmate healthcare is in terms of the County’s legal obligation. As noted repeatedly in the HOK report, County adult custody healthcare is “excellent in all areas and meets and *exceeds* Title 15 requirements under the California Code of Regulations.” The report states that, “the County's level of care for this service [mental health care] is among the highest in the state, and interviews during the survey of other counties provided unsolicited testimonials to the quality of this care.”

Another measure of quality is that, according to the Executive Director of SCVHHS, "the County has not had any lawsuit claiming inadequate inmate care in the past 10 years." This was not always the case. During the 1980s, three lawsuits were filed against the County that resulted in either consent decrees or damages. In Branson v. Winter (1981), a decree was issued involving conditions of overcrowding and human rights for male inmates in correctional facilities. A subsequent complaint by Fischer alleged unequal treatment for female inmates. In Ochoa v. Superior Court (Santa Clara County, 1985) a settlement was reached regarding inadequate healthcare in juvenile detention that resulted in a death because of unreasonable delay in providing treatment for severe, bilateral pneumonia.

Since the 1980s, the quality of inmate healthcare and its corresponding costs have increased substantially. A question the Grand Jury seeks to answer is, "Has the pendulum perhaps swung too far in the opposite direction?"

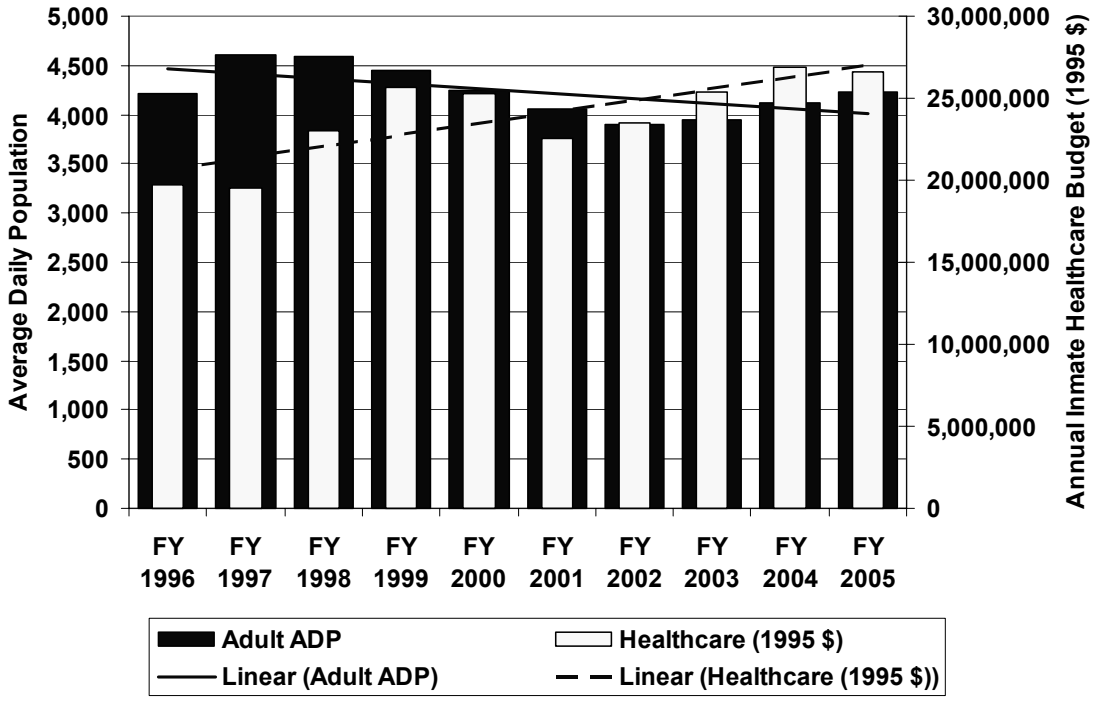


Figure 5: Historical plot of inmate ADP compared to the SCVHHS budget for adult inmate healthcare in constant-value 1995 dollars (the inflation adjustment uses the historical federal Bureau of Labor Statistics Consumer Price Index for Bay Area healthcare costs).

The Grand Jury obtained historical data from DOC for adult inmate "average daily population" (ADP), and historical data from the SCVHHS for the costs of adult inmate healthcare. The SCVHHS data included both the core CHS budget and the amounts for the Unreimbursed VMC Services category. Figure 5 shows a plot of inmate ADP compared with the adult inmate healthcare budget measured in constant-value (1995) dollars. The federal Bureau of Labor Statistics (BLS) Consumer Price Index (CPI) for Bay Area healthcare was used to normalize the historical SCVHHS budget data so as to show *real* changes in expenditures for healthcare. Linear trend lines are shown for each dataset in

the Figure. Over the past 10 years, while inmate ADP has declined about 12%, the constant-dollar investment in inmate healthcare has increased about 29%. (This corresponds to an increase of about 65% over 10 years in terms of inflated dollars.) From a business perspective, one might expect that the cost of a service would be more closely related to the "customer" base. The Grand Jury has not been able to obtain an explanation for this counter-intuitive, negatively correlated growth in expenditures.

A closer look at the annual inmate healthcare budget, separating it into components for on-site and off-site care, reveals an encouraging trend. These two components are shown in Figure 6, where it can be seen that the general trend is to *reduce* the off-site component over time, even though off-site costs show significant year-to-year fluctuations. In fiscal years 1996-1999, average off-site costs amounted to 30% of the total, whereas, in fiscal years 2003-2005, they amounted to 18% of the total. This means that relatively more care was being provided on-site, thereby reducing DOC off-site transportation and security costs (not included).

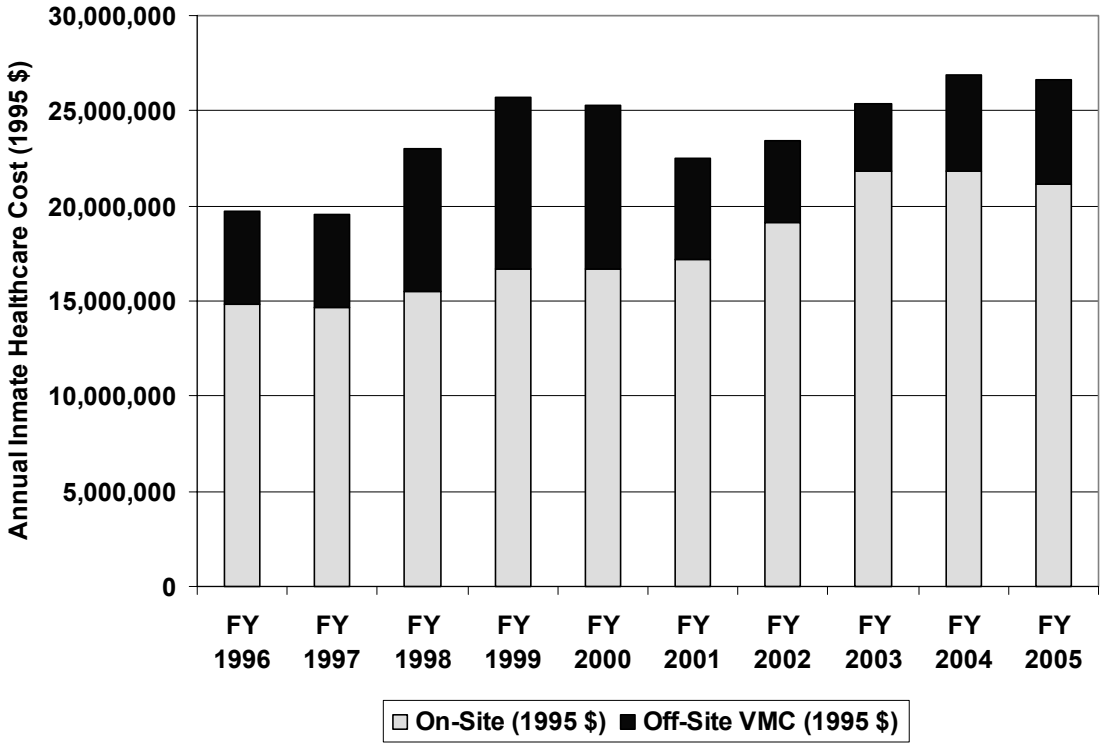


Figure 6: Historical comparison of on-site and off-site (VMC) costs for inmate healthcare (1995 $). The data are "stacked", i.e., off-site data are added to the corresponding on-site data.

More quantitatively, SCVHHS provided a special data report to the BOS in May 2004, which showed for FY 2003-2004, 377 inmate inpatient admissions at VMC with an average length of stay of 3.48 days and 6,905 outpatient visits to VMC clinics or the Emergency Department. In order to assess the impact on correctional officer time to maintain security for these off-site medical visits, the Grand Jury consulted with DOC and the Transportation

Unit of the Sheriff's Office. Using their best estimates, assuming it takes 1.4 correctional officers to transport an inmate to a VMC clinic visit lasting about 4.5 hours each, and 2.7 officers per shift to provide 24-hour security watch for inpatient stays, this comes to about 35 man-years of off-site healthcare surveillance by correctional officers each year (about $3.8 million for correctional officers making an average of $110,000 per year with benefits). This estimate takes into account handling inmates with various security risks and doubling up where possible for transports and inpatient stays. It shows clearly that the investment of correctional officer time in inmate healthcare is substantial. *None of the cost for this correctional surveillance is included in the above SCVHHS cost figures, but efforts to reduce it are acknowledged by the Grand Jury as positive progress.*

Another commonly used index of comparative investment in healthcare is the cost per participant. So, for example, the cost per inmate for healthcare can be computed and compared to what the County pays for healthcare benefits for another group, e.g., its own employees. Although this is not a perfect comparison, no other quantitative information was available from County officials as they have not done any comparison of their costs against other similar entities. From Figure 5, the historical values of inmate ADP and the annual cost of custody healthcare are known, so the historical values of the cost-per-inmate index can be computed. The Grand Jury also obtained from ESA the 10-year record of healthcare benefits rates fully paid by the County for employees for care at Valley Medical Center. ESA included rates for County-paid employee dental and eye care so that the data would be roughly comparable to the full range of inmate healthcare services. Figure 7 shows the plot of inmate healthcare costs per year as compared with County-paid employee health benefits using fixed-value (1995) dollars – again adjusted using the federal BLS CPI for Bay Area healthcare costs.

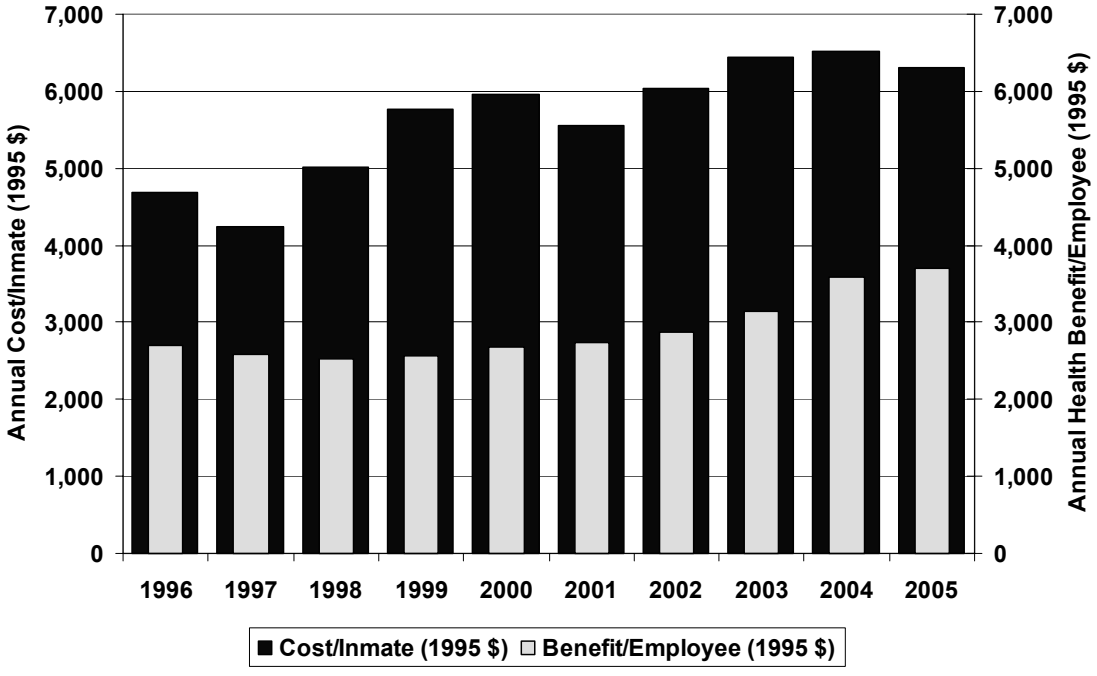


Figure 7: Comparison of historical annual County healthcare cost per inmate with County healthcare benefits paid for employees (based on constant-value 1995 dollars).

It can be seen that inmate healthcare costs have been higher than employee benefits costs for the entire 10-year period. Even using 1995 dollars, they have been more than double employee benefits costs for much of the period and, in recent years, are about 75% higher. This amounts to a difference of $2,800 per year in 1995 dollars or $3,900 per year in current dollars spent for each inmate as compared to each employee. Applied over the entire County inmate ADP (4,200), this amounts to $16.4 million per year in current dollars.

The disparity between the current healthcare cost per inmate and the County employee healthcare benefit rate can be seen from still another perspective in Figure 8 – that of individual detention facilities in the County system. The cost-per-inmate values shown in Figure 8 are computed from the SCVHHS budget as allocated to each facility divided by the ADP for that facility recorded by DOC. Since we have no more detailed breakdown from SCVHHS, the Unreimbursed VMC Services costs are prorated between facilities in Figure 8 based on the relative ADP for each facility and the total of $7.8 million in Unreimbursed VMC Services for FY 2004-2005. The current County healthcare benefit rate is overlaid for comparison.

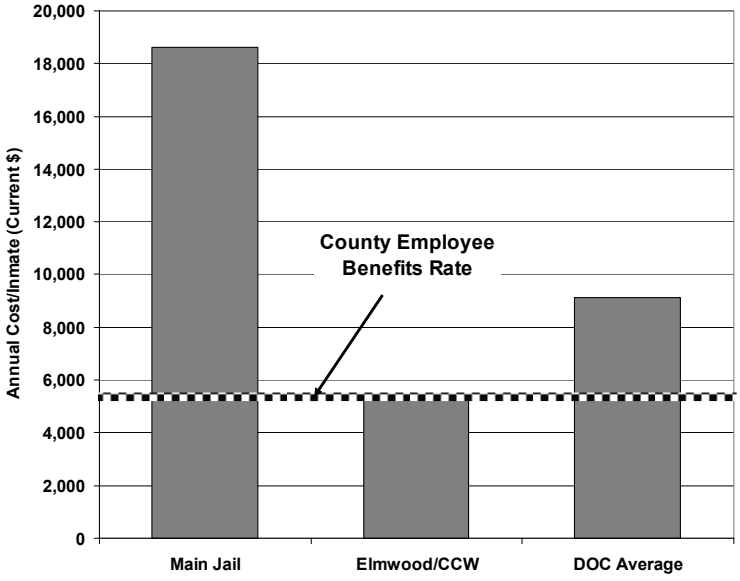


Figure 8: Comparison of the healthcare cost per inmate for the Main Jail, the Elmwood/CCW Facility, the DOC average, and the County healthcare benefits rate paid for employees. The costs shown are in FY 2004-2005 dollars.

The Grand Jury could not determine quantitatively from data available from DOC or SCVHHS how the Main Jail cost per inmate of about $18,600 per year could be explained. The Executive Director of SCVHHS stated that he "is not surprised by the differences in per inmate costs between the facilities," but could not offer any quantitative justification – only qualitative possibilities. It is noted that the Main Jail serves multiple purposes, including being the central processing center for all bookings, holding higher security inmates, providing a lock-down mental health facility (cell block 8A), serving as the main infirmary for more serious inmate care (but not requiring services at VMC), and housing

inmates with mobility problems or with prostheses. Each of these subpopulations has a different headcount. It is especially noteworthy that there are 65,000 bookings handled each year. However, when asked for a more detailed breakdown of functions versus cost at the Main Jail, the Executive Director of SCVHHS stated that, “Those details are not recorded or available.” When asked for an estimate so that the Grand Jury could more fairly allocate Main Jail costs across these different functions, the SCVHHS Executive Director declined to provide one.

For lack of what would seem to be essential management data that the Grand Jury expected would be available, this analysis is left with the gross breakdown of interfacility costs shown in Figure 8. The fact that the cost per inmate at the Main Jail is 3.5 times higher than that at Elmwood/CCW is unexplained.

The Grand Jury wants to add one final note about the healthcare-cost-per-inmate index. This index is used in several publications, including the HOK report (see their Exhibit 1.E) and newspaper accounts, to try to compare unit inmate care costs between counties. Such intercounty comparisons would be extremely useful as a metric of current practice, if it were certain that the budget representations were done in comparable ways. In the HOK report, for example, other Bay Area counties are shown with healthcare costs per inmate considerably lower than those of Santa Clara County. The Executive Director of SCVHHS points out emphatically, however, that such comparisons “are useless – they are like comparing apples and oranges.” When asked how he thought the comparisons were deficient and how a more quantitative comparison could be made, he had nothing specific to offer.

It is beyond the scope of the current inquiry for the Grand Jury to investigate inmate healthcare costs in other counties in sufficient detail to be assured that an accurate comparison can be made. For this reason, no intercounty comparison is included in this report. It would be very useful, however, for County management to undertake such a comparison in the future so that it could be used fairly in judging current County inmate healthcare practice. The Grand Jury notes that the BOS and County management have not requested this quantitative comparison before now.

## CAN THE EXTRA COSTS FOR ADULT INMATE HEALTHCARE OVER COUNTY EMPLOYEE BENEFITS BE EXPLAINED?

The population of County employees and that of adult inmates each represents a group of mostly ambulatory people. They come from different backgrounds though, and adult inmates may be expected to present healthcare problems with different likelihoods than those seen in the County employee group. It is difficult to quantitate this statement, however, because SCVHHS generally uses manual patient records for adult custody healthcare and cannot easily extract population statistics for the rates of occurrence of various diseases or the reasons for seeking care among the people they treat. Nevertheless, SCVHHS management offered compelling qualitative arguments that suggest that inmates suffer a higher incidence of substance abuse, infectious diseases (such as STDs and HIV), and mental health problems.

Other factors that may also cause differences in the cost of care include the need for check-in health screening and tuberculosis testing upon booking as well as the need to

administer medications by nursing personnel in inmate cell areas – only a small fraction of minimum-security inmates can self-administer safe over-the-counter drugs.

Still other possible differences might be a result of the turn-over of inmate population. The average length of stay in County detention facilities is 100 days so the inmate population changes on average three times per year. This may present a somewhat higher diagnostic load to inmate care providers, but the Grand Jury could not document any important differences in this area from SCVHHS data. Except for chronic illnesses, the County employee population visit care facilities with new ailments during the year, and the providers must diagnose these as well. The HOK report and SCVHHS personnel did not identify any other major interpopulation differences in the incidence of chronic or acute illnesses (than those noted above) between County employees and adult inmates that would affect cost differences significantly.

It may be that there is a difference in the number of frivolous calls for healthcare intervention. The SCVHHS annual reports on custodial healthcare operations document the frequency of interventions on a general basis, as summarized in the Background section of this report. The Grand Jury could not easily translate those rates of interventions to costs or validity of the intervention. As an example, we do not know what actually happened with the nearly 300,000 inmate evaluations at Sick Call.

In October 2003, the DOC Financial Services Manager issued a report about a study of the feasibility of a medical co-payment scheme for County detention facilities. A review was conducted of five California counties that have had such a system implemented for several years. The results indicated that all but one county reported a measurable reduction in unnecessary medical visits – Contra Costa County abandoned its experiment because doctors refused to fill out the required visit forms. The study also noted that there was no impact on the staffing levels for correctional personnel to implement the co-payment system in the four counties continuing with their programs. The co-payment systems used are benevolent in the sense that the co-payment rate is $3 per visit and is waived for essential services and for indigent inmates. Santa Clara County DOC decided not to experiment with such a co-payment system because it lacked an adequate automated inmate management system to keep track of the transactions and DOC argued that the revenues, about $43,000, *not* counting saved medical personnel and escort custody officer time, “would not be worth the effort.” The Grand Jury questions this conclusion, given that the whole point of such a system is to cut down on unnecessary calls on caregiver time.

One additional factor worth noting is that the VMC healthcare benefit rate for County employees appears to be pegged to that of the Kaiser-Permanente healthcare option. As noted by the Executive Director, SCVHHS does not make any separate actuarial calculation of the expected costs of County employee healthcare and the VMC rate has been identical to the Kaiser rate for at least 10 years (based on ESA data). Kaiser must bid competitively on benefits plans using actuarial analyses of risks and costs for each contract to maintain an acceptable bottom line. These bids must include allocations for *all* costs, including components such as management overhead, physical plant amortization and renewal, services and utilities, and information infrastructure. Nothing corresponding to these latter Kaiser costs appears in the SCVHHS budget for inmate healthcare – such

overhead costs are borne in separate parts of the SCVHHS and DOC budgets from the County and are not counted toward inmate healthcare.

## SCVHHS PHARMACY SERVICES

One area of refreshing precision in responses to Grand Jury inquiries was in SCVHHS Pharmacy Services. Because drug costs have attracted significant attention, especially atypical psychotropic drugs used in mental healthcare, the Grand Jury approached Pharmacy Services with a set of questions:

- How do SCVHHS formulary drug costs compare with costs for drugs from other sources (e.g., drugs obtained from Canadian suppliers, the Veterans Administration (VA), or others)?
- How do medications prescribed for inmates compare statistically with prescriptions for other SCVHHS ambulatory populations, for example comparisons of:
  - The number of medications prescribed per person;
  - The distribution of the types of medications prescribed; and
  - The cost of medications prescribed per person.

Because of the highly effective computerized database system used to record and manage Pharmacy activities, that group was able to extract the data and put together a presentation that was fully responsive to Grand Jury questions in just two days. Only the principal conclusions of that analysis are included here. The Grand Jury was convinced that the way in which the Pharmacy group procures drugs, focusing on the most expensive psychotropic drugs, achieves cost parity with other possible sources. This is especially true because the Pharmacy has initiated a pill-splitting strategy to lower costs, based on the fact that drug companies charge the same for many pills, independent of how much medication is contained in each pill.

In FY 2004-2005, approximately 46% of total inmate pharmaceutical costs are budgeted for the purchase of antipsychotic medications. In the 30 months from June 2002 to December 2004, the number of inmates on antipsychotic drugs increased from 500 to 700 (out of a total population of about 4,200) – i.e., an increase from 12% to 17% of the total inmate population. Finally, the average cost of medications per inmate per day in the County is $1.73 (over the entire population of inmates), whereas the cost per actual patient per day is $4.80 (note that not all inmates are sick whereas “patients” are already diagnosed and on treatment).

Interestingly, as seen in Figure 4, prescribed drugs represent only a small portion of the overall inmate healthcare budget (about 4%), but they are among the most important tools to deal with mentally ill patients, and appear to be under the best management control.

## A $16.4 MILLION GAP

This leaves the question of how to explain the $16.4 million difference in the effective annual healthcare cost for a group of 4,200 inmates versus the cost for a corresponding group of 4,200 County employees. Neither the SCVHHS nor the Grand Jury could obtain

adequate quantitative data about differences between the inmate and County employee populations in order to explain the significant difference in costs. The following is an approximate calculation just to show the magnitude of the dollars involved.

If approximately half of the inmate pharmaceutical budget would not be needed for County employee healthcare (because of a lower incidence of mental health conditions), the difference comes down to roughly $15.4 million. This amount of money is approximately equivalent to the annual cost for 115 nurses or 80 doctors.

This Grand Jury is hard pressed to justify how such expenditures are warranted based on the identified differences between the population of inmates and that of County employees. A possible explanation is that the *real* cost of County employee benefits at SCVHHS is actually much higher than the rate used by ESA (based on the Kaiser Permanente bid), and that SCVHHS is not really making any actuarial or business-like calculation to manage its costs.

## HAVE CORRECTIONAL FACILITIES BECOME A POINT OF HEALTHCARE DELIVERY FOR COUNTY INDIGENT AND MENTALLY ILL POPULATIONS?

Despite the emphasis on cost issues, the Grand Jury is not insensitive to the healthcare needs of the County's indigent population or the needs of those with limitations due to mental health conditions. The Grand Jury evaluated current approaches with the intent to seek better ways to take advantage of the outstanding healthcare professionals in the County in order to deliver needed care in a humane, but more cost-effective and uninterrupted manner. A relatively short, although sometimes recidivistic, 100-day stay in County correctional facilities would appear to be less efficient in providing mental health care.

It was noted above that approximately 700 inmates (about 17% of the County inmate population) are currently on psychotropic medications. On average nationally, about 3% of the total population suffers from some form of mental illness. The HOK report made a point of stating that, "…the jails have in many cases become the 'safety net' for mentally ill individuals, since the de-institutionalization of mental illness and continued budget reductions have significantly reduced these mental health facilities and services in recent years…". Similarly, HOK makes the point that the SCVHHS mission emphasizes "…preventing and treating disease and injury and enabling inmates to re-enter the outside community in better health" with the implication that many inmates come from settings where they either do not have access to or do not take advantage of healthcare services.

This emphasis on indigent and mental health care, particularly in the Main Jail where cell block 8A is a lock-down facility for inmates with severe mental illness, may help explain part of the disparity between the healthcare cost-per-inmate index as measured at the Main Jail, the Elmwood Facility, and the overall DOC average (see Figure 8).

A January 2005 Miami-Dade County (Florida) Grand Jury report focused on adults with mental illness who are recycled through the Florida criminal justice system, and police encounters with persons suffering from mental illness. The Miami-Dade County Grand Jury report notes that,

> There were "…560,000 patients in mental hospitals in 1955. Over the next four decades, while asylum populations nationwide decreased by 90 percent, the

> prison population grew by 400 percent. There are presently less than 40,000 patients in mental hospitals in the United States. Now, the majority of persons suffering from mental illness are in our jails, prisons and on our streets…
>
> …Nationally, more than 500,000 persons with mental illness are on probation. The United States ranks number one in the world in the number of persons suffering from mental illness. The United States also ranks number one with the largest number of untreated cases of mental illness. According to a recent report, there are three times as many men and women with mental illnesses in U.S. prisons as in state psychiatric hospitals. [(*The Sheriff's Star*, September/October 2004)] Further, nearly half the inmates with a mental illness in state or federal custody in the United States are incarcerated for committing a nonviolent crime…[(Ditton PM)]"

The Miami-Dade County Grand Jury goes on to say,

> "…it is estimated that from one-half to two-thirds of our homeless population suffers from mental illness. Drug problems or substance abuse disorders are also prevalent for 70 – 80 % of persons who suffer from mental illness.
>
> With the release of patients from our state mental hospitals, what had been a state problem became a local issue…"

This, of course, raises questions about whether the money spent on caring for inmates in County correctional facilities could be better spent on treatment in other community-based facilities. This might be especially important in light of the fact that the average length of stay in County correctional facilities is only about 100 days, and it is not clear what kind of treatment progress can be made in that time period, given that it must include diagnosing new mentally ill patients (not true for repeat offenders who may be recognized by the system) and initiating medication and counseling. There are simply no outcomes data to document the success or failure of the current approach.

The Grand Jury emphasizes that it is not making any finding about bias or unfairness in the County justice system toward mentally ill persons. Interviews with County corrections and healthcare professionals indicate that the current system encourages a recurrent cycle of events – a person's mental illness may give rise to unlawful behavior which causes them to enter the justice system. They are incarcerated and treated for a period and eventually released, often with conditions for supervision or continued treatment. The mental illness may relapse in the open community so that the person is unable or unwilling to comply with supervision requirements, and again encounters the justice system. This raises the question, "How can we break this unproductive cycle?"

Santa Clara County was the first county in the country to establish a Juvenile Mental Health Court in 2001, to try to help juveniles avoid the above cycle of contact with the justice system. It may be that such an approach to adult inmates with mental health problems could be more continuously effective. The Executive Director of SCVHHS stated that he "was not aware of any quantitative study data regarding indigent and/or mentally ill persons in County correctional facilities that casts any light on the business case for an alternative community approach." He did say that, in his opinion, "…there are clear inefficiencies in the current system that do not serve either the healthcare needs of the

inmates or make effective use of DOC resources." It is beyond the scope of the current Grand Jury inquiry to document hard data about these issues for Santa Clara County.

Such community care facilities, of course, could apply only to non-violent persons so as not to expose County residents to unwarranted security risks. The cost savings of this approach may come mainly from eliminating the need for correctional personnel to accompany patients for any healthcare visit rather than from reductions in the number of medical personnel. Much as it is very expensive to have people without medical insurance coverage use County emergency departments for routine primary care when needed, correctional facilities are a high-cost means to meet the human and survival needs of minimum-security indigent and mentally ill people. A program along these lines is underway in San Francisco and might offer guidance to Santa Clara County.

## DOES THE CURRENT DOC/SCVHHS MANAGEMENT STRUCTURE HELP OR HINDER?

It was noted in the Background material of this report that the County intentionally established DOC and SCVHHS by ordinance with distinct and separate reporting lines – one responsible for custody security services and the other responsible for custody healthcare. During the Grand Jury's interviews for this inquiry, it became clear that cooperation between the two organizations depends on the goodwill of the respective management and operations teams. In the past, some previous administrators could not get along well and the tension was high. That does not appear to be the situation today.

Nevertheless, in the area of fiscal control, the budget for inmate healthcare resides administratively in the DOC budget, but is negotiated between the Executive Director of SCVHHS and the CE, independent of the Chief of DOC. It appears further, in agreement with observations made in the HOK study, that the inmate healthcare budget is relatively insignificant to SCVHHS. Inmate healthcare accounts for about $42.5 million annually out of an overall $1.2 billion budget for SCVHHS – i.e., less than 3.5% of the SCVHHS budget. It is easy to see how this activity might get lost managerially in the complexity of an organization responsible for County inpatient and outpatient healthcare facilities, public health, alcohol and drug services, and mental health services.

The Grand Jury could not determine where in this management structure incentives arise to lower costs voluntarily. In its interviews, the Grand Jury encountered many dedicated people working on custodial healthcare who have high professional standards, including sometimes competing standards for high-quality and cost-effective care. Both DOC and SCVHHS have been "under siege" in recent years with forced annual budget reduction requirements, and so have a natural reaction to protect what exists and to provide continuity for their organizations. Since much of the budget involved in adult inmate healthcare pays staff salaries, any reductions have the painful consequence of layoffs or reductions through attrition – in either case, most likely resulting in at least a perceived need to continue the same level of services with fewer staff.

## HOW WELL DO EXISTING INFORMATION SYSTEMS AND DATA RESOURCES SUPPORT THE BUSINESS CASE FOR INMATE HEALTHCARE COST TRADE-OFFS?

As noted by the lack of quantitative data throughout this report, information system technology is poorly deployed in both DOC and especially in SCVHHS. As part of a business process review and strategy plan done for Santa Clara County adult custody health services in 2002 by Sierra Systems Group, Inc., it was noted that:

> "Much of the service delivery and documentation is performed manually, impeding service delivery to inmates and increasing the costs in the provision of services. The goal of the business process-reengineering project is to determine ways to improve service delivery to inmates through the use of streamlined processes and utilization of information technology…"

By and large, this situation persists today – with the exception of a few islands of light such as the information system that supports Pharmacy Services so well, as noted earlier. Routine day-in day-out inmate care is provided with paper records. During Grand Jury visits for this inquiry, file rack after file rack of paper medical records were observed at the correctional facilities. Innovations to better manage inmate requests for care have to await installation of a better record system so the administrative parts of the task do not become overwhelming. Data for utilization, cost, adherence to standards of care, and outcomes analyses are generated from manual records and so are very scarce because of the tedium in doing retrospective studies.

The need for change is recognized and is felt in a pressing way by DOC and by the inmate healthcare organization of SCVHHS. During visits, the Grand Jury was told that, "an electronic medical record (EMR) system for inmates was absolutely essential to track care of the transient inmate population." It was further stated that, "an EMR system was just around the corner".

Prior to the business-process review mentioned above (in FY 2000), the Associate Director for Adult Custody Health Services approached the previous Chief Information Officer (CIO) of SCVHHS to assist with the specification and procurement of an EMR system. This request was rebuffed and ignored so that the Associate Director of CHS turned instead to the County CIO and initiated the study under Sierra Systems. The Grand Jury has reviewed the resulting functional and detailed requirements specification and the documentation for procurement. It was very impressed and would like to recognize the initiative taken by the Associate Director for Adult Custody Health Services. A Request for Proposals (RFP) for this procurement was issued in late 2004 and interactions with potential vendors were in process during the Grand Jury's inquiry. From the Grand Jury's point of view, a significant problem was unresolved – the procurement and deployment of an EMR is an extremely complex process, which must take into account all of the information inputs, outputs, and flows to support and coordinate patient care within the system. Since inmates are cared for both on-site at the correctional facilities and off-site in the clinics and care units of the VMC, it makes little sense not to have the EMR development and deployment for the two sites coordinated – the move that was rejected by the previous SCVHHS Chief Information Officer.

Thus the Grand Jury found a chaotic situation with respect to the management of the specification, development/procurement, and deployment of information systems in support of inmate healthcare within the DOC/SCVHHS system. Within a week of Grand Jury visits and interviews for this inquiry, the Request for Proposal for a "Jail Medical Information Management System" went from a status of having been issued for vendor response, to being rescinded, to being reissued, and again to being rescinded. There appears to be almost no coordination of IT planning and implementation activities between the SCVHHS IT Services Department and the County CIO and DOC. Until this situation is rectified, the County will be faced with a lack of a system to deliver inmate healthcare and the information needed to provide the basis for making the quantitative business analyses so lacking in justifying, scoping, planning, and implementing inmate healthcare.

## Conclusions

In the course of its inquiry into adult inmate healthcare, the Grand Jury has attempted to find and document a rationale for the reasonableness of the current care system from various perspectives. The Grand Jury found itself frequently frustrated by the lack of quantitative information on which to base its analyses and conclusions. It found a gap of $16.4 million per year between the almost $40 million the County spends on adult inmate healthcare and what the County spends on healthcare benefits for a comparable number of County employees. All levels of County management involved in decisions about inmate healthcare appear to rely mostly on qualitative information. The Grand Jury notes in particular an observation by a County Supervisor about how "passionate and persuasive the Executive Director of SCVHHS is in describing the needs of County inmates for care, especially those from backgrounds of homelessness and of mental health disorders."

Ultimately, the tradeoffs involved among inmate healthcare and other aspects of County services in a cash-strapped economy come down to Board of Supervisors policy decisions about how much is appropriate – from a humanitarian perspective, from a perspective of identifying irreducible core services and from a perspective of ensuring services are delivered with optimal efficiency. In contrast, the Grand Jury firmly believes that these tradeoffs and evaluations are best made in a quantitative, information-driven, objective, and business-like manner.

The Grand Jury accordingly makes four findings and corresponding sets of recommendations, as detailed below:

## Finding 1

Overall, DOC and SCVHHS appear to provide a high quality of adult inmate healthcare. All reports and assessments of the quality of care made available to the Grand Jury, as well as Grand Jury tours of facilities, indicate that care meets or exceeds criteria established by state law – Title 15 of the California Code of Regulations.

## Recommendation 1

None.

## Finding 2

The cost of adult inmate healthcare in Santa Clara County, about $38.3 million per year (or $9,100 per inmate per year for an average daily population of 4,200), is high by a number of measures. The County is spending about $16.4 million more per year ($3,900 per inmate per year) on inmate healthcare than on healthcare benefits for a comparable number of County employees. Although this is not a perfect comparison, no other quantitative information was available from County officials as they have not done any comparison of their costs against other similar entities. The responsible County managers cannot explain this difference in any adequate, quantitative way.

## Recommendation 2a

Top County management (Board of Supervisors and County Executive) should give greater attention to understanding and controlling the costs of inmate healthcare. A high priority initial step should be to require a quantitative, business justification for the County adult inmate healthcare budget. This should include defining clearer indices for the "community standard of care" criteria used, as well as developing accurate means and methods to capture and track actual expenses for inmate healthcare services to determine if current budget allocations are appropriate. It may be appropriate to hire an outside consultant to perform a suitable financial and performance audit of baseline costs of inmate healthcare.

## Recommendation 2b

County management should comprehensively review and consider implementing previous consultant recommendations for reducing inmate healthcare costs, such as those made in the HOK Report of April 2004, and suggestions for imposing a benevolent inmate co-payment system to reduce frivolous calls on care providers. The Board of Supervisors should consider an executive-level study session on the HOK recommendations, as was promised during Grand Jury interviews for this report.

A risk management analysis of inmate healthcare should be conducted as part of the review to better understand the cost/benefit tradeoff of maintaining the current standard of care, with an independent third party analysis of the tradeoffs of outsourcing at least some aspects of care, as is done in several neighboring Bay Area counties.

## Recommendation 2c

It is recommended that the Board of Supervisors investigate the establishment of alternative community-based housing and care environments for indigent citizens and those with mental health, substance abuse, or other problems that might be operated more cost effectively than providing such care in correctional facilities.

## Finding 3

Adult inmate healthcare involves both the Custody Health Services organization of SCVHHS and Custody Services within DOC. By design these organizations have distinct reporting lines, in that the Director of SCVHHS reports to the County Executive, whereas the Chief of DOC reports to the Board of Supervisors. This reporting structure makes inmate healthcare cost assessment, management, and accountability difficult. There appear to be no clear incentives for SCVHHS and DOC to provide more cost-effective inmate healthcare. Since DOC has no way to influence the inmate healthcare budget negotiation, its role appears to be simply that of a placeholder to provide a fiscal home for the budget line item and to work out the Memorandum of Understanding regarding inmate healthcare procedures.

## Recommendation 3

The Board of Supervisors should realign the direct management reporting structures of DOC and SCVHHS (including Custody Health Services) to report to a single entity (e.g., the CE) with fiscal and operational control and with the power to create incentives for or to impose cost controls and accountability. Alternately, the BOS should formally delegate joint management oversight to the CE with adequate powers to ensure fiscal and operational accountability for inmate healthcare, perhaps with the advice of an expert public panel with members who can judge the adequacy and appropriateness of the necessary medical care criteria and trade-offs.

## Finding 4

The previous findings and recommendations are significantly based on the lack of management data about inmate healthcare practices and operations. Current IT-based record systems in DOC and SCVHHS are inadequate, are uncoordinated, and are deployed to only a limited extent, if at all. Most record keeping is still manual. Current systems do not facilitate continuous medical record access for inmates during interfacility transfers. Systems in SCVHHS provide limited access to reports from specialty services, often with slow response times, but do not track physician and nursing orders. They do not allow collection and careful tracking of quantitative measures of utilization, adherence to standards of care, outcomes, etc. for cost management and medical controls. The SCVHHS Pharmacy Services group is an exception to this finding and serves as an example of what can be accomplished with appropriate and professionally implemented information services.

## Recommendation 4

Top County management and officers in charge of DOC and SCVHHS should move urgently to implement appropriate electronic inmate and healthcare record management systems for the correctional facilities to enable the more efficient delivery of care and the collection of management information so that the costs of inmate healthcare can be

understood and analyzed with an eye toward more justifiable policies and improved cost effectiveness.

The inefficient and uncoordinated efforts of the SCVHHS Director of Information Services and of the County CIO should be reorganized immediately under coherent management to plan and implement appropriate and coordinated IT systems. These systems should be designed carefully to be responsive to the needs of the Chief of DOC and the Associate Director of Custody Health Services. The CE and the Board of Supervisors should ensure that funding is available to carry out the recommended plan.

PASSED and ADOPTED by the Santa Clara County Civil Grand Jury on This 21st day of April 2005.

_____

Michael A. Smith
Foreperson

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## Interviews


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2. Santa Clara County Supervisor for District 2, Chair of the Public Safety & Justice Committee and Vice Chair of the Health & Hospitals Committee, 20 Oct. 2004.
3. Santa Clara County Executive, 25 Oct. 2004.
4. Santa Clara County Deputy County Executive, 25 Oct. 2004.

## **Interviews** (cont'd.)

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6. Executive Director, SCVHHS, 1 Feb. 2005 and 28 March 2005.
7. Chief Financial Officer, SCVHHS, 1 Feb. 2005 and 28 March 2005
8. Associate Director for Adult Custody Health Services, SCVHHS, 1 Feb. 2005, 3 Feb. 2005, and 28 March 2005.
9. Director Pharmacy Services, SCVHHS, 11 Feb. 2005.
10. Director, Information Systems, SCVHHS, 31 Jan. 2005.
11. Associate Medical Director, Clinical Informatics, SCVHHS, 31 Jan. 2005.
12. Chief Information Officer, Santa Clara County, 7 Feb. 2005.

## **Visits**

1. Elmwood Facility, 9 Aug. 2004.
2. Main Jail, 23 Aug. 2004.
3. Juvenile Hall, 20 Sept. 2004.
4. Valley Medical Center, 2 Oct. 2004.

# Appendix A

# Provisions of California Penal Code and Regulations Governing Inmate Healthcare

## Penal Code Section 6030 et seq.

6030. (a) The Board of Corrections shall establish minimum standards for local detention facilities by July 1, 1972. The Board of Corrections shall review such standards biennially and make any appropriate revisions.

(b) The standards shall include, but not be limited to, the following: health and sanitary conditions, fire and life safety, security, rehabilitation programs, recreation, treatment of persons confined in local detention facilities, and personnel training.

(c) Such standards shall require that at least one person on duty at the facility is knowledgeable in the area of fire and life safety procedures.

(d) The standards shall also include requirements relating to the acquisition, storage, labeling, packaging, and dispensing of drugs.

(e) In establishing minimum standards, the Board of Corrections shall seek the advice of the following:

(1) For health and sanitary conditions:

The State Department of Health Services, physicians, psychiatrists, local public health officials, and other interested persons.

[…]

6031.4. (a) For the purpose of this title, "local detention facility" means any city, county, city and county, or regional facility used for the confinement for more than 24 hours of adults, or of both adults and minors, but does not include that portion of a facility for the confinement of both adults and minors which is devoted only to the confinement of minors.

[…]

## California Code of Regulations (Local Detention Facilities)

TITLE 15. Crime Prevention and Corrections

Division 1. Board of Corrections

Chapter 1. Board of Corrections

Subchapter 4. Minimum Standards for Local Detention Facilities

Article 1. General Instructions

[…]

§1006. Definitions

[…]

“Type I facility” means a local detention facility used for the detention of persons for not more than 96 hours excluding holidays after booking. Such a Type I facility may also detain persons on court order either for their own safekeeping or sentenced to a city jail as an inmate worker, and may house inmate workers sentenced to the county jail provided such placement in the facility is made on a voluntary basis on the part of the inmate. As used in this section, an inmate worker is defined as a person assigned to perform designated tasks outside of his/her cell or dormitory, pursuant to the written policy of the facility, for a minimum of four hours each day on a five day scheduled work week.

“Type II facility” means a local detention facility used for the detention of persons pending arraignment, during trial, and upon a sentence of commitment.

“Type III facility” means a local detention facility used only for the detention of convicted and sentenced persons.

“Type IV facility” means a local detention facility or portion thereof designated for the housing of inmates eligible under Penal Code Section 1208 for work/education furlough and/or other programs involving inmate access into the community.

[…]

Article 11. Medical/Mental Health Services

§1200. Responsibility for Health Care Services.

(a) In Type I, II, III and IV facilities, the facility administrator shall have the responsibility to ensure provision of emergency and basic health care services to all inmates. Medical, dental, and mental health matters involving clinical judgments are the sole province of the responsible physician, dentist, and psychiatrist or psychologist respectively; however, security regulations applicable to facility personnel also apply to health personnel.

Each facility shall have at least one physician available to treat physical disorders. In Type IV facilities, compliance may be attained by providing access into the

community; however, in such cases, there shall be a written plan for the treatment, transfer, or referral in the event of an emergency.

(b) In court holding and temporary holding facilities, the facility administrator shall have the responsibility to develop written policies and procedures which ensure provision of emergency health care services to all inmates.

[…]

## California Code of Regulations (California Director of Corrections)

TITLE 15. Crime Prevention And Corrections

Division 3. Department of Corrections

Chapter 1. Rules and Regulations of the Director of Corrections

[…]

Article 8. Medical and Dental Services

§3350. Provision of Medical Care and Definitions.

(a) The department shall only provide medical services for inmates which are based on medical necessity and supported by outcome data as effective medical care. In the absence of available outcome data for a specific case, treatment will be based on the judgment of the physician that the treatment is considered effective for the purpose intended and is supported by diagnostic information and consultations with appropriate specialists. Treatments for conditions which might otherwise be excluded may be allowed pursuant to section 3350.1(d).

(b) For the purposes of this article, the following definitions apply:

(1) Medically Necessary means health care services that are determined by the attending physician to be reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain, and are supported by health outcome data as being effective medical care.

(2) Outcome Study means the definition, collection and analysis of comparable data, based on variations in treatment, concerning patient health assessment for purposes of improving outcomes and identifying cost-effective alternatives.

(3) Outcome Data mean statistics such as diagnoses, procedures, discharge status, length of hospital stay, morbidity and mortality of patients, that are collected and evaluated using science-based methodologies and expert clinical judgment for purposes of outcome studies.

(4) Severe pain means a degree of discomfort that significantly disables the patient from reasonable independent function.

(5) Significant illness and disability means any medical condition that causes or may cause if left untreated a severe limitation of function or ability to perform the daily activities of life or that may cause premature death.

§3350.1. Medical Treatment/Service Exclusions.

(a) Treatment refers to attempted curative treatment and does not preclude palliative therapies to alleviate serious debilitating conditions such as pain management and nutritional support. Treatment shall not be provided for the following conditions:

(1) Conditions that improve on their own without treatment. Examples include, but are not limited to:

(A) Common cold.

(B) Mononucleosis.

(C) Viral hepatitis A.

(D) Viral pharyngitis.

(E) Mild sprains.

(2) Conditions that are not readily amenable to treatment, including, but not limited to, those which may be made worse by treatment with conventional medication or surgery, and those that are so advanced in the disease process that the outcome would not change with existing conventional or heroic treatment regimens. Examples include, but are not limited to:

(A) Multiple organ transplants.

(B) Temporomandibular joint dysfunction.

(C) Grossly metastatic cancer.

(3) Conditions that are cosmetic. Examples include, but are not limited to:

(A) Removal of tattoos.

(B) Removal of nontoxic goiter.

(C) Breast reduction or enlargement.

(D) Penile implants.

(b) Surgery not medically necessary shall not be provided. Examples include, but are not limited to:

(1) Castration.

(2) Vaginoplasty (except for Cystocele or Rectocele).

(3) Vasectomy.

(4) Tubal ligation.

(c) Services that have no established outcome on morbidity or improved mortality for acute health conditions shall not be provided. Examples include, but are not limited to:

(1) Acupuncture.

(2) Orthoptics.

(3) Pleoptics.

(d) Treatment for those conditions that are excluded within these regulations may be provided in cases where all of the following criteria are met:

(1) The inmate's attending physician prescribes the treatment.

(2) The service is approved by the medical authorization review committee and the health care review committee. The decision of the review committee to approve an otherwise excluded service shall be based on:

(A) Available health care outcome data supporting the effectiveness of the services as medical treatment.

(B) Other factors, such as:

1. Coexisting medical problems.

2. Acuity.

3. Length of the inmate's sentence.

4. Availability of the service.

5. Cost.

§3350.2. Off-Site Health Care Treatment.

(a) Each facility shall maintain contractual arrangements with local off-site agencies for those health services deemed to be medically necessary as defined in section 3350(b)(1), and that are not provided within the facility. Such services may include medical, surgical, laboratory, radiological, dental, and other specialized services likely to be required for an inmate's health care.

