HOUSE OF REPRESENTATIVES
COMMONWEALTH OF PENNSYLVANIA

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Prison Health Care

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HOUSE HEALTH AND WELFARE
and JUDICIARY COMMITTEES

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Philadelphia City Hall
City Council Chambers
Broad and Market Streets
Philadelphia, Pennsylvania

Friday, April 23, 1993 - 10:15 a.m.

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BEFORE:

Honorable David P. Richardson, Chairman
Honorable Babette Josephs
Honorable Harold James
Honorable Kathy M. Manderino

KEY REPORTERS
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ALSO PRESENT:

Phillip Parrish, Majority Executive Director
Health & Welfare Committee

Jawal Boyd, Majority Research Analyst

John O'Connell, Minority Research Analyst

David Krantz, Executive Director
Judiciary Committee

C O N T E N T S

MR. CHAIRMAN: Good morning. Let me call the House Health and Welfare and House Judiