

23 EXPERT TESTIMONY ON THE PUBLIC HEALTH IMPLICATIONS OF
24 HEALTHCARE IN FACILITIES
25 MS. SCHLANGER: So I think we'll get

1 started. On behalf of the Commission on Safety and
2 Abuse in America's Prisons, I'd like to welcome
3 Dr. Robert Greifinger, Dr. David Kountz and Secretary
4 Jeffrey Beard.

5 This distinguished group has agreed to
6 appear before us today to address the public health
7 concerns that arise in prisons and jails and, in
8 particular, the health risks and financial costs
9 created by failure when it occurs to adequately detect
10 and treat infectious diseases in prisons and jail
11 populations.

12 Our last panel discussed the most
13 serious failures to provide adequate medical care in
14 jails and prisons and some of the consequences of
15 those failures, but I think we even began to hear last
16 time, and we certainly heard some yesterday, that the
17 consequences of inadequate medical care in prison
18 extend far beyond the prison walls.

19 Most of our inmate population and all
20 of our nation's correctional officers return to their
21 communities. According to research conducted by
22 Dr. Greifinger and others for the National Commission
23 on Correctional Healthcare, in 1996 alone, somewhere
24 between 1.3 and 1.4 million people infected with
25 hepatitis C were released into the general population

1 from prisons and jails and an estimated 560 some odd
2 thousand inmates with TB infection returned to their
3 communities after some form of incarceration.

4 These numbers only scratch the surface
5 of the health problems prisons and jails address daily
6 and we hope that this panel which help us to identify
7 risks and think creatively about solutions to the
8 public health challenges our prisons and jails pose.

9 I guess in particular there's this
10 question of whether prisons and jails are posing a
11 challenge or presenting an opportunity for public
12 health and medical professionals and from looking at
13 the written versions of your testimony, I think that
14 you would have a lot to offer on which of those or
15 whether both of those are the right way to think about
16 this question, so I hope you will do that.

17 The three members of our panel have
18 extensive experience in managing prison and jail
19 healthcare services and so let me start by introducing
20 them.

21 Dr. Robert Greifinger has worked in
22 correctional healthcare for 18 years managing health
23 services at both Riker's Island in New York City and
24 for the New York State Department of Corrections. He
25 now works as a consultant examining the conditions of

1 confinement and health services in over 100
2 correctional facilities in 33 states. I assume not
3 all at once. Dr. Greifinger will help us to
4 understand the scope of the problem and the
5 opportunities we have to address the risks through
6 improved correctional healthcare.

7 Our next witness, Dr. David Kountz, is
8 a specialist in internal medicine, the chief of
9 primary care services at Robert Wood Johnson
10 University Hospital and the management director of the
11 Somerset County Jail here in New Jersey. Dr. Kountz
12 will speak to the unique challenges that short term
13 jail confinement poses in screening and treating
14 infectious and chronic diseases and will address the
15 value of the partnership between his medical school
16 and the county jail.

17 Jeffrey Beard is the secretary of the
18 Pennsylvania Department of Corrections and he spent a
19 long and successful career in corrections management.
20 He brings knowledge and expertise about the
21 connections and about the various issues we're
22 grappling with today and he can help us explore models
23 for success. He will speak directly to the strategies
24 that Pennsylvania has employed to address the public
25 health challenges posed by an incarcerated population

1 and to protect the health of both inmates and
2 correction staff.

3 So once again, let me thank you for
4 coming and testifying today and I'm confident that
5 your testimony will be really invaluable to us and so
6 I'm looking forward to it.

7 Our business, I've been instructed to
8 give you each -- to tell you each that you have 12
9 minutes. I'm not keeping time, however, that's over
10 there, she's keeping time. At the end of the 12
11 minutes I may start off with a question or two and
12 Judge Sessions will also help us get things started
13 and, at that point, we'll open it up to the rest of
14 the commissioners for other questions and to the panel
15 for answers.

16 So I think we'll start with
17 Dr. Greifinger. Thank you very much.

18 DR. GREIFINGER: Thank you, Margo.
19 After the news announcement last night at 9:00 I want
20 to say, may it please the Commission.

21 I am very pleased to be here myself and
22 I want to talk with you a little bit about a journey
23 that I've been on for the last 18 years. I began a
24 journey 18 years ago to try to learn a little bit
25 about the health status of the inmates, to learn about

1 access to medical care and quality of medical care for
2 prisoners, to learn about the burden of illness. And
3 after that I wanted to learn, well, how can we measure
4 performance the way we do outside in the free world?
5 How can we identify barriers to reasonable quality of
6 medical care and to reasonable access to medical care?

7 And then I asked myself the question
8 what can I do to help formulate solutions, to
9 formulate remedies so that we can address some of the
10 challenges that we've identified?

11 What I found early on was this was not
12 just about humane or legal treatment of inmates. This
13 was all about our health. It was about my health and
14 yours and the health of our families because, among
15 other things, the burden of illness among inmates is
16 really very, very extraordinary. As you know, inmates
17 as a group in the United States have extraordinary
18 prevalence of communicable diseases such as sexually
19 transmitted diseases, tuberculosis, viral hepatitis,
20 HIV and the recent scourge that we've had throughout
21 prisons and jails across the country is drug resistant
22 skin infections.

23 I also learned on my journey that the
24 quality of medical care varies really tremendously
25 across the country. Some healthcare programs such as

1 the one Dr. Beard is going to discuss with you are
2 really excellent. And others in this country, too
3 many of them are shameful with the kind of -- and I've
4 seen the kinds of things that Drs. Goldenson and Cohen
5 described with shameful, not only in terms of what we
6 do to the individuals, but shameful in terms of the
7 risks we put our staff to and the risks of the public
8 health.

9 Just recently, in the last couple of
10 years -- again, I'll give you a few examples -- I was
11 at the Julia Tutwiler Correctional Facility for Women
12 in Alabama and there was a woman with active
13 contagious tuberculosis. And was she in a respiratory
14 isolation room? No. She was walking around the
15 infirmary and walking through the segregated unit for
16 HIV infected women, the most vulnerable to
17 tuberculosis of anybody in this state. But that was
18 not alone.

19 I went to Parchman Prison in
20 Mississippi to another unit that segregates
21 HIV-infected inmates and I found an outbreak of boils
22 that went throughout that unit, with dozens of people
23 having boils that were weeping puss, but no one was
24 looking at it and trying to address it from a public
25 health point of view. So not only were the

1 HIV-infected inmates at risk, but so were staff that
2 worked there, the medical staff, the correctional
3 officers and so were their families to whom they each
4 returned at the end of the day, each day.

5 A few years ago at the Fulton County
6 Jail in Atlanta, Georgia the care of HIV-infected
7 inmates was essentially denied; it wasn't being given,
8 and so people were dying. There had been something
9 like -- I don't remember the exact numbers -- 29

10 deaths in 24 months, which when that system was
11 fixed -- because of a consent decree and great work by
12 the Southern Center for Human Rights, when that system
13 was fixed it went down to two deaths in the next 24
14 months, so you can really make a big difference and
15 protect the public's health.

16 I've learned on my journey that there's
17 widespread ignorance about the value of inmate medical
18 care, not just to the inmates themselves, but to all
19 of us and to our families and to our communities. But
20 I don't understand why we don't seize these
21 opportunities that are there. Isn't it only rational
22 to put our money in places where it makes the most
23 sense for public safety, where it makes the most sense
24 for public health?

25 The only thing I've learned is that

1 good policy often doesn't make good politics and that
2 leads me to the conclusion that we need better
3 leadership. We need leadership from each and every
4 person on this Commission and from anyone who is going
5 to take the time to read your recommendations. We
6 need leadership that says this is in our interests,
7 because the public forgets that every inmate who
8 returns to the community with an untreated sexually
9 treated disease or with HIV or with hepatitis C or
10 tuberculosis puts our children at risk. Every inmate
11 who returns to the community with untreated mental
12 illness or with treatment that is interrupted, it's
13 aborted on re-entry into the community puts our public
14 safety at risk. Every inmate who returns to the
15 community with untreated drug addiction puts our
16 property at risk and puts our safety at risk.

17 We need to think about this window of
18 opportunity that we have to really make a difference.
19 So our challenge is to try to make good politics out
20 of what is clear, I think, to everyone about what
21 would be good public policy and I would like to give
22 you seven steps. This may sound like a one-minute
23 manager type of a talk, but I think there are only and
24 simply seven things we could do that could really make
25 a difference beyond the larger issue that was

1 discussed earlier, and that's to put fewer people
2 behind bars, finding call it diversion programs or
3 whatever through drug treatment and treatment of
4 mental illness and perhaps being less harsh with some
5 of our crimes.

6 But for the people who we are going to
7 put behind bars, we need to do seven things. Primary
8 and secondary prevention, that's number one. By
9 primary prevention I mean preventing things from ever
10 happening in the first place. Good examples of that
11 are vaccines. If you get vaccinated against hepatitis
12 B, you are not going to get hepatitis B. If you get
13 vaccinated against influenza or pneumococcus, you are
14 not going to get those diseases.

15 Secondary prevention means the early
16 detection of something that's there in a medical
17 intervention that's going to lead to cure. So if we
18 screen for sexually transmitted diseases, we can cure
19 those before they infect other people in the
20 community. If we screen for HIV and hepatitis C and
21 tuberculosis, we have short run gains, we're
22 protecting against transmission in the community and
23 there are good data -- if you look at the report to
24 Congress on the health status of soon-to-be-released
25 inmates, you will see good data that it's cost

1 effective for our society to do these -- this primary
2 prevention and this screening and intervention. There
3 are cost savings which will accrue directly to our
4 society. But we can't be fooled by that, they're not
5 cost savings that accrue directly to the Departments
6 of Corrections which will have to bear the cost.

7 So when we allocate monies for
8 correction, we have to remember that there will be
9 cost savings for us socially and it may be worth a
10 penny investment to get a dollar return by adding a
11 public health agenda to our correctional budgets.

12 Second, alcohol treatment and drug
13 treatment is mandatory. We don't do enough of it,
14 everybody knows that. Drug treatment is effective,
15 alcohol treatment is effective, not in everybody who
16 goes through and not always the first time, but if you
17 look at the data, there's cost effectiveness and we
18 can't control this vicious cycle of people going --
19 reentering the community and getting back on their
20 substances to which they're addicted, we're going to
21 have this vicious cycle of recidivism, increased cost
22 and danger to public safety.

23 As Dr. Cohen and Dr. Goldenson
24 emphasized, we need to have a quality of medical care

25 behind bars, it's the same as the quality in the free

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1 world. There's no reason that it should be different.
2 There's no reason that we should be treating hepatitis
3 C differently behind bars than we do outside in the
4 community. There was no reason for three or four or
5 five years during the late 1980s when we were denying
6 treatment to HIV-infected people after there was
7 treatment available and there's certainly no excuse
8 today. And there's no excuse to do that for hepatitis
9 C and there's no excuse not to look for and treat
10 sexually transmitted diseases and other curable
11 diseases.

12 If the problem is we have treatment
13 that will last longer than the term of incarceration,
14 then our challenge is to find a way to have continuity
15 and coordination of care on release so if a person is
16 partially treated while they're inside, the minute
17 they step out the door they've got insurance coverage
18 and a place to go where the medical records can be
19 transferred and they can continue their treatment.

20 We need to recognize the huge value of
21 preparation for re-entry. We heard good testimony
22 this morning about some of the problems. We know
23 there are terrible consequences to inmates, especially
24 those who are -- are coming off long-term

25 incarcerations. We need to learn more about what

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1 works. We need to learn more about how to build
2 linkages with public health departments, with
3 community mental health centers, with community health
4 centers and other private resources in the community.

5 We need to acknowledge and reduce five
6 barriers to change that I see. We've got the
7 leadership problem that I've mentioned earlier, and I
8 think that's the most critical. We've got a problem
9 with cynicism. There is a cynicism that's pervasive,
10 that keeps us from being able to do our jobs as
11 professionals. We need to do research and evaluation
12 and we need to learn more about the consequences of
13 incarceration.

14 So I'm asking you to help find a way to
15 view inmates as public health sentinels. We all have
16 contact with returning inmates, we all have
17 responsibilities, we all stand to gain economically,
18 as well as gain in terms of our health. We need to
19 learn how to promote the notion that public health is
20 public safety. Thank you.

21 MS. SCHLANGER: Thank you,
22 Dr. Greifinger.

23 We'll move to Dr. Kountz.

24 DR. KOUNTZ: Thank you. As the only

25 resident living and practicing in New Jersey on this

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1 panel, let me welcome all of you to New Jersey and
2 thank you for this opportunity to share my
3 perspectives with you.

4 I'm going to touch on two themes that I
5 think I'm best qualified to comment on. One is the
6 public health issues in jail settings and then to
7 share some observations on a relationship that we have
8 had at our medical school with a county jail and
9 speculate on how this type of relationship might be in
10 the public's best interest to expand into different
11 communities to do some of what we have been able to do
12 in the last seven years.

13 The care of inmates in jails should be
14 of central concern to all citizens. Well-designed
15 protocols and opportunities for follow-up are
16 available in many prisons, but less so in jails, with
17 more rapid turnover of inmates and greater challenges
18 to make accurate diagnosis and initiate appropriate
19 treatment.

20 One of our greatest challenges is the
21 identification of infectious disease in our jail
22 setting. There is a rich literature on the prevalence
23 of infectious diseases in prisons, but not nearly as
24 much as jails. It has been suggested that infectious

25 diseases are even more prevalent in jails than in

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1 prisons, as the rapid turnover makes diagnosis
2 challenging. Further, there is a natural tendency to
3 deal with acute crisis type medical problems, such as
4 drug withdrawal, uncontrolled diabetes and accelerated
5 hypertension.

6 This winter and spring, as I believe
7 you heard yesterday, many jails and prisons focused
8 their attention on an outbreak of a new community
9 acquired -- community-acquired resistant staff aureus
10 or MRSA. A relatively new infectious disease that was
11 at risk of rising to epidemic proportions in
12 institutionalized settings. It was through the superb
13 oversight in communication between our staff and the
14 state and county Department of Health that this
15 potential epidemic was halted.

16 Here are some examples of the steps
17 that were taken to control this infection in our
18 facility. Because of our close working relationship
19 with our state DOC, as well as our county Department
20 of Health and dissemination of new information at the
21 medical school, we become aware of the increasing
22 number of cases of MRSA. Memos were crafted to our
23 staff (medical, nursing and correctional staff), as
24 well as inmates regarding surveillance and prevention.

1 Bureau of Prisons and worked with the administrative
2 leadership in the jail regarding putting in place
3 enhanced infection control strategies. A specific
4 skin infection log was initiated using New Jersey
5 Department of Health and Senior Services Data
6 Collection Forms, which allowed pooling of data from
7 many sites and early recognition of infection trends.

8 Procedures were implanted for
9 identification of suspected skin infections, wound
10 culturing, isolation and treatment recommendations
11 were also put into place. Infection information
12 sheets were posted in housing units for inmates to
13 read and, of course, this information was available in
14 multiple languages at low literacy levels. Custodial,
15 administrative and visitor bathrooms had proper
16 handwashing technique posters placed in them. Nurses
17 and physicians spoke to inmates during intake
18 examinations and during all sick calls visits,
19 answering questions and reviewing good hygiene
20 practices.

21 We also found that education was
22 crucial for officers who assist in first recognition
23 of hygiene issues and referral of inmates to the
24 medical unit. Certainly, this was a challenging

25 process but, ultimately, it was successful. I can say

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1 with confidence that the number of confirmed cases
2 were few, and that officers, inmates, visitors and
3 staff were comforted by the degree of education and
4 attention that this problem received.

5 Frankly, no stone was left unturned.
6 The health of the public was secured through this
7 close oversight of this potentially serious infectious
8 process. It was encouraging for me to realize that
9 the education of inmates was a strategy that could
10 change behavior regarding hygiene and risk, and this
11 bodes well when they are released.

12 At our institution the average duration
13 of incarceration is eight days, but this is
14 misleading. About ten percent of inmates are state
15 inmates with prolonged stays. The remainder turn over
16 much more quickly, thus, the inmate that one is most
17 likely to randomly encounter is gone in three or four
18 days. These statistics speak to the challenge of
19 routine identification of high risk inmates,
20 initiation of screening, treatment if necessary and
21 follow-up.

22 Strategies to increase diagnosis of
23 STDs is one example, or other infectious diseases,
24 could be put into place but at what cost? Routine

25 testing of all inmates with the use of rapid screening

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1 tests would place a significant burden on laboratory
2 and pharmacy costs. As suggested, this increase in
3 diagnosis would not necessarily be translated into
4 increased rates of treatment due to the turnover
5 issues.

6 A practical consideration that we face
7 with this population beyond cost, and perhaps this is
8 a sad reality of our times, is managing expectations
9 in a litigious environment. Making a diagnosis when
10 an inmate is walking out the door places a burden on
11 the facility to track that inmate down, certified and
12 registered letters and other outreach. This places an
13 additional burden on facilities that are often
14 understaffed from the start.

15 Several correction centers, such as
16 Hampden County in Massachusetts, have been effective
17 in putting public health services in place in jail
18 settings. Their model is not only of early detection
19 and comprehensive assessment of health problems,
20 treatment, disease prevents programs and health
21 education, but also continuity of care in the
22 community, with collaboration between the county
23 health services department, community health centers

24 and other local healthcare providers.

25 Could we develop such a model in

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1 Somerset County or in other counties in our state
2 where jails are present? If so, who would staff such
3 health centers? Are local providers really out there
4 who are willing to accept inmates as patients? These
5 are all practical problems and ones that I have faced
6 in the last seven years.

7 The value of hearings such as this is
8 to give us an opportunity to speculate on best
9 practice models, with a clear eye towards cost and
10 practical processes. Most jail populations are
11 extremely transient. The expectation that inmates
12 will follow up in a local, that is to the jail
13 community, is, I believe, somewhat unrealistic.

14 When we release records -- request
15 release of medical records from our inmates to verify
16 prior treatment and current medications, they are
17 addressed across the state and beyond. Local
18 physicians are often anxious about having inmates as
19 patients, not just from the standpoint of image to
20 their other patients, but also related to
21 reimbursement.

22 As I conclude, let me speculate on the
23 future and the role of medical schools to potentially

24 advance the cause of improving care in jails. There
25 are an increasing number of medical schools partnering

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1 with state departments of corrections to provide or
2 oversee all or part of correctional healthcare. In
3 2004 our university partnered with our state DOC to
4 provide mental health services, and we are planning a
5 national conference to address such partnerships next
6 year.

7 As schools develop correctional health
8 institutes or departments of correctional health,
9 there will be a framework for expanding this mission
10 to local jails. Medical schools, or, for that matter,
11 schools of public health are not always the perfect
12 partner. We tend to be inefficient and less costly,
13 have missions that are competing, are overly
14 bureaucratic compared with a private practice or
15 in-house providers.

16 However, we have a steady stream of
17 enthusiastic, idealistic future healthcare
18 professionals eager to work in a variety of healthcare
19 settings. As a medical student at Buffalo New York in
20 the early 1980s I remember working on the ward where
21 inmates from Attica Prison were transferred. With
22 appropriate supervision, this was a superb opportunity
23 to provide direct patient care and learn about

24 infectious diseases. At that time it was beginning of
25 the AIDS epidemic.

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1 Medical, nursing and public health
2 students take on community-based projects all the
3 time. In our city of New Brunswick our students have
4 begun a clinic providing care free of charge to
5 citizens who have nowhere else to receive their care.
6 Social services are also available. These examples
7 exist in every school in this country. Why couldn't
8 this model be expanded to counties for inmates or at
9 centers near sites where inmates receive parole and
10 social services?

11 Let me again thank the Commission for
12 this opportunity to express my views on this important
13 subject. To summarize, protocol driven care,
14 attention to regional state and national trends for
15 existing and emerging infectious diseases, chart
16 audits and other monitoring to ensure the policies are
17 being followed, education of staff and inmates and
18 close linkage with county health departments are all
19 tenets to control emerging infectious diseases.
20 Further, I believe that there are new models that can
21 and should be studied to provide best care for
22 inmates. Thank you.

23 MS. SCHLANGER: Thank you, Dr. Kountz.

24 Secretary Beard.

25 MR. BEARD: Good afternoon. I want to

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1 that you for inviting me here today to discuss this
2 important topic and this is a topic that's important
3 to us in corrections and it's important to the public
4 as a whole.

5 I want to begin by saying that I
6 believe that our prisons and jails generally do a good
7 job providing healthcare to the inmate populations.
8 There are a few systems where we're having problems --
9 California everybody has read about that in the
10 newspaper -- and we do see problems in some of our
11 jails and I think when we see those problems, they're
12 largely related to funding issues and probably
13 overcrowding.

14 But I believe the system works. And
15 when the system doesn't work, the courts do intervene,
16 just like they have in California. I would hope that
17 we don't let a few facilities that are having
18 problems, a few systems that are having problems or
19 emotionally-charged anecdotal reports define what is
20 happening in our corrections' healthcare today. If we
21 do, we could do the same in any profession.

22 Just think about some of the problems
23 that you've read about in the newspapers recently with

24 police departments or police officers or hospitals,
25 the high infection rates. I believe these reports do

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1 not give us a true picture of what's going on in those
2 areas. They don't give us a true picture of the fine
3 job that's being done by thousands and thousands of
4 hardworking men and women in our police departments
5 and in our hospitals that are providing for the
6 public's health and for the public's safety, and I
7 believe the same is true in corrections.

8 And in corrections we have an even
9 greater problem, and, that is, the public's perception
10 of what occurs in our prisons and jails. It's a
11 perception that is largely driven by the media who,
12 unfortunately, in our case, reality does not sell, but
13 sex, violence and corruption does.

14 If you want to know what is really
15 happening in our prisons and jails, I ask that you
16 take the time to visit and see what's really happening
17 and in that regard I would invite you, and you have a
18 standing invitation, to come and visit any prison that
19 we have in Pennsylvania any time. Or if you would
20 like to hold one of your commission meetings near one
21 and come visit, please feel free to do and we'll work
22 with you in setting it up.

23 Beyond visits to our facilities, if we

24 are to conduct a review with meaningful outcomes, we
25 need to move away from anecdotes and questionable

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1 statistics and we need to focus on facts. To do so we
2 must define what it is we want to know and then we
3 have to establish objective measures to answer our
4 questions.

5 While we are required in corrections to
6 meet certain constitutional standards for healthcare
7 and to do so we must focus on our inmates as being
8 patients, I believe that we have a further obligation
9 to our staff and our communities to do more. Our
10 staff go home each day and they interact with their
11 families and others in the community, and over
12 90 percent of our inmates will themselves go home some
13 day. The inmates' risky behavior before they came to
14 prison, their exposure to infectious diseases in the
15 community, their substance toxicity and their
16 socioeconomic instability all create a substantial
17 public health risk.

18 We, therefore, also need to treat our
19 inmates as vectors, as sources of infection and
20 disease. While they bring their disease from the
21 community to us, we must be careful to not to let
22 these diseases multiply, which can easily occur in the
23 close confines of our prisons. And we need to be

24 concerned about their impact on our communities upon
25 discharge.

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1 We in corrections do have a unique
2 window of opportunity. It's really an ideal situation
3 for treatment because we don't usually lose our
4 patients and when we do, we get into other problems.
5 And we can provide a consistency of treatment that
6 can't be provided in the community.

7 We also need to look at our inmates as
8 being surrogates for our poor and minority
9 communities. If we study our inmates in greater
10 detail, we can better understand the healthcare in the
11 communities from which they came. In Pennsylvania I
12 think we are not only dealing with the basic required
13 healthcare for inmates, we are also focusing on public
14 health issues. I provided a written statement
15 relative to how we are handling hepatitis C. I think
16 what we do with HIV/AIDS, which can be a very
17 complicated disease to treat, is state of the art as
18 well. And we also focus very closely on TB and
19 hepatitis B because of their ease of transmission.

20 Beyond assessment, prevention and
21 treatment for these and other diseases, we also expend
22 considerable effort on education and training for both

23 our staff and inmates and we do comprehensive
24 discharge planning which is critical for them to
25 receive the continuity of care that they're going to

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1 need.

2 But we have two major problems in
3 corrections healthcare which prevents us from doing a
4 better job in dealing with these and other public
5 health concerns. First, there is a lack of data, a
6 lack of general information about what's going on in
7 our healthcare within our system. We have poor
8 estimates of chronic diseases, for instance, like
9 asthma, diabetes and hypertension. We lack other
10 morbidity data, causes of hospitalization, causes of
11 death, causes of medical expenditure. This is
12 information that, if it was available, would be able
13 to help drive the research agenda and this prevents us
14 from better understanding the healthcare problem in
15 corrections.

16 Second problem we have is funding.
17 Corrections healthcare is not only a complicated and
18 difficult business, it's one that could be very
19 expensive. So that brings me to what I think this
20 commission can do.

21 First, I think that you can help decide
22 what it is we want to know about corrections

23 healthcare, you can help us define the problem.

24 Second, you can help us establish
25 standards and measures so that we have more data and a

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1 better understanding of the problem and this will also
2 help inform and drive a research agenda.

3 Third, you can help educate others in
4 the public, and many in corrections as well, as to the
5 public healthcare implications of correctional
6 healthcare.

7 Fourth, and maybe most importantly, you
8 can help educate those who fund corrections healthcare
9 as to its importance to the public.

10 Fifth, just as we have with re-entry,
11 you can help focus the need on a collaborative
12 approach with other agencies and with public
13 healthcare hospitals and the like.

14 Sixth, you can let people know that if
15 they can't do it all today, there are things that they
16 can do that's not that costly. They can focus on
17 education, they can focus on training for better
18 health habits, maybe they can focus on immunization
19 for some of their staff first and then for some of the
20 higher-risk inmates later.

21 Finally, you can help educate the
22 public on the broader systemic issues; how are we

23 dealing with substance abuse within the community? In
24 Pennsylvania one out of ten people who need treatment
25 can get it. How about the mentally ill? Why are we

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1 seeing more and more mentally ill in our prisons?
2 What are we doing in our community with the mentally
3 ill? And how about the public health system's
4 interface with the poor and minority communities?

5 And we can look at who comes to our
6 prisons and jails. We know that many of them come
7 from a few, poor, inner city neighborhoods. We know
8 that they have had a poor education. We know that
9 there is a lack of employment opportunities. We know
10 that many of them were at-risk children themselves,
11 where their parents were in jail, where their parents
12 had drug or alcohol problems. We could have
13 intervened with them earlier on.

14 These things directly address who we
15 can find in our prisons. It directly addresses our
16 growing inmate population which further tends to
17 squeeze our limited resources. These are things that
18 can make a real difference.

19 Again, I invite this Commission to
20 visit any of our prisons in Pennsylvania to look at
21 healthcare or any other area of concern. I thank you
22 for your time and I look forward to further dialogue.

23 MS. SCHLANGER: Thank you very much.

24 I have kind of an initial question that
25 comes out of something that we heard -- that we on the

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1 Commission heard yesterday so for those of you who
2 weren't here, I hope I get this right to get your
3 responses to it.

4 We were told yesterday that the
5 mortality within prison, I think it was, I don't think
6 it was jail and prison, the mortality within prison
7 for various diseases is half what it is outside, once
8 you control for age and socioeconomic status. That's
9 not a figure I had ever heard before and I wonder do I
10 have this right and what does that mean and what does
11 that tell us about the existence or nonexistence of
12 the problem?

13 DR. GREIFINGER: Well, that's kind of a
14 red herring argument. Think about who is behind bars;
15 it's mostly young men, 92 percent are young men,
16 almost all of those are between the ages of 20 and 45.
17 And what do men between the ages of 20 and 45 die
18 from? They die from motor vehicle accidents, they die
19 from gunshot wounds, they die from suicide, they die
20 from -- if you think about all those things, those --
21 there's a protective effect of prison against those
22 things because they're not driving cars, they're not

23 getting drunk very much and they're not using drugs
24 that much. So I think that's a little deceptive.

25 If you look at inmates' morbidity for

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1 chronic diseases, we see -- we all -- no one has ever
2 measured this scientifically, but all of us who work
3 in correctional healthcare believe that inmates are
4 ten years older, their bodies are ten years older than
5 their chronologic age and it just seems to happen,
6 their heart disease comes earlier, their diabetes
7 comes earlier, their chronic pulmonary disease comes
8 earlier and I think that speaks to several things; one
9 is the lifestyle they live prior to being incarcerated
10 and, secondly, the stresses and other adverse health
11 consequences of prolonged incarceration.

12 MR. BEARD: Yeah, I'd just like to say
13 I agree with a lot of what Dr. Greifinger said there,
14 but I would also want to say that many of the inmates
15 who come to us didn't know they had diseases when they
16 got to us. We, for instance, in Pennsylvania test
17 everybody for hepatitis C. Many of the inmates did
18 not know they had hepatitis C when they came. Many of
19 the inmates did not know that they had AIDS when they
20 came and if they had stayed out in the community where
21 they really don't have good access to healthcare,
22 where they don't have the monies to pay for that

23 healthcare, where many of them don't care to go for
24 that healthcare, you know, I think they would have
25 progressed much more rapidly in those diseases, where

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1 we catch it, we're able to treat them and maybe slow
2 down some of the deaths that would have otherwise
3 occurred.

4 MS. SCHLANGER: I have one last -- I
5 have one other question -- oh, please. I'm sorry.

6 DR. KOUNTZ: Yeah, I just was going to
7 reserve that in our facility a young inmate came in
8 with diabetes, as an example, which is an increasingly
9 important problem, particularly among minority
10 populations, they would be placed on a American
11 Diabetes Association recommended treatment which
12 includes several medications, careful attention to
13 their glycemc and blood pressure control, and they
14 would very likely do better than an age-advanced
15 individual not incarcerated.

16 So the problem may be a later
17 diagnosis, but with the protocol of care in place, if
18 we had someone for a prolonged stay, we would be able
19 to effect probably a reduction in their expected
20 mortality or morbidity.

21 MS. SCHLANGER: So that gets me to
22 second question and then I'll got to Judge Sessions,

23 which is something that I think you said, Dr. Kountz,
24 which is that there's this opportunity raised by the
25 incarceration -- this opportunity raised by the

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1 incarceration of these folks who are medically very
2 needy, and what I'm curious about is it sounds like in
3 your facility you try to take advantage of that
4 opportunity.

5 I'm a little curious, what are the
6 obstacles to other facilities taking advantage of that
7 opportunity? Why don't -- why aren't public health
8 departments around the country pounding on the doors
9 of jails saying, let us in so we can treat people,
10 they're all coming out, and we could get this chance
11 to really get a lot of bang for the buck here. But
12 you don't hear that. You hear people calling for it
13 but you don't hear it happening, and I'm wondering
14 what are the obstacles to that happening?

15 MR. BEARD: You know, I think that the
16 obstacles there are on the same obstacles we see with
17 re-entry in general. You know, one of the most
18 important things for inmates to go out there and for
19 them to succeed, they need to get a place to live,
20 they need to get a meaningful job; if they've got
21 healthcare issues or mental health issues it's got to
22 be taken care of, and it's very difficult when we

23 interface with the public because, largely, the public
24 doesn't care about those things. The public doesn't
25 want them to come out. The public wants to keep them

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1 locked up and put away in prison and I think it's that
2 lack of the public's willingness to reach out is
3 what's causing the problems in the healthcare area as
4 well.

5 DR. KOUNTZ: In response to your
6 question, in our setting I think it has less to do
7 with our county department of health, although they
8 have been a superb partner, but it gets to a word that
9 Dr. Greifinger used, which is leadership, leadership
10 within our facility.

11 We've had a longstanding nurse
12 administrator who has taken as her passion to put into
13 place protocol driven care that -- and she's very
14 willing to do to administration within the facility
15 and others to fight for it. And I think we've just
16 developed a good partnership, but I think many times
17 the answer to why these things don't happen is we
18 don't have a leadership within the facility who are
19 willing to fight for it.

20 DR. GREIFINGER: I agree with David.
21 It's a leadership issue and it's a leadership issue at
22 the top of each level of government and public policy

23 makers. Public health departments are funded usually
24 by disease. They get a lot of their funding from the
25 federal government, they get funding from one

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1 department for tuberculosis and another for hepatitis
2 and another for sexually transmitted diseases, and
3 they really have never thought about and don't think
4 about coming into prisons and jails to work in those
5 areas, with the exception of TB, when we were having
6 outbreaks of drug-resistant tuberculosis especially.
7 Certainly, with tuberculosis it's a little different,
8 but, for the other conditions they just -- they don't
9 have the mandate to do it. No one is paying them to
10 do it and so they say not my job. It's a very simple
11 silo situation where they say not my job.

12 And corrections departments even, where
13 there is enlightened leadership, have difficulty
14 getting the resources to do what they want to do in
15 order to do it right.

16 JUDGE SESSIONS: Dr. Greifinger, your
17 mention of alcohol and drug treatment drove me to ask
18 the question that I've always been curious about, long
19 before I ever came on this commission, and that is
20 about the timing of alcohol addiction and drug
21 addiction in the prisons and when it should be and how
22 it should be done.

23 DR. GREIFINGER: That's a good
24 question. I'm not sure I have a good answer.
25 Jeff, do you know more about that than

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1 I do?

2 JUDGE SESSIONS: Dr. Beard?

3 MR. BEARD: You mean once they come to
4 us?

5 JUDGE SESSIONS: Once they come to you,
6 what about the timing of the actual treatment? If you
7 know that a person is a drug addict or you know that
8 they're an alcohol addict and so many times they say,
9 well, the last three months of a prison sentence --

10 MR. BEARD: First of all, if you try to
11 do the last three months, you are not going to get too
12 much.

13 JUDGE SESSIONS: I would think so.

14 MR. BEARD: Because three months is not
15 sufficient amount of time to put somebody in the
16 program, particularly if they have a serious drug and
17 alcohol program. You probably need more like six,
18 nine, maybe even 12 months in an intensive therapeutic
19 community.

20 Ideally what you would like to do is
21 try to engage that person in the treatment early in
22 their admission into the institution and then put them

23 into some kind of a relapse group once they finish
24 that up. But the reality is because of the lack of
25 resources within the prison setting, we're normally

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1 only getting to those people before they get out,
2 because we want to get the people before they leave so
3 you tend to focus on them and you have to put off the
4 people that are coming in because you are getting the
5 ones going out.

6 JUDGE SESSIONS: What part of the
7 prison system actually drives that particular
8 training, that particular treatment; is it the
9 medical, is it the psychological? Who is it that does
10 it?

11 MR. BEARD: It depends in different
12 areas. In our system it's, you know, a separate area,
13 the drug and alcohol treatment program is really
14 separate, it's really more with the counselors. It's
15 not really tied with the psychologist or the medical
16 department.

17 JUDGE SESSIONS: Dr. Greifinger,
18 talking about screening --

19 MS. SCHLANGER: I think Dr. Greifinger
20 had an answer to your first question.

21 JUDGE SESSIONS: Oh. I thought he said
22 he did not.

23 DR. GREIFINGER: I did, but then I had
24 something to supplement.

25 JUDGE SESSIONS: Pardon me.

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1 DR. GREIFINGER: The last part of your
2 question about who does the treatment is a real
3 barrier in a lot of correctional systems. Typically,
4 the mental health folks are completely separate from
5 the drug treatment folks and in the systems -- there
6 are some models of drug treatment that say you may not
7 be taking any drugs, meaning you may not be taking any
8 medication.

9 So if you have bipolar disorder and
10 need to be on Lithium or you have schizophrenia and
11 need to be on anti-psychotic drug, you don't get into
12 the drug treatment program. Now, that's a shame
13 because these are co-existing disorders, but they're
14 different disorders, and we are punishing people who
15 have these dual diagnoses by setting up that kind of
16 an artificial barrier.

17 JUDGE SESSIONS: You talked about
18 screening earlier on, Dr. Greifinger. What kind of
19 system do you recommend for intake screening in
20 prisons for those diseases that you've discussed and
21 exit screening for those particular diseases that

22 you've talked about?

23 DR. GREIFINGER: It's very important
24 for the public health to screen for tuberculosis
25 immediately on intake.

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1 JUDGE SESSIONS: Routinely?

2 DR. GREIFINGER: Routinely, because --
3 except in areas where there's no background level of
4 TB. There may be a few states in the country that
5 done have much TB and I would say it would be less
6 important, but, typically, I would say to screen for
7 that. All correctional systems should be screening on
8 intake for syphilis, they should be screening for, I
9 believe, for HIV on a more routine basis than we do,
10 I'm not advocating mandatory testing, but we should
11 just offer the way we say we're going to draw your
12 blood and test you for syphilis, we're going to draw
13 your blood and test you for HIV.