(b) When medically necessary services are not available for an inmate within a facility, the facility's chief medical or dental officer may request the institution head's approval to temporarily place that inmate in a community medical facility for such services.

(c) In an extreme emergency when a physician is not on duty or immediately available, the senior custodial officer on duty may, with assistance of on-duty health care staff, place an inmate in a community medical facility. Such emergency action shall be reported to the facility's administrative and medical officers-of-the-day as soon as possible.

[…]

§3360. Availability of Mental Health Services.

(a) The department will provide a broad range of mental health services to inmates and parolees by assessing the needs of its population and developing specialized programs of mental health care, to the extent resources are available for this purpose. Necessary and appropriate mental health services will be provided to inmates and parolees, and adequate staff and facilities will be maintained for the delivery of such services.

(b) When an inmate is found to require mental health care not available within these resources, but which is available in the Department of Mental Health, the case will be referred to the director for consideration of temporary transfer to that department pursuant to Penal Code Section 2684.

(c) Recognizing that many parolees have unique treatment needs not readily met by community mental health programs, and that the promptness and appropriateness of those needs affect public safety, the department provides outpatient clinics for parolees. These clinics are conducted in widely distributed locations throughout the state at times and places such that they are available to parolees, and that they shall maintain close working relationships with parole supervisors, paroling authorities, and the community in which the parolee resides.

§3361. Responsibility.

(a) All required mental health treatment or diagnostic services shall be provided under the supervision of a psychiatrist licensed to practice in this state, or a psychologist licensed to practice in this state and who holds a doctoral degree and has at least two years of experience in the diagnosis and treatment of emotional and mental disorders. Facilities for mental health treatment and diagnostic services shall be under the direction of such a psychiatrist or psychologist. A psychiatrist shall be available to assume responsibility for all acts of diagnosis or treatment that may only be performed by a licensed physician and surgeon.

(b) When an inmate or an inmate's guardian or relative, or an attorney or other interested party desires to have an inmate examined by a private psychiatrist or other mental health professional, a request shall be submitted in writing by such person or persons to the warden. After consulting with the institution's chief psychiatrist or, in his absence, the chief medical officer, the warden will grant the request unless there are specific case factors which, in the judgment of the warden, warrant denial. If the request is denied, the person making the request will be notified in writing of the reason for the denial and the right to appeal the decision, to the director. Any financial responsibility or obligation for private consultants or examinations will be assumed by the inmate or the person requesting the service. Private consultants will not be permitted to order mental health treatment for any inmate. However, the private consultant may be asked to make a report of findings and recommendations to the warden.

(c) Recognizing that mental health care often involves revealing deeply personal and private matters, all mental health care shall be provided in such a manner as to maintain the dignity of the inmate. Professional relationships shall be conducted

with proper privacy, with due regard to the professional to take necessary and appropriate action to prevent harm to the patient or to others. Records of mental health diagnosis, evaluation and treatment prepared or maintained by the department shall remain the property of the department and are subject to all applicable laws governing their confidentiality and disclosure. Treatment will be in accord with sound principles of practice and will not serve a punitive purpose.

# Appendix B

# Memorandum of Understanding Between DOC and SCVHHS Governing Inmate Healthcare

Draft dated 12/9/2004

## Memorandum of Understanding
## Between
## Santa Clara Valley Health and Hospital System
## and the Department of Correction
## for the Provision of Health Care Services to the
## Inmates Incarcerated in the Santa Clara County Jail Facilities

The Department of Correction facility administrator (Chief, DOC) shall have the responsibility to ensure provision of emergency and basic health care services to all inmates. The Department of Correction, as the Agency responsible for the management of inmates remanded to the custody of the Santa Clara County Jail facilities, and Santa Clara Valley Health and Hospital System, as the agency responsible for medical, dental and mental health matters involving clinical judgments, agree to the following conditions in respect to the delivery of medical and mental health services to incarcerated individuals within the jail facilities, the ambulatory clinics and inpatient units of Santa Clara Valley Medical Center.

Philosophy of Health Care

The provision of health care will focus on the prevention of illness, the control of pre-existing pathologies, and the restoration to health once the inmate becomes compromised by illness.

The care will be offered in an objective, non-judgmental environment and will meet or exceed Title XV regulations.

Santa Clara Valley Health and Hospital System

- The medical and mental health services programs will be administered by a health care professional appointed by the CE or designee, Santa Clara Valley Health and Hospital System. The Administrator will jointly oversee the delivery of health care services with the Medical Director, Adult Custody Health Services.
- The Medical Director, Adult Custody Health Services, is the responsible physician and the authority on all matters that require medical judgment.
- Matters related to the extent and level of health care services to be provided to the inmate population remain the sole province of the Medical Director.
- Appropriate levels of physician, nursing, pharmacy, mental health and dental staff will be provided to ensure that safe and effective levels of health services are rendered. The two departments will review staffing levels on a regular basis.

- Pharmacy services will be provided through on-site pharmacies licensed by the California State Board of Pharmacy.
- Dental services will be provided at the dental clinics at the Main Jail and at the Elmwood complex.
- Internal medicine clinics will be conducted daily at the Main Jail and the Elmwood Complex.
- OB/GYN clinics will be conducted on-site at the Women's Facility and as needed at the Main Jail.
- Crisis intervention services will be provided 24 hours a day, 7 days a week.
- Inpatient acute care services will be provided at SCVMC. Inmates who are hospitalized at other local acute facilities will be transferred to SCVMC upon stabilization of their condition.
- Inmates will receive a tuberculosis screening test in the Booking/Processing areas prior to their housing.
- An annual report pursuant to Title XV regulations will be compiled by the Jail health care Administrator and forwarded to the Chief of the DOC at the end of each fiscal year.
- The Administrator of the Adult Custody Health Service Organization and the Chief of the Department of Correction will meet regularly at defined times to discuss, plan and problem solve any issues related to the provision of healthcare services to the inmate population. Additionally, the Administrator, Adult Custody Health Services, will participate in the DOC's Executive Team meetings.
- Representatives from Custody Health Services and the DOC will participate in the following meetings: Monthly Quality Improvement Committee, Executive and Management Staff Suicide Prevention Committee, AED and Safety meetings.
- DOC will review and be provided signature authority on salient health-related policies and procedures as determined by Custody Health Services.
- Janitorial Services will be provided on the Medical Unit at Elmwood and on the second floor and Unit 8A of the Main Jail.
- Monthly statistical data related to the provision of health care issues to inmates will be submitted to the DOC pursuant to State Board of Corrections requirements.
- Custody Health will provide DOC on an annual basis a line item budget for providing medical care in the facilities and a line item budget for providing mental health care services in the SA unit in the Main Jail including authorized FTEs.

<u>Department of Correction</u>

- The Department of Correction in conjunction with the Sheriff's Department will insure transportation of inmates to scheduled and unscheduled medical appointments.

- Custody personnel will escort medical personnel having direct interaction with inmates during medication rounds and clinic appointments.
- Security orientation will be provided by the DOC to all new medical personnel.
- Adequate space will be provided to medical personnel to render health care services to the inmate population.
- Department of Correction will be responsible for maintenance of the facility and the infirmary beds.
- DOC will provide VMC with timely notification of the jurisdiction status of State and Federal prisoners who require non-routine medical services in accordance with billing procedures.
- DOC will confer with medical for program planning and expansion of services, including the provision of health services to out-of-county inmates. The departments shall develop a methodology for sharing revenue and augmenting resources when needed.

The agreement is in effect until written notification to rescind is submitted by either department. Modification may be requested by either party at any time.

_____ _____

Robert Sillen Date
Director, Santa Clara Valley Health & Hospital System

_____ _____

Edward C. Flores Date
Acting Chief, Department of Correction

# Appendix C

# Executive Summary of the Helmuth, Obata, and Kassabaum Study – Goals, Recommendations, and Findings as well as County Response Summary

The Helmuth, Obata, and Kassabaum (HOK) study of adult inmate healthcare in the County was commissioned by the County Executive's Office in October 2003 and completed in April 2004. The following summarizes the goals, recommendations, findings and conclusions from the study executive summary. County responses to the study.

Study Goals:

- Maintain quality of care consistent with California Code of Regulations Title 15 and "community standards".
- Find ways to improve operational efficiency.
- Find ways to reduce overall cost to county.

