EXPERT TESTIMONY ON THE PUBLIC HEALTH IMPlications OF

MS. SCHLANGER: So I think we'll get
started. On behalf of the Commission on Safety and Abuse in America's Prisons, I'd like to welcome Dr. Robert Greifinger, Dr. David Kountz and Secretary Jeffrey Beard.

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

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

Most of our inmate population and all of our nation's correctional officers return to their communities. According to research conducted by Dr. Greifinger and others for the National Commission on Correctional Healthcare, in 1996 alone, somewhere between 1.3 and 1.4 million people infected with hepatitis C were released into the general population
from prisons and jails and an estimated 560 some odd thousand inmates with TB infection returned to their communities after some form of incarceration.

These numbers only scratch the surface of the health problems prisons and jails address daily and we hope that this panel which help us to identify risks and think creatively about solutions to the public health challenges our prisons and jails pose. I guess in particular there's this question of whether prisons and jails are posing a challenge or presenting an opportunity for public health and medical professionals and from looking at the written versions of your testimony, I think that you would have a lot to offer on which of those or whether both of those are the right way to think about this question, so I hope you will do that.

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

Dr. Robert Greifinger has worked in correctional healthcare for 18 years managing health services at both Riker's Island in New York City and for the New York State Department of Corrections. He now works as a consultant examining the conditions of
confine and health services in over 100 correctional facilities in 33 states. I assume not all at once. Dr. Greifinger will help us to understand the scope of the problem and the opportunities we have to address the risks through improved correctional healthcare.

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

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

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

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

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

DR. GREIFINGER: Thank you, Margo.

After the news announcement last night at 9:00 I want to say, may it please the Commission.

I am very pleased to be here myself and I want to talk with you a little bit about a journey that I've been on for the last 18 years. I began a journey 18 years ago to try to learn a little bit about the health status of the inmates, to learn about
access to medical care and quality of medical care for prisoners, to learn about the burden of illness. And after that I wanted to learn, well, how can we measure performance the way we do outside in the free world? How can we identify barriers to reasonable quality of medical care and to reasonable access to medical care? And then I asked myself the question what can I do to help formulate solutions, to formulate remedies so that we can address some of the challenges that we've identified? What I found early on was this was not just about humane or legal treatment of inmates. This was all about our health. It was about my health and yours and the health of our families because, among other things, the burden of illness among inmates is really very, very extraordinary. As you know, inmates as a group in the United States have extraordinary prevalence of communicable diseases such as sexually transmitted diseases, tuberculosis, viral hepatitis, HIV and the recent scourge that we've had throughout prisons and jails across the country is drug resistant skin infections.

I also learned on my journey that the quality of medical care varies really tremendously across the country. Some healthcare programs such as
the one Dr. Beard is going to discuss with you are really excellent. And others in this country, too many of them are shameful with the kind of -- and I've seen the kinds of things that Drs. Goldenson and Cohen described with shameful, not only in terms of what we do to the individuals, but shameful in terms of the risks we put our staff to and the risks of the public health.

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

I went to Parchman Prison in Mississippi to another unit that segregates HIV-infected inmates and I found an outbreak of boils that went throughout that unit, with dozens of people having boils that were weeping puss, but no one was looking at it and trying to address it from a public health point of view. So not only were the
HIV-infected inmates at risk, but so were staff that worked there, the medical staff, the correctional officers and so were their families to whom they each returned at the end of the day, each day.

A few years ago at the Fulton County Jail in Atlanta, Georgia the care of HIV-infected inmates was essentially denied; it wasn't being given, and so people were dying. There had been something like -- I don't remember the exact numbers -- 29 deaths in 24 months, which when that system was fixed -- because of a consent decree and great work by the Southern Center for Human Rights, when that system was fixed it went down to two deaths in the next 24 months, so you can really make a big difference and protect the public's health.

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

The only thing I've learned is that
good policy often doesn't make good politics and that leads me to the conclusion that we need better leadership. We need leadership from each and every person on this Commission and from anyone who is going to take the time to read your recommendations. We need leadership that says this is in our interests, because the public forgets that every inmate who returns to the community with an untreated sexually treated disease or with HIV or with hepatitis C or tuberculosis puts our children at risk. Every inmate who returns to the community with untreated mental illness or with treatment that is interrupted, it's aborted on re-entry into the community puts our public safety at risk. Every inmate who returns to the community with untreated drug addiction puts our property at risk and puts our safety at risk.