14 I believe we should do risk assessment
15 for screening for hepatitis C, that is we should say
16 does the person have any risk factors; are they
17 injection drug users, are they men sex who have sex
18 with men and all the other risks and if they do, then
19 they should be offered the opportunity for testing for
20 hepatitis C.

21 JUDGE SESSIONS: Speak a moment about
22 costs associated with that testing.

23 DR. GREIFINGER: The cost -- the
24 testing for tuberculosis and syphilis is minimal, it's
25 pennies and it's insignificant. Testing for hepatitis

1 C is much more substantial and has more consequences.

2 Remember that 80 percent of injection
3 drug users, roughly, across the country are infected
4 with hepatitis C, so that's probably somewhere between
5 20 and 40 percent of inmates are infected with
6 hepatitis C.

7 So once we do the test itself, the test
8 itself cost money and for those who test positive,
9 we're going to have the reflex second level of testing
10 to see if they're candidates for treatment. So that's
11 money that's typically not in correctional healthcare
12 budgets, with the exception of Pennsylvania.

13 The programs you are hearing about
14 today are special, they're best practices, but they
15 are not typical across the country. I don't know of
16 any correctional healthcare program other than
17 Pennsylvania that has as extensive screening and
18 testing for hepatitis C.

19 JUDGE SESSIONS: What about HIV and
20 tuberculosis?

21 DR. GREIFINGER: A few states still
22 have mandatory testing for HIV, back from the days
23 when folks thought staff would be at risk, but mostly
24 it's voluntary, it varies in the assertiveness. Some
25 places don't really want to find it, others are pretty

1 assertive.

2 For tuberculosis, fairly universal to
3 have TB screening which is screened by a
4 questionnaire; are you coughing, do you have night
5 sweats, et cetera, put on a TB skin test, although too
6 often it's not done until the 14th day, when I believe
7 it should be done sooner, and then chest x-rays for
8 those who have positive findings.

9 JUDGE SESSIONS: Do you have any
10 suggestions of what can be done to ensure continuity
11 of care of that prisoner or that inmate leaving prison
12 and going back in the community?

13 DR. GREIFINGER: Yes. I think we need
14 to build linkages and we can't depend on friendly
15 collaboration between agency heads and community
16 providers. We have to find a way to hold someone
17 accountable for re-entry.

18 JUDGE SESSIONS: Dr. Kountz, your
19 testimony gave me questions that -- oh, I'm sorry.

20 MS. SCHLANGER: Wait. I'm actually
21 very -- the question you just asked, I wonder if
22 Secretary Beard could speak to that at all.

23 How has Pennsylvania addressed the
24 continuity of care on re-entry, and we've just heard
25 that your program is a model program. Is it a model

1 in that way as well?

2 MR. BEARD: I don't know if we're a
3 model in that way as well, but what we've been doing
4 is working very closely with the Department of Public
5 Welfare when we have people who are seriously mentally
6 ill, people who have a need for further treatment,
7 HIV, hepatitis C, whatever, and we're actually getting
8 the medical assistance established before they leave
9 and then we do the actual comprehensive discharge
10 planning, like I said, by going out and trying to link
11 them up with somebody out in the community where they
12 can continue whatever treatment they need, be it
13 mental health or be it medical.

14 MS. SCHLANGER: So you actually have
15 somebody who tries to find an actual provider and make
16 an appointment?

17 MR. BEARD: Yes -- well, I don't know
18 if we got as far as make an appointment -- till they
19 get out to our community correction centers. Our
20 people -- most of our people leave our prisons and go
21 to community corrections; when they get there, they
22 would take that next step. Before they even leave the
23 prison, though, we're setting up the medical
24 assistance funding, which sometimes can take an
25 awfully long time and then you have these people that

1 need the medical and mental health treatment and just
2 go on and on and don't get it, and so in that way I
3 think we are sort of ahead of the curve in getting
4 things set up.

5 MS. SCHLANGER: And the medical
6 assistance funding, is that the thing that we were
7 hearing about before lunch with the Medicaid, Medicare
8 suspension or withdrawal of folks who are --

9 MR. BEARD: Yes, because when people
10 come to prison, they're not eligible for Medicaid
11 anymore, and so that stops. And, you know, the
12 difficulty is a lot of times -- some state departments
13 of welfare don't want to really start them until
14 they're back out into the community again. You know,
15 we've established a good collaborative relationship
16 with our department of health and welfare and they
17 work with us and we get it set up and they can
18 actually fill the applications out online -- or they
19 don't fill it out our staff fills it out online, we
20 don't let them use the internet, and then the
21 assistance is ready when they get out there.

22 MS. SCHLANGER: Dr. Greifinger had
23 another thing to say.

24 JUDGE SESSIONS: Dr. Kountz, you had
25 taken and discussed continuity of care.

1 Do you have some observations about
2 that in the jail setting?

3 DR. KOUNTZ: It's very difficult, sir,
4 in the jail setting. It is --

5 JUDGE SESSIONS: Virtually impossible?

6 DR. KOUNTZ: It's almost impossible. I
7 think to tackle that is a primary goal and would not
8 necessarily be the best direction.

9 JUDGE SESSIONS: Let's talk about
10 intake because I was amazed, again, at what you do on
11 intake in jails.

12 DR. KOUNTZ: Yeah.

13 JUDGE SESSIONS: Tell us about the
14 infectious diseases and the feasibility of actually
15 testing on intake.

16 DR. KOUNTZ: Well, as Dr. Greifinger
17 said, we universally screen and place a PPD within 24
18 hours, so we are universal with regard to testing for
19 tuberculosis and we'll certainly initiate treatment or
20 follow-up with a chest x-ray, regardless of the
21 duration of incarceration.

22 With regard to the other infectious
23 diseases, we are less consistent. When an inmate
24 requests, who is in a high risk group -- based on our
25 nursing and our physician screening, meet criteria for

1 a high risk group, if they request testing, we will
2 provide it, but we are not routinely testing for
3 hepatitis C, for example, at this point.

4 JUDGE SESSIONS: Do you have any
5 mechanism that you use in your jail systems to provide
6 information, for instance, to a prison if that
7 particular individual ends up going to a prison?

8 DR. KOUNTZ: Yeah, that's very
9 important, the communication between the facilities --
10 and thank you for mentioning that -- is exceedingly
11 important and we probably invest more staff time in
12 ensuring that we have as up-to-date record transfer as
13 we can.

14 Records go with inmates, phone calls
15 are made to convey information between facilities.
16 That is a very routine part of our business.

17 JUDGE SESSIONS: So the prisoner is
18 part of the mechanism to actually convey the
19 information?

20 DR. KOUNTZ: Well, we wouldn't rely on
21 the prisoner. We rely on documents from a facility
22 that may travel with the prisoner but we don't rely on
23 the prisoner --

24 JUDGE SESSIONS: How do you assure some
25 degree of quality control across the mechanisms that

1 you have?

2 DR. KOUNTZ: One of the things that we
3 do is -- I do random chart audits as medical director
4 so --

5 JUDGE SESSIONS: What are random chart
6 audits?

7 DR. KOUNTZ: Random chart audits might
8 be picking 30 to 50 charts over a month and reviewing
9 every aspect of the care of that inmate, including
10 ensuring that there are signatures and clear
11 completion of intake records; that if laboratory tests
12 were ordered, received, they were documented and acted
13 upon, that progress notes, et cetera, so that's one
14 thing I do.

15 Once a year I have an outside
16 physician, not part of our facility, do the same
17 thing. It certainly could be more complete, but
18 that's what we've done to this point.

19 JUDGE SESSIONS: Is it an audit upon
20 which that physician makes an active continuing report
21 for you?

22 Dr. Beard -- pardon me.

23 MS. SCHLANGER: Senator Romero had a
24 question.

25 SENATOR ROMERO: Attitudes certainly

1 have changed in society, but there still are some very
2 strong taboos, specifically when it comes to testing
3 for HIV and full blown AIDS, and these, of course, can
4 put the inmate at risk or perhaps find them segregated
5 within an institution.

6 How have you handled these in your
7 institutions; if you test, do you then treat and if
8 you test and treat, how do -- what precautions, what
9 education takes place, what choices are left to that
10 inmate so that he or she does not become further
11 victimized and/or isolated or discriminated against
12 for working in, for example, the cafeterias of
13 facilities?

14 MR. BEARD: Well, in Pennsylvania we
15 don't universally test everybody for HIV because it's
16 against state law, there's confidentiality things
17 there, but what we do do is we try to encourage the
18 inmates to take testing, particularly if there's
19 symptomology there we do do the testing.

20 If we find that somebody is HIV
21 positive, we work very closely with them to educate
22 them about what it means and about what their
23 treatment options are. I think the education part is
24 probably almost as important as the treatment part.

25 SENATOR ROMERO: Well, what about

1 education of other inmates, because sooner or later,
2 at least in my experience, is that other inmates will
3 know of the HIV status of a particular inmate?

4 MR. BEARD: We have groups within the
5 institution where people who are HIV positive and
6 people who aren't HIV positive can go to the groups
7 and learn more about HIV, if they want.

8 We have noticed a big problem with
9 that, we did back when it first came out in the late
10 '80s and everything, there was a lot of hysteria among
11 the staff and among the other inmates and, you know,
12 there was this segregation and everything, but at this
13 particular point we don't segregate HIV inmates.
14 They're out there, it's mainstream. And people -- we
15 don't find that they're being discriminated against
16 and I think part of is because we talk about it, it's
17 open, people know how it gets transmitted and while we
18 don't talk about who has the HIV, you know, you are
19 right, people do find out that, you know, this person
20 has it or that person has it, but we're not seeing a
21 major problem with it.