Recommendations: Timeline

The following exhibit "Recommendations: Timeline" is a summary by topic and by timeframe for implementation (the next 3-5 years). The Timeline is also color coded to highlight the primary benefit anticipated from each action, as follows:

**Operational Efficiency** (yellow items) is the primary benefit expected from most of the suggestions on service delivery and location. Recommendations regarding on-site Emergency Response and Dialysis would probably cost as much to implement as they would save in DOC transport staff cost, so their primary benefit would be reduced disruption of jail routines by enabling custody officers to man their normal posts instead of having long periods off-site to accompany inmates for emergency or dialysis runs.

**Interdepartmental Communication/Collaboration and Continuum of Care** (blue items) are the primary benefits expected from most of the management/organizational recommendations. These include refining performance measures and service level/cost indices, expediting IT improvements, on-site CHS management, and improved CHS budgeting processes to resolve trade-offs between DOC and SCVHHS. Another recommendation whose primary benefit is interdepartmental alignment relates to inpatient psychiatric services, because this is primarily a question of allocation of resources. The bottom line question for the Board on this topic is whether to invest in improving/expanding inpatient psychiatric capacity at the jail (in order to enable increased contract revenue by housing psych inpatients from other jurisdictions) or use these resources in another way.

**Cost Control and Potential Savings** (green items) are the primary anticipated benefits for three recommendations:

- Clarified policies on antipsychotic medications (to reduce pharmacy expense by as much as $.5 million this year, and more in coming years);

- Consideration of contracting out Pharmacy and possibly other jail health care services (by issuing an RFP with specified performance standards, the County can confirm more precisely the potential cost savings); other counties spend substantially less on jail healthcare by contracting out to private companies;
- In the long term, one of the most promising ways to control jail healthcare costs is to reduce recidivism, such as by addressing "frequent flyers" who often are dual-diagnosed mentally ill and substance abusers. This would require more integration of the currently-separate County departments responsible for Mental Health and Drug and Alcohol.

**Risk Management and Control of Exposure** (red text) are included in two recommendations to control the County's risk. For instance, before undertaking expansion of contracted inpatient psych jail beds, there should be due consideration of implications and possible exposure to implied costs (of facilities and staffing) without guarantee of corresponding revenues.

Also relevant to controlling risk is the recommendation to clarify policy on atypical antipsychotic medication, because of the rapidly escalating costs of these new drugs.

Findings & Conclusions

The consultant team worked with the input of the Steering committee and the members of the County Executive's team to develop findings and recommendations, which are summarized on the following pages with references to the report pages where more detailed analysis can be found.

## I. Findings

### Quality of Care

Title 15 mandated levels are met, or in some cases, exceeded in Santa Clara County. Moreover, ACHS [Adult Custodial Healthcare Services] provides an equal or higher level of care than most jail healthcare systems of similar size in California. For example, Santa Clara County has an inpatient psychiatric unit on site at the Main Jail. Very few other counties include inpatient psychiatric care among the services on site at the jail, and numerous counties contract with Santa Clara County to house their inpatient psychiatric inmates for a fee. Thus the County's level of care for this service is among the highest in the state, and interviews during the survey of other counties provided unsolicited testimonials to the quality of this care.

Because County health services have been hard hit by budget cuts, and jail healthcare continues to be held to Title 15 standards for healthcare access, the care received by inmates is in some ways better than they would receive outside jail in the community. Measures of quality in this regard include timely access to care, time to first clinician appointment, and identification/treatment of communicable diseases and mental illness. Because inmates go through intake/assessment upon booking, conditions are often identified that might have gone untreated had the individual not entered the jail system.

Moreover, the jails have in many cases become the "safety net" for mentally ill individuals, since the de-institutionalization of mental illness and continued budget reductions have significantly reduced these mental health facilities and services in recent years.

*In conclusion*, ACHS level of care measures up well against mandated standards of both other jails and the community standard of care in Santa Clara County. In no case did our team find reason to question the quality of care, and by some measures the care is at an enhanced level compared to most other jail systems and to the outside community.

**Strained Relations Due to Budget Pressures**

However, repeated budget cuts in County government have strained the budgets of all agencies: CHS, DOC, and other health partners such as VMC, County Public Health, Mental Health and Drug and Alcohol Services departments. The pressure to make repeated budget cuts has also strained relations between agencies as they struggle to maintain high levels of service measured by their very different missions: that of DOC relating to housing inmates and maintaining control and security, and that of CHS emphasizing preventing and treating disease and injury and enabling inmates to re-enter the outside community in better health.

**Type of Recommendations**

There are two major types of issues and recommendations coming out of this study: 1) service delivery options for health care itself; and 2) management/organizational topics such as reporting relationships, information systems, planning and budgeting processes and contracting procedures.

Our study has identified several recommendations that offer near-term potential to reduce cost and/or improve operational efficiency. However, perhaps the more important findings concern management/organizational issues and approaches which may in the longer term have much greater potential to reduce cost, improve service efficiency, and enhance communication and collaboration among the agencies concerned with jail health care.

Conclusion

We respectfully submit this report for the consideration of the County Executive in preparation for presenting findings to the Public Safety and Justice Committee and the Board of Supervisors. Within the short timeframe allowed for the study. some very positive potential opportunities have been identified to improve operational efficiency and reduce costs while maintaining service quality. Some of these opportunities may be controversial, and will require a careful fact-based review. Perhaps our most important recommendation is to form a continuing Task Force to jointly work on cost reduction and other initiatives that cross the lines between the many county agencies concerned with healthcare and jails, which constitute such a large part of the county budget. There will be a greater likelihood of creating positive change in these difficult areas if there is a forum for communication, information sharing, and innovative thinking.

Summary of More Detailed HOK Study Recommendations:

**Service Option Recommendations**

- Increase handling of emergency responses at jail sites
- Add on-call responsibility to jail docs
- Consider on-site dialysis services
- Increase use of once/twice daily meds to reduce contact requirements
- Set realistic policy for antipsychotic meds
- Evaluate scope, site, and delivery changes to mental health based on cost/benefit analyses
- Consider outsourcing pharmacy or other aspects of custodial healthcare delivery

**Management and Organizational Option Recommendations**

- Define, collect data regarding, and report indices of care utilization, outcomes, and cost for CHS
- Expedite and coordinate IT improvements for delivery and coordination of CHS
- Better integrate and coordinate budget setting and management
- Consider alternative programs to reduce population of inmates requiring care and "frequent flyers" with substance abuse and mental health problems.
- Improved coordination at CEO level of standards (formulary, care guidelines, mental health approaches); measurable indices of care, outcomes, and cost; policy alternatives for Board of Supervisors; and strategic organizational and management efficiency improvements.

**Other Observations:**

- Reporting structure for DOC and SCVHHS inconsistent – DOC reports directly to the Board of Supervisors and SCVHHS reports through the CEO (Exhibit 1.A)
- Stakeholder viewpoints are inconsistent – DOC emphasizes control and security of inmates and jails and SCVHHS emphasizes quality of care for all patients at SCVHHS sites.
- Information systems are still largely manual, outdated, and unintegrated.

Summary of County Executive Response to HOK Study (June 2004)

- References Memorandum of Understanding between Dept of Corrections and Santa Clara Valley Health and Hospital System which states that, "community standards of care will be adhered to and afforded to the inmate population."
- Administration agrees that impacts of "adopting policy-driven, fiscally prudent approaches that positively impact the County" must be assessed regularly and county-wide.

- Administration will continue to provide the link necessary for departmental collaboration and cooperation.
- Administration does not agree with issuing an RFP to determine cost reference for outsourcing some or all inmate health care. This effectively refuses the HOK recommendation to examine pharmacy services in particular.
- Administration agrees that review by some unspecified means is needed for use of pharmaceutical agents (especially psychotropic drugs), including cost issues.
- Administration does not agree with recommendation to examine expansion of inpatient psychiatric services.
- Administration agrees with need for specific, measurable indices of performance, quality, and costs for custodial health care services. Discussion suggests action on updating the MOU and putting in place IT services to help with management oversight but no details are available.
- Administration agrees with need to pursue cross departmental approaches to mental health and substance abuse.