We need to think about this window of opportunity that we have to really make a difference. So our challenge is to try to make good politics out of what is clear, I think, to everyone about what would be good public policy and I would like to give you seven steps. This may sound like a one-minute manager type of a talk, but I think there are only and simply seven things we could do that could really make a difference beyond the larger issue that was
discussed earlier, and that's to put fewer people behind bars, finding call it diversion programs or whatever through drug treatment and treatment of mental illness and perhaps being less harsh with some of our crimes.

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

Secondary prevention means the early detection of something that's there in a medical intervention that's going to lead to cure. So if we screen for sexually transmitted diseases, we can cure those before they infect other people in the community. If we screen for HIV and hepatitis C and tuberculosis, we have short run gains, we're protecting against transmission in the community and there are good data -- if you look at the report to Congress on the health status of soon-to-be-released inmates, you will see good data that it's cost
effective for our society to do these -- this primary prevention and this screening and intervention. There are cost savings which will accrue directly to our society. But we can't be fooled by that, they're not cost savings that accrue directly to the Departments of Corrections which will have to bear the cost.

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

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

As Dr. Cohen and Dr. Goldenson emphasized, we need to have a quality of medical care
behind bars, it's the same as the quality in the free world. There's no reason that it should be different. There's no reason that we should be treating hepatitis C differently behind bars than we do outside in the community. There was no reason for three or four or five years during the late 1980s when we were denying treatment to HIV-infected people after there was treatment available and there's certainly no excuse today. And there's no excuse to do that for hepatitis C and there's no excuse not to look for and treat sexually transmitted diseases and other curable diseases.

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

We need to recognize the huge value of preparation for re-entry. We heard good testimony this morning about some of the problems. We know there are terrible consequences to inmates, especially those who are -- are coming off long-term
incarcerations. We need to learn more about what works. We need to learn more about how to build linkages with public health departments, with community mental health centers, with community health centers and other private resources in the community. We need to acknowledge and reduce five barriers to change that I see. We've got the leadership problem that I've mentioned earlier, and I think that's the most critical. We've got a problem with cynicism. There is a cynicism that's pervasive, that keeps us from being able to do our jobs as professionals. We need to do research and evaluation and we need to learn more about the consequences of incarceration.

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

MS. SCHLANGER: Thank you,

Dr. Greifinger.

We'll move to Dr. Kountz.

DR. KOUNTZ: Thank you. As the only
I'm going to touch on two themes that I think I'm best qualified to comment on. One is the public health issues in jail settings and then to share some observations on a relationship that we have had at our medical school with a county jail and speculate on how this type of relationship might be in the public's best interest to expand into different communities to do some of what we have been able to do in the last seven years.

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

One of our greatest challenges is the identification of infectious disease in our jail setting. There is a rich literature on the prevalence of infectious diseases in prisons, but not nearly as much as jails. It has been suggested that infectious
diseases are even more prevalent in jails than in prisons, as the rapid turnover makes diagnosis challenging. Further, there is a natural tendency to deal with acute crisis type medical problems, such as drug withdrawal, uncontrolled diabetes and accelerated hypertension.

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

Here are some examples of the steps that were taken to control this infection in our facility. Because of our close working relationship with our state DOC, as well as our county Department of Health and dissemination of new information at the medical school, we become aware of the increasing number of cases of MRSA. Memos were crafted to our staff (medical, nursing and correctional staff), as well as inmates regarding surveillance and prevention.
We obtained resource material from the Bureau of Prisons and worked with the administrative leadership in the jail regarding putting in place enhanced infection control strategies. A specific skin infection log was initiated using New Jersey Department of Health and Senior Services Data Collection Forms, which allowed pooling of data from many sites and early recognition of infection trends. Procedures were implanted for identification of suspected skin infections, wound culturing, isolation and treatment recommendations were also put into place. Infection information sheets were posted in housing units for inmates to read and, of course, this information was available in multiple languages at low literacy levels. Custodial, administrative and visitor bathrooms had proper handwashing technique posters placed in them. Nurses and physicians spoke to inmates during intake examinations and during all sick calls visits, answering questions and reviewing good hygiene practices.