22 SENATOR ROMERO: And let me just ask
23 one other question; what about other populations,
24 let's say immigrants, particularly undocumented
25 immigrants, I'm curious as to what outreach or

1 protections you may employ to test and try to provide
2 treatment for immigrants, particularly those who are
3 undocumented, and then also women, any particular
4 public health needs and concerns for women inmates?

5 DR. GREIFINGER: Well, the immigrant
6 question, you need to think about two things; one is
7 are they at risk for different conditions and,
8 certainly, for tuberculosis they are much more -- have
9 much higher risk than anyone else and you certainly
10 look for that.

11 Secondly, in making a treatment
12 decision with the patient, certainly you have to think
13 about how long they are going to be around; if they're
14 going to be deported soon and will be unable to
15 continue treatment then it might not make sense to
16 start, but I think I would make that on a case by case
17 basis.

18 DR. KOUNTZ: With regard to women, at
19 least at our jail, and, again, I think we are
20 fortunate because we have a very proactive setting.
21 We have a separate women's clinic where women inmates
22 can go for pelvic exams, which is a little bit more
23 convenient to do in a particular separate setting, and
24 some of the presentation of these diseases,
25 particularly infectious disease, can be different in

1 women. And by setting up a separate women's clinic,
2 we feel we're able to address those needs.

3 DR. GREIFINGER: Jails have a very
4 special issue with women. About four percent of women
5 coming into jails in the United States are pregnant,
6 so they certainly have a different health condition
7 that needs to be attended to.

8 SENATOR ROMERO: If I could just
9 thought finally say in California, of course Los
10 Angeles, there are significant numbers of immigrants
11 who are incarcerated. I would express concern that
12 the decisions might be made in terms of treatment for
13 immigrants because of the question of deportation. I
14 think that does raise a question -- to me at least it
15 raises concerns about the fair treatment within the
16 setting and my urge would be that immigration status
17 should not be a condition upon which treatment is then
18 decided, even if they're going to be deported.

19 The reality is the TB will spread
20 anyway so how do we check it?

21 DR. GREIFINGER: Well, I agree with you
22 in principal and, certainly, I wouldn't hesitate to
23 treat tuberculosis as something transmissible that
24 way, but I would be careful about starting treatment
25 for something like HIV because, you know, treatment

1 interruptions cause drug resistance and make it harder
2 for that patient to find the right drug combination
3 when they do get back on it. So it really has to be a
4 very -- an individual decision and a careful decision.

5 MR. BEARD: In Pennsylvania we wouldn't
6 treat immigrants any differently, and we do have a
7 number of cases that are there for the INS. They
8 would be treated just as anybody else, but we would
9 pay attention to the time they're going to be there.
10 If they're not going to be there long enough to
11 complete whatever treatment it is, hepatitis C or
12 whatever, then we wouldn't begin that treatment.

13 MS. SCHLANGER: We're developing a
14 fairly long list so know that you are on your list if
15 you have raised your hand.

16 MR. MAYNARD: I have a quick comment.
17 Dr. Greifinger implied that Pennsylvania would be the
18 only state that screened for hepatitis C and that's
19 not true, Iowa does, and I imagine there are many
20 others.

21 DR. GREIFINGER: I apologize.

22 MS. SCHLANGER: Mr. Nolan.

23 MR. NOLAN: I have a question for
24 Dr. Kountz and Dr. Beard, and then for all three of --

25 JUDGE SESSIONS: Can't hear you.

1 MR. NOLAN: I have a question for
2 Dr. Kountz and Dr. Beard about their systems, all
3 three of you for system-wide.

4 When an inmate is being treated for a
5 condition and received medication and they're
6 released, are they given any supply of medication,
7 number one?

8 Number two, is an appointment made for
9 them on the outside so they can continue the treatment
10 and is any provision made for coverage, if they had
11 prior coverage or some sort of transmittal of them to
12 a public health facility?

13 And, also, are there records copied and
14 sent with them or transmitted in some way to the
15 facility?

16 I would like to know within your own
17 facilities what the practice is and, also, then
18 nationwide what the standard of practice is in other
19 systems throughout the country.

20 MR. BEARD: I can just say in
21 Pennsylvania that we do give them -- as I said
22 earlier, we start out, we get their medical
23 assistance. If they have some serious medical or
24 mental health problem, they're given a supply of
25 medication when they leave, I believe it's a 60-day

1 supply at this particular point that they take with
2 them.

3 Those people would normally go out to
4 one of our community correction centers and at that
5 point they would make specific appointments for them
6 to get what they needed, and we wouldn't give the
7 records normally to inmate to take, but the records
8 would be forwarded to wherever, by fax or by mail or
9 whatever would be most convenient.

10 MR. NOLAN: And why wouldn't the
11 inmates be given their records?

12 MR. BEARD: We just normally wouldn't
13 give the inmates their records because we wouldn't be
14 assured that the inmates would get the records where
15 they should get them.

16 DR. KOUNTZ: With regard to our jail
17 setting, because of the short length of stay, it's
18 usually not a case where we're able to easily and
19 consistently provide follow-up. We do provide inmates
20 with public health departments. We ask what county
21 they plan to go to and we have a list of facilities
22 where we think it's likely they can receive or apply
23 for care.

24 If they have come from a private
25 practitioner, we will offer to summarize information

1 and provide that information to that other provider.

2 MR. NOLAN: And how about medications?

3 DR. KOUNTZ: We tend not, with the
4 exception of, perhaps, treatment for tuberculosis, we
5 don't provide them medication when they leave.

6 DR. GREIFINGER: I would say we do a
7 very bad job at this. Even -- some systems do fine,
8 prisons tend to do a little better than jails, but we
9 just do a very bad job. So when we're doing what we
10 should be doing and getting people diagnosed and
11 treated and getting them on meds and then we just drop
12 them off and let them out, it's a terrible shame.
13 It's a tragedy. It's an area that we need to all do
14 better on and that's going to include better
15 communication between the corrections folks and
16 correctional healthcare people, and the courts have to
17 be involved as well.

18 Some jurisdictions -- in jails people
19 go to court, they're released from court and there may
20 be some medication waiting for them in jail but you
21 know the guy is not going to go back to pick it up.

22 MR. NOLAN: Just one comment. As
23 inmates come out, they face a myriad of decisions and
24 they're coming from a condition -- a circumstance
25 where they have had no control over virtually any

1 decision in their life and that night they have to
2 decide where they're going to sleep, what they do when
3 they get up the next morning, how they look for a job,
4 who they turn to for help, do they slide into their
5 old habits and old patterns?

6 The difficulty of or the priority of
7 continuing medication and medical treatment, from my
8 experience, is not very high on their list and when
9 they slip off their medications, they're a danger to
10 the rest of us.

11 So, again, providing care while they're
12 inside is very, very important and I commend you for
13 that, but, also, helping them think through ahead of
14 time and, if possible, making provision for them,
15 saves them the burden of doing that while they're
16 facing, literally, where they sleep that night and how
17 they eat the next day.

18 MR. GREEN: Secretary Beard, in your
19 opening statement I believe you indicated that the
20 majority of corrections department are doing a good
21 job in providing healthcare. One of the challenges
22 facing this commission is documenting and gathering
23 the data to support the kind of report we're going to
24 have to make.

25 In making that statement, what kind of

1 data are you relying upon and what kind of data is
2 available to us in reviewing and making judgement
3 about the quality of healthcare being provided?

4 MR. BEARD: Okay. I think what -- two
5 things I would like to say. I think, first of all,
6 what I am relying largely on is the fact that I am
7 part of an association of state correctional
8 administrators and I meet with these administrators on
9 a regular basis. I talk to them about a lot of things
10 that go on in their system, they talk to me about
11 things that go on in my system. We talk about
12 healthcare issues as well.

13 And, you know, I think from the
14 feedback I'm getting from them is that while, yes,
15 there's a challenge there, that these people are
16 concerned and they care. Maybe 20 years ago people
17 didn't care, but today people do care. Healthcare is
18 important to us in corrections today. It's important
19 to these other directors that I talk to. And so I
20 think that's where I make my statement that I feel
21 that most are doing good.

22 But the second thing I would like to
23 say is you bring up a good point. I can sit here and
24 say something that, gee, I think they're doing good
25 and somebody else can sit up here and say, gee, I

1 think they're doing bad and they can show you this
2 horrific thing that has occurred somewhere. So what
3 is the truth?

4 And that's why I also said what I think
5 this commission needs to do is to define the problem
6 and set measures that you can go out there and find
7 out what really is happening. Well, I say that I go
8 out and provide this aftercare, medical aftercare for
9 my inmates and everything, and I think a lot of other
10 places do too, even though it is a challenge and it is
11 difficult, I couldn't sit here and tell you how many
12 do it. Well, maybe that's one of the things this
13 commission has got to go and say, well, let's go and
14 see, how many are providing that? And that's a good
15 question. Those are the kinds of data that we really
16 need. And so just like I can make a statement that I
17 don't have the foundation, so can other people.