We also found that education was crucial for officers who assist in first recognition of hygiene issues and referral of inmates to the medical unit. Certainly, this was a challenging
process but, ultimately, it was successful. I can say

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

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

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

Strategies to increase diagnosis of
STDs is one example, or other infectious diseases,
could be put into place but at what cost? Routine
testing of all inmates with the use of rapid screening tests would place a significant burden on laboratory and pharmacy costs. As suggested, this increase in diagnosis would not necessarily be translated into increased rates of treatment due to the turnover issues.

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

Several correction centers, such as Hampden County in Massachusetts, have been effective in putting public health services in place in jail settings. Their model is not only of early detection and comprehensive assessment of health problems, treatment, disease prevents programs and health education, but also continuity of care in the community, with collaboration between the county health services department, community health centers
24 and other local healthcare providers.
25 Could we develop such a model in Somerset County or in other counties in our state where jails are present? If so, who would staff such health centers? Are local providers really out there who are willing to accept inmates as patients? These are all practical problems and ones that I have faced in the last seven years.

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

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

22 As I conclude, let me speculate on the future and the role of medical schools to potentially
advance the cause of approving care in jails. There are an increasing number of medical schools partnering with state departments of corrections to provide or oversee all or part of correctional healthcare. In 2004 our university partnered with our state DOC to provide mental health services, and we are planning a national conference to address such partnerships next year.

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

However, we have a steady stream of enthusiastic, idealistic future healthcare professionals eager to work in a variety of healthcare settings. As a medical student at Buffalo New York in the early 1980s I remember working on the ward where inmates from Attica Prison were transferred. With appropriate supervision, this was a superb opportunity to provide direct patient care and learn about
infectious diseases. At that time it was beginning of
the AIDS epidemic.

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

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

MS. SCHLANGER: Thank you, Dr. Kountz.
that you for inviting me here today to discuss this
important topic and this is a topic that’s important
to us in corrections and it’s important to the public
as a whole.

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

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

Just think about some of the problems
that you've read about in the newspapers recently with
police departments or police officers or hospitals,
the high infection rates. I believe these reports do

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

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

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

Beyond visits to our facilities, if we
are to conduct a review with meaningful outcomes, we
need to move away from anecdotes and questionable

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

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

We, therefore, also need to treat our
inmates as vectors, as sources of infection and
disease. While they bring their disease from the
community to us, we must be careful to not to let
these diseases multiply, which can easily occur in the
close confines of our prisons. And we need to be
concerned about their impact on our communities upon discharge.

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

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

Beyond assessment, prevention and treatment for these and other diseases, we also expend considerable effort on education and training for both
our staff and inmates and we do comprehensive
discharge planning which is critical for them to
receive the continuity of care that they're going to

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

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

First, I think that you can help decide
what it is we want to know about corrections
healthcare, you can help us define the problem.

Second, you can help us establish standards and measures so that we have more data and a better understanding of the problem and this will also help inform and drive a research agenda.

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

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

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

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

Finally, you can help educate the public on the broader systemic issues; how are we
dealing with substance abuse within the community? In Pennsylvania one out of ten people who need treatment can get it. How about the mentally ill? Why are we seeing more and more mentally ill in our prisons? What are we doing in our community with the mentally ill? And how about the public health system's interface with the poor and minority communities?

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

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

Again, I invite this Commission to visit any of our prisons in Pennsylvania to look at healthcare or any other area of concern. I thank you for your time and I look forward to further dialogue.
MS. SCHLANGER: Thank you very much.

I have kind of an initial question that comes out of something that we heard -- that we on the Commission heard yesterday so for those of you who weren't here, I hope I get this right to get your responses to it.

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

DR. GREIFINGER: Well, that's kind of a red herring argument. Think about who is behind bars; it's mostly young men, 92 percent are young men, almost all of those are between the ages of 20 and 45. And what do men between the ages of 20 and 45 die from? They die from motor vehicle accidents, they die from gunshot wounds, they die from suicide, they die from -- if you think about all those things, those -- there's a protective effect of prison against those things because they're not driving cars, they're not
getting drunk very much and they're not using drugs that much. So I think that's a little deceptive.

If you look at inmates' morbidity for

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

MR. BEARD: Yeah, I'd just like to say I agree with a lot of what Dr. Greifinger said there, but I would also want to say that many of the inmates who come to us didn't know they had diseases when they got to us. We, for instance, in Pennsylvania test everybody for hepatitis C. Many of the inmates did not know they had hepatitis C when they came. Many of the inmates did not know that they had AIDS when they came and if they had stayed out in the community where they really don't have good access to healthcare, where they don't have the monies to pay for that
healthcare, where many of them don't care to go for
that healthcare, you know, I think they would have
progressed much more rapidly in those diseases, where

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

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

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

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

MS. SCHLANGER: So that gets me to
second question and then I'll got to Judge Sessions,
which is something that I think you said, Dr. Kountz, which is that there's this opportunity raised by the incarceration -- this opportunity raised by the

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

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

MR. BEARD: You know, I think that the obstacles there are on the same obstacles we see with re-entry in general. You know, one of the most important things for inmates to go out there and for them to succeed, they need to get a place to live, they need to get a meaningful job; if they've got healthcare issues or mental health issues it's got to be taken care of, and it's very difficult when we
interface with the public because, largely, the public
doesn't care about those things. The public doesn't
want them to come out. The public wants to keep them
locked up and put away in prison and I think it's that
lack of the public's willingness to reach out is
what's causing the problems in the healthcare area as
well.

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

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

DR. GREIFINGER: I agree with David.
It's a leadership issue and it's a leadership issue at
the top of each level of government and public policy
Public health departments are funded usually by disease. They get a lot of their funding from the federal government, they get funding from one department for tuberculosis and another for hepatitis and another for sexually transmitted diseases, and they really have never thought about and don't think about coming into prisons and jails to work in those areas, with the exception of TB, when we were having outbreaks of drug-resistant tuberculosis especially. Certainly, with tuberculosis it's a little different, but, for the other conditions they just -- they don't have the mandate to do it. No one is paying them to do it and so they say not my job. It's a very simple silo situation where they say not my job.

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

JUDGE SESSIONS: Dr. Greifinger, your mention of alcohol and drug treatment drove me to ask the question that I've always been curious about, long before I ever came on this commission, and that is about the timing of alcohol addiction and drug addiction in the prisons and when it should be and how it should be done.
DR. GREIFINGER: That's a good question. I'm not sure I have a good answer.

Jeff, do you know more about that than I do?

JUDGE SESSIONS: Dr. Beard?

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

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

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

JUDGE SESSIONS: I would think so.

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

Ideally what you would like to do is try to engage that person in the treatment early in their admission into the institution and then put them
into some kind of a relapse group once they finish
that up. But the reality is because of the lack of
resources within the prison setting, we're normally

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

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

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

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

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

JUDGE SESSIONS: Oh. I thought he said
he did not.
DR. GREIFINGER: I did, but then I had something to supplement.

JUDGE SESSIONS: Pardon me.

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

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

JUDGE SESSIONS: You talked about screening earlier on, Dr. Greifinger. What kind of system do you recommend for intake screening in prisons for those diseases that you've discussed and exit screening for those particular diseases that
DR. GREIFINGER: It's very important for the public health to screen for tuberculosis immediately on intake.

JUDGE SESSIONS: Routinely?

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

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

JUDGE SESSIONS: Speak a moment about costs associated with that testing.
DR. GREIFINGER: The cost -- the testing for tuberculosis and syphilis is minimal, it's pennies and it's insignificant. Testing for hepatitis
C is much more substantial and has more consequences.

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

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

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

JUDGE SESSIONS: What about HIV and tuberculosis?

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

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

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

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

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

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

How has Pennsylvania addressed the continuity of care on re-entry, and we've just heard that your program is a model program. Is it a model
in that way as well?

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

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

MR. BEARD: Yes -- well, I don't know if we got as far as make an appointment -- till they get out to our community correction centers. Our people -- most of our people leave our prisons and go to community corrections; when they get there, they would take that next step. Before they even leave the prison, though, we're setting up the medical assistance funding, which sometimes can take an awfully long time and then you have these people that
need the medical and mental health treatment and just go on and on and don't get it, and so in that way I think we are sort of ahead of the curve in getting things set up.

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

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

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

JUDGE SESSIONS: Dr. Kountz, you had taken and discussed continuity of care.
Do you have some observations about that in the jail setting?

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

JUDGE SESSIONS: Virtually impossible?

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

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

DR. KOUNTZ: Yeah.

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

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

With regard to the other infectious diseases, we are less consistent. When an inmate requests, who is in a high risk group -- based on our nursing and our physician screening, meet criteria for
a high risk group, if they request testing, we will provide it, but we are not routinely testing for hepatitis C, for example, at this point.