18 MS. SCHLANGER: Dr. Dudley.

19 DR. DUDLEY: Dr. Kountz, I was struck
20 by your example of employing inmate health education
21 and about the implications -- the larger public health
22 implications, as well as the goal of addressing the
23 particular situation that you found yourself in. And
24 I'm curious, I guess, from all of you about what your
25 thoughts are about inmate health education as a public

1 health vehicle and do you see that as only something
2 related to particular crisis that come up in a
3 particular setting or do you see a larger role for
4 inmate education, number one?

5 Number two, you and everybody else has
6 spoken about the importance of the public coming to
7 understand the public health implications of what
8 happens with regard to health services within jails
9 and prisons and I was wondering if you had any
10 thoughts about how that could be facilitated as well.

11 DR. KOUNTZ: I can start with your
12 question about inmate education and I think it's so
13 easy to become cynical, but that was a very rewarding
14 aspect of a difficult situation was -- which was
15 seeing the look of interest on the part of inmates
16 when we talked about, in this case it was the MRSA
17 outbreak.

18 Now, granted, this is something that
19 would effect them when they went right back to their
20 pod and how do I keep from getting a boil like the guy
21 next door, but it was a wonderful dialogue and I have
22 great confidence that those individuals, when they
23 leave the facility, will have a new awareness of
24 hygiene.

25 Beyond that, educating inmates about

1 diabetes, about high blood pressure; often this is the
2 very first time any healthcare person has taken the
3 time to sit down with them and explain a condition
4 that they were aware of, and their parents and
5 grandparents. And it makes relationships within the
6 facility much better, it creates a better sense of
7 trust and so it's hard for me to quantitate the
8 impact, but the goodwill and the ability to dialogue
9 around care issues is -- (inaudible).

10 MR. BEARD: You know, I think that
11 and -- I think I said that earlier, that education can
12 be one of the most important components that we can do
13 with the inmates and I know that during one of the
14 things that we do on intake is we talk about the
15 various infectious diseases and go over the things and
16 how they can take care of themselves, how they can
17 prevent from picking these diseases up, and we talk to
18 our inmates about that.

19 And then we give further training to
20 those if we find somebody who is positive -- say, hep
21 C positive, they can get further education about the
22 nature of their disease and everything like that. So
23 that's something that is extremely critical, it's
24 something that doesn't cost a lot of money and
25 particularly in the jails, it's probably one of the

1 most important things that they can do because they
2 don't have a lot of time to do anything else.

3 MS. SCHLANGER: Secretary Beard, I
4 wonder if you could talk to us a little bit about
5 private healthcare contracts and, in particular, I
6 gather from some of the materials that I received that
7 Pennsylvania has some contracts with Prison Health
8 Services, which we've all been reading about as a --
9 not an always very effective provider.

10 So I wondered what you do to try to
11 make sure that they are an effective provider in your
12 facilities and if there are principles if there can be
13 gleaned from that.

14 MR. BEARD: Well, I think the bottom
15 line with privatized healthcare, and I sort of have
16 mixed feelings about this because I've dealt with it
17 over the years, and back and forth, and I don't know
18 what the best answer is.

19 And, in fact, right now we in
20 Pennsylvania are doing a study and we have a company
21 that's in there taking a look at all the different
22 ways that we can provide healthcare and see if we can
23 do it better than what we're doing.

24 But the basic thing with corrections
25 healthcare is you get what you pay for. And a lot of

1 these things that I read about PHS and, you know,
2 they're all the same; CMS, PHS, Wexford, they all have
3 their horror stories out there, and the ones -- the
4 most recent ones I just read they were from, you know,
5 a bunch of county jails, and I think in the New York
6 area and, you know, when you really read through
7 there -- I mean the RFPs that they did, you know, what
8 they asked for probably wasn't done very well. You
9 really have to know what you are looking for here.
10 They probably don't have any kind of centralized
11 ability to oversight these things.

12 In Pennsylvania what we do is we have
13 very good RFPs that we've developed over the last 15
14 or 16 years and so we know exactly what we want and we
15 ask for exactly what we want and we expect to get
16 that. And we have people who work in our central
17 office. We have about 20-some people, we have
18 contract compliance monitors, we have quality
19 assurance people that go out into the field on a
20 regular basis, we have our own physician, our own
21 doctor, our own dentist who goes out and checks on
22 these people so then, you know, if I say something
23 isn't right, they can he say, well, you are not a
24 doctor, well, I have my own doctor that can go do
25 that.

1 And also in Pennsylvania we haven't
2 fully privatized; all we privatized is the doctors and
3 the hospital care. They do that. The nurses work for
4 us and we have a corrections healthcare administrator,
5 so we have a little bit of balance there within the
6 institutions.

7 So do I think it can be done right?
8 Yes. Is it easy to do? No. Is it cheap? No. But
9 if you really stay on top of it, if you've got good
10 people to monitor it, if you put together good RFPs,
11 you can do it, but I'm still looking for a better way.

12 MS. SCHLANGER: Dr. Greifinger.

13 DR. GREIFINGER: I agree with
14 Dr. Beard. The matter of risk has to be taken into
15 account. I think it is dangerous for government
16 entities to think that if they lay off risk, it's
17 going to be less expensive, so that risk is the issue.
18 The specificity of the contract and the oversight is
19 critically important.

20 I don't think it makes a difference if
21 it's public or private, as long as you attend to those
22 things. Some jurisdictions have reasons that they
23 need to privatize. If, for example, the civil service
24 pay rate for a physician is X and you can't get a
25 competent physician for X, you know you've got to pay

1 Y, you've got to contract it out.

2 If you have a civil service system that
3 has nurses that have been going from job to job,
4 hanging out, you know, they work for the public health
5 department, then they work for the -- in the mental
6 hospital and then they finally got thrown out of the
7 mental hospital but they're still on the civil service
8 list and the only place they have to go is the prison,
9 I'm not sure you want that nurse, but if you have to
10 take that nurse, you're stuck. So the only way around
11 it is to say, well, we have to contract out for
12 nurses.

13 So unless governments can become more
14 flexible with their pay and their personnel practices,
15 sometimes it's better to go with a private contract,
16 but it's got to be overseen, just like public
17 employees have to be overseen, and we've seen some
18 very bad care given by public employees as well.

19 MS. SCHLANGER: Let me follow up what
20 Secretary Beard said with just one question. Why is
21 it that we keep hearing about these bad RFPs? I mean,
22 we also keep hearing about the terrific correctional
23 professional organizations that help jurisdictions
24 share information. Is this one of the gaps in that
25 and so people don't share their RFPs, or -- I mean, is

1 there an obstacle there that's a barrier?

2 MR. BEARD: I don't know. I think one
3 of the reasons is -- again, most of what you saw here
4 were in jails and I don't know that the RFPs that we
5 write would be all that applicable to the jails and to
6 the jail settings because it's a whole different thing
7 there. We certainly don't hide ours. Our stuff is
8 put up online. It's available for people.

9 So, you know, I think what it is is
10 you've got, you know, the smaller jails, they're not
11 funded the way they should, they're looking for low
12 bid and if you ask for low bid, that's what you get.

13 MS. SCHLANGER: Judge Sessions.

14 JUDGE SESSIONS: Yes. We haven't
15 talked about correctional staff, infectious diseases.
16 How do you go about protecting the staffs in jails and
17 prisons?

18 MR. BEARD: Well, there's a couple
19 things that we do. One of the things that we do, it's
20 part of the education program, we have an actual --
21 part of our basic training and then we have actually
22 it's a two year renewal that staff have to go through
23 where we talk about all of these infectious diseases
24 and we really preach universal precautions here.

25 And the other thing that we do is we

1 offer -- where it's appropriate we offer immunization
2 to our staff. So, for instance, we're immunizing for
3 hepatitis B. I know that's something that the CDCC
4 would like to see everybody in prisons and jails do
5 but, it's a funding issue. Fortunately, I had the
6 money that I could spend on it, but not everybody has
7 the money to spend on it. I know they were looking
8 for some federal funds maybe and I guess that just
9 never happened, but those are just a couple ways that
10 we --

11 JUDGE SESSIONS: Does it include giving
12 specific information about specific inmates, for
13 instance, or questions about care?

14 MR. BEARD: We would prefer to leave it
15 as a universal precaution because once you start
16 telling them who has it -- first of all, I told you we
17 don't test everybody for HIV so we probably have some
18 there that have it that nobody knows it. So as soon
19 as you start telling staff that these are the people
20 that have it and they start focusing on that, rather
21 than the universal precautions, that's an extremely
22 dangerous situation.

23 JUDGE SESSIONS: So you do not, as a
24 practice?

25 MR. BEARD: As a practice, no, but we

1 do have a union contract that requires us to keep a
2 list and we don't identify what the infectious disease
3 is, but we do have a list that people can go look at
4 the list. I personally wouldn't do it, but,
5 unfortunately, contractually we're obligated to do
6 that.

7 JUDGE SESSIONS: But you feel a very
8 definite responsibility to protect your staff?

9 MR. BEARD: Absolutely, absolutely
10 responsibility.

11 JUDGE SESSIONS: Dr. Greifinger.

12 DR. GREIFINGER: It's very, very
13 important, and I think most prison systems and most
14 large jails do a fairly decent job of educating staff
15 about how to protect themselves from blood borne
16 diseases like HIV and hepatitis B and have them tested
17 for tuberculosis. Not enough systems provide
18 hepatitis B vaccination, I think that's a shame.
19 That's an area where public health departments could
20 take a very, very strong role in trying to get staff
21 protected against hepatitis B.