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

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

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

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

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

JUDGE SESSIONS: How do you assure some degree of quality control across the mechanisms that
DR. KOUNTZ: One of the things that we do is -- I do random chart audits as medical director so --

JUDGE SESSIONS: What are random chart audits?

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

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

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

Dr. Beard -- pardon me.

MS. SCHLANGER: Senator Romero had a question.

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

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

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

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

SENATOR ROMERO: Well, what about
education of other inmates, because sooner or later, at least in my experience, is that other inmates will know of the HIV status of a particular inmate?

MR. BEARD: We have groups within the institution where people who are HIV positive and people who aren't HIV positive can go to the groups and learn more about HIV, if they want. We have noticed a big problem with that, we did back when it first came out in the late '80s and everything, there was a lot of hysteria among the staff and among the other inmates and, you know, there was this segregation and everything, but at this particular point we don't segregate HIV inmates. They're out there, it's mainstream. And people -- we don't find that they're being discriminated against and I think part of is because we talk about it, it's open, people know how it gets transmitted and while we don't talk about who has the HIV, you know, you are right, people do find out that, you know, this person has it or that person has it, but we're not seeing a major problem with it.

SENATOR ROMERO: And let me just ask one other question; what about other populations, let's say immigrants, particularly undocumented immigrants, I'm curious as to what outreach or
protections you may employ to test and try to provide treatment for immigrants, particularly those who are undocumented, and then also women, any particular public health needs and concerns for women inmates?

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

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

DR. KOUNTZ: With regard to women, at least at our jail, and, again, I think we are fortunate because we have a very proactive setting. We have a separate women's clinic where women inmates can go for pelvic exams, which is a little bit more convenient to do in a particular separate setting, and some of the presentation of these diseases, particularly infectious disease, can be different in
women. And by setting up a separate women's clinic, we feel we're able to address those needs.

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

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

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

DR. GREIFINGER: Well, I agree with you in principal and, certainly, I wouldn't hesitate to treat tuberculosis as something transmissible that way, but I would be careful about starting treatment for something like HIV because, you know, treatment
interruptions cause drug resistance and make it harder
for that patient to find the right drug combination
when they do get back on it. So it really has to be a
very -- an individual decision and a careful decision.

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

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

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

DR. GREIFINGER: I apologize.

MS. SCHLANGER: Mr. Nolan.

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

JUDGE SESSIONS: Can't hear you.
MR. NOLAN: I have a question for Dr. Kountz and Dr. Beard about their systems, all three of you for system-wide.

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

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

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

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

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

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

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

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

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

If they have come from a private practitioner, we will offer to summarize information
and provide that information to that other provider.

MR. NOLAN: And how about medications?

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

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

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

MR. NOLAN: Just one comment. As inmates come out, they face a myriad of decisions and they're coming from a condition -- a circumstance where they have had no control over virtually any
decision in their life and that night they have to
decline where they're going to sleep, what they do when
they get up the next morning, how they look for a job,
who they turn to for help, do they slide into their
old habits and old patterns?

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

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

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

In making that statement, what kind of
data are you relying upon and what kind of data is available to us in reviewing and making judgement about the quality of healthcare being provided?

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

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

But the second thing I would like to say is you bring up a good point. I can sit here and say something that, gee, I think they're doing good and somebody else can sit up here and say, gee, I
think they're doing bad and they can show you this horrific thing that has occurred somewhere. So what is the truth?

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

MS. SCHLANGER: Dr. Dudley.

DR. DUDLEY: Dr. Kountz, I was struck by your example of employing inmate health education and about the implications -- the larger public health implications, as well as the goal of addressing the particular situation that you found yourself in. And I'm curious, I guess, from all of you about what your thoughts are about inmate health education as a public
health vehicle and do you see that as only something
related to particular crisis that come up in a
particular setting or do you see a larger role for
inmate education, number one?

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

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

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

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

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

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

don't have a lot of time to do anything else.

MS. SCHLANGER: Secretary Beard, I

wonder if you could talk to us a little bit about

private healthcare contracts and, in particular, I

gather from some of the materials that I received that

Pennsylvania has some contracts with Prison Health

Services, which we've all been reading about as a --

not an always very effective provider.

So I wondered what you do to try to

make sure that they are an effective provider in your

facilities and if there are principles if there can be

gleaned from that.