22 JUDGE SESSIONS: Dr. Kountz.

23 DR. KOUNTZ: Much of the staff at our
24 jail is not under my direct control so I can't
25 comment. It's education. There's a great sense of

1 awareness and concern among the staff of, particularly
2 infectious issues, so it's something I think the staff
3 is very, very much aware of.

4 We, of course, keep inmates the first
5 24 hours in a holding area to reduce the potential
6 risk of exposure to someone with active tuberculosis,
7 and I think that's one of the most day-to-day, obvious
8 way we protect staff and officers from that
9 potentially infectious problem.

10 JUDGE SESSIONS: And what about other
11 dangers to staff such as mental capabilities,
12 violence, et cetera, how do you deal with that in
13 informing the staff and protecting the staffs?

14 DR. KOUNTZ: Well, I think close
15 presence of officers. We have a separate mental
16 health provider will come in and be actively engaged
17 in the care of an inmate if there was issues seem to
18 be brought to bear. I'm not sure we do anything else
19 that's specific. I'm not sure what you are looking
20 for.

21 MR. BEARD: We tend to -- we put the
22 mentally ill inmates in special needs units, so
23 they're segregated in those units for their own
24 protection a lot of times rather than for other
25 peoples' protections so the staff are aware who have

1 those.

2 We also have units where we can
3 actually commit -- short term inpatient units within
4 our prisons that we can commit people to and we run a
5 forensic hospital as well. We have a pretty good
6 system in dealing with the mentally ill, I think, in
7 Pennsylvania.

8 And, you know, it's something I looked
9 at recently and, you know, I shouldn't say, we haven't
10 had a homicide in our state for a long time, a staff
11 homicide, and -- but when you go back and look at
12 those staff homicides back in the 1970s, invariably it
13 was mentally ill inmates who were involved in those
14 homicides. And so I think that that's just one
15 measure. I think we are doing a better job catching
16 them when they come into the system.

17 We, for instance, have a special
18 observation unit at our reception center. When we
19 have a mentally ill inmate, they're pulled right out,
20 they're put into that observation unit, they're set up
21 on the treatment that they need, the regimen that they
22 need and it seems to be working very effectively to
23 deal with that issue.

24 JUDGE SESSIONS: Dr. Greifinger.

25 DR. GREIFINGER: I agree many systems

1 do a good job, but our officers also tend to be
2 undertrained in a lot of places. We've had a lot of
3 abuse, abuses of force on people who are mentally ill,
4 people who are agitated for mental -- because of
5 mental illness or agitated, because of their physical
6 illness, often get punished, they get restrained, they
7 get confined, they get segregated and it happens too
8 often. I see it way too much.

9 So we shouldn't become complacent
10 because we have standards that say we're supposed to
11 have training and even when we do have training it's
12 something that needs constant vigilance.

13 MR. BRIGHT: Could I just follow-up
14 with that, Secretary Beard. How many of those units
15 do you have -- mental health, how much has that
16 increased let's say in the last five years, how many
17 psychiatrists do you have? And are the numbers of
18 that being a problem, because we were talking about
19 how there are more mentally ill people coming into the
20 system.

21 MR. BEARD: Well, there is definitely
22 more mentally ill coming in, it is a problem. Four
23 years ago about 14 percent of our population was
24 mentally ill. Today 19 percent of our population is
25 mentally ill. Now, seriously mentally ill is

1 something less than that, it's more like three or four
2 percent that are really seriously mentally ill, but we
3 do see a growing number of cases.

4 We have special needs units in all of
5 our institutions to handle that, but we have the
6 inpatient units in five facilities, we only run at
7 about 80 percent capacity of those units. So we're
8 not filling the units up. I think part of the reason
9 is because we're dealing with these people quicker and
10 getting them earlier on before we have to actually
11 commit them. We're not letting them, you know,
12 deteriorate and getting so bad that we have to put
13 them into these units because at one time years ago we
14 were talking about building these mental health units
15 within all of our institutions, we actually built a
16 bunch but we never had them open because we never go
17 much beyond about 80 percent of our capacity.

18 So even though we are getting more
19 mentally inmates, I think our system is dealing better
20 with the mentally ill so they don't get to that point
21 where they become acute or chronic and need to be put
22 into these inpatient units.

23 As far as psychiatrists, I can't give
24 you a number, I could go find it out, but we have
25 psychiatrists, again, in all of our institutions. We

1 have, actually, a separate mental health contract that
2 we get our psychiatrists from.

3 MR. BRIGHT: Do you find that these
4 prisons in remote places, that that's a problem at all
5 in finding doctor, nurses?

6 MR. BEARD: There's no question it's
7 more difficult to recruit in some of the remote areas
8 of the state and, of course, that's where we build
9 most of our prisons, away from the -- you know, the
10 urban areas and these places for economic development
11 reasons and it is difficult in some prisons to get
12 some of the professional people. It goes beyond
13 doctors and it goes to teachers and psychologists and
14 people like that are much more difficult to recruit.

15 But -- and, occasionally, in a prison
16 we are short and if it's a doctor, our vendor has to
17 cover, they have to get somebody in there to provide
18 that coverage and that's one of the reasons why we
19 went to a vendor, because they can more easily recruit
20 people, they can pay more money than we can under the
21 civil service that was mentioned and everything else.

22 MS. SCHLANGER: We have two people who
23 want to ask questions and I think Dr. Greifinger had
24 something he wanted to add and we'll break for a few
25 minutes.

1 DR. GREIFINGER: I just want to say
2 we're not doing well enough. I found a guy in a
3 county jail last year who was in on a misdemeanor
4 charge, he was lost there for two years, he was
5 psychotic and he only spoke Vietnamese so everybody
6 just stayed away from him because they didn't
7 understand him. That's an abuse.

8 I saw a guy a couple weeks ago in a
9 jail that is under court supervision and under the
10 supervision -- under court supervision who was
11 psychotic, agitated, angry, violent, he had been there
12 for four months, had refused care once and so the
13 psychiatrist said, well, he refuses, I'm not going to
14 do anything. So they also made the assumption that
15 they couldn't get him into a state hospital where he
16 needed to be, so what did they do? They went to the
17 judge and they said, Judge, we can't handle this guy
18 in the jail, he's too violent and he's mentally ill.
19 The judge said, fine, and then released him to the
20 street.

21 That's a danger to public health.
22 That's an abrogation of responsibility by the mental
23 hospital that doesn't have a bed, by the jail that
24 didn't try to make sure he got care and by the judge
25 who let him go out onto the street, and we still have

1 that and we see that all over the country.

2 MS. SCHLANGER: Judge Gibbons.

3 JUDGE GIBBONS: Dr. Kountz, your
4 arrangement on behalf of Robert Wood Johnson to

5 provide medical services at the Somerset County Jail
6 is very interesting.

7 Do you know whether any other New
8 Jersey county jails have contracts with either a
9 medical school or a New Jersey teaching hospital?

10 DR. KOUNTZ: I don't -- I don't know
11 the exact answer. I would doubt it, but I think it's
12 a model that -- for our jail and for our county and
13 for us has worked very well.

14 JUDGE GIBBONS: And do you know whether
15 or not any of the New Jersey penitentiaries have such
16 an arrangement?

17 DR. KOUNTZ: I think as I mentioned in
18 my testimony, in 2004 mental health services in the
19 state are now provided by our University Behavioral
20 Healthcare, which is one of the units of the
21 University of Medicine and Dentistry of New Jersey.

22 JUDGE GIBBONS: But only mental health?

23 DR. KOUNTZ: At this point only mental
24 health.

25 MS. SCHLANGER: Dr. Dudley.

1 DR. DUDLEY: I just wanted to go back a
2 second to the mental health question. I was
3 wondering, do you have any sense of distinguishing
4 between those who come into the facility with a known
5 history of mental illness compared to those who come
6 to the institution without having had, obviously,
7 adequate health and mental healthcare and had not been
8 previously diagnosed or were not known to have mental
9 illness and, therefore, the capacity of your health
10 system to identify those people and get them to a
11 mental health services, as opposed to people who were
12 previously diagnosed, known to be -- inaudible.

13 MR. BEARD: I think in Pennsylvania
14 most of them have been previously diagnosed. There
15 are some cases where, I think we can find them but I
16 think most of them have been diagnosed in the
17 community, just haven't been handled very well in the
18 community. We've closed our mental hospitals out
19 there and while we're dealing fine with the people
20 that were in the mental hospitals, I think they have
21 resources for that, they're eating up all the
22 resources so the new people that have mental health
23 problems don't end up getting taken care of and then
24 they, of course, end up, some of them, coming into our
25 prison systems.

1 DR. GREIFINGER: Jails are a larger
2 problem, there's a lot of undiagnosed illness, a lot
3 of first episode manias, a lot of new schizophrenics,
4 a lot of -- PTSD is terribly underdiagnosed,
5 especially you know how prevalent it is among female
6 inmates, so there is a lot of opportunity for
7 diagnosis.

8 Some well in some places and it's
9 missed in others. Other places at best you get a
10 suicide screen. If you are not suicidal, nobody pays
11 any attention to you in terms of a behavioral
12 evaluation. Other places really do look, take a
13 look-see but, unfortunately, most jails are way too
14 passive about it.

15 MS. SCHLANGER: Dr. Griefinger,
16 Dr. Kountz, Secretary Beard, thank you very much for
17 coming before us. This has been very informative.