MR. BEARD: Well, I think the bottom

line with privatized healthcare, and I sort of have

mixed feelings about this because I've dealt with it

over the years, and back and forth, and I don't know

what the best answer is.

And, in fact, right now we in

Pennsylvania are doing a study and we have a company

that's in there taking a look at all the different

ways that we can provide healthcare and see if we can

do it better than what we're doing.

But the basic thing with corrections

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

In Pennsylvania what we do is we have
very good RFPs that we've developed over the last 15
or 16 years and so we know exactly what we want and we
ask for exactly what we want and we expect to get
that. And we have people who work in our central
office. We have about 20-some people, we have
contract compliance monitors, we have quality
assurance people that go out into the field on a
regular basis, we have our own physician, our own
doctor, our own dentist who goes out and checks on
these people so then, you know, if I say something
isn't right, they can he say, well, you are not a
doctor, well, I have my own doctor that can go do
that.
And also in Pennsylvania we haven't fully privatized; all we privatized is the doctors and the hospital care. They do that. The nurses work for us and we have a corrections healthcare administrator, so we have a little bit of balance there within the institutions.

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

MS. SCHLANGER: Dr. Greifinger.

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

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

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

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

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

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

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

MS. SCHLANGER: Judge Sessions.

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

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

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

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

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

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

MR. BEARD: As a practice, no, but we
do have a union contract that requires us to keep a list and we don't identify what the infectious disease is, but we do have a list that people can go look at the list. I personally wouldn't do it, but, unfortunately, contractually we're obligated to do that.

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

MR. BEARD: Absolutely, absolutely responsibility.

JUDGE SESSIONS: Dr. Greifinger.

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

JUDGE SESSIONS: Dr. Kountz.

DR. KOUNTZ: Much of the staff at our jail is not under my direct control so I can't comment. It's education. There's a great sense of
awareness and concern among the staff of, particularly infectious issues, so it's something I think the staff is very, very much aware of.

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

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

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

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

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

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

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

JUDGE SESSIONS: Dr. Greifinger.

DR. GREIFINGER: I agree many systems
do a good job, but our officers also tend to be
undertrained in a lot of places. We've had a lot of
abuse, abuses of force on people who are mentally ill,
people who are agitated for mental -- because of
mental illness or agitated, because of their physical
illness, often get punished, they get restrained, they
get confined, they get segregated and it happens too
often. I see it way too much.

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

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

MR. BEARD: Well, there is definitely
more mentally ill coming in, it is a problem. Four
years ago about 14 percent of our population was
mentally ill. Today 19 percent of our population is
mentally ill. Now, seriously mentally ill is
something less than that, it's more like three or four percent that are really seriously mentally ill, but we do see a growing number of cases.

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

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

As far as psychiatrists, I can't give you a number, I could go find it out, but we have psychiatrists, again, in all of our institutions. We
have, actually, a separate mental health contract that
we get our psychiatrists from.

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

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

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

MS. SCHLANGER: We have two people who
want to ask questions and I think Dr. Greifinger had
something he wanted to add and we'll break for a few
minutes.
DR. GREIFINGER: I just want to say we're not doing well enough. I found a guy in a county jail last year who was in on a misdemeanor charge, he was lost there for two years, he was psychotic and he only spoke Vietnamese so everybody just stayed away from him because they didn't understand him. That's an abuse.

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

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

MS. SCHLANGER: Judge Gibbons.

JUDGE GIBBONS: Dr. Kountz, your arrangement on behalf of Robert Wood Johnson to provide medical services at the Somerset County Jail is very interesting.

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

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

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

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

JUDGE GIBBONS: But only mental health?

DR. KOUNTZ: At this point only mental health.

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

MR. BEARD: I think in Pennsylvania most of them have been previously diagnosed. There are some cases where, I think we can find them but I think most of them have been diagnosed in the community, just haven't been handled very well in the community. We've closed our mental hospitals out there and while we're dealing fine with the people that were in the mental hospitals, I think they have resources for that, they're eating up all the resources so the new people that have mental health problems don't end up getting taken care of and then they, of course, end up, some of them, coming into our prison systems.
DR. GREIFINGER: Jails are a larger problem, there's a lot of undiagnosed illness, a lot of first episode manias, a lot of new schizophrenics, a lot of -- PTSD is terribly underdiagnosed, especially you know how prevalent it is among female inmates, so there is a lot of opportunity for diagnosis.

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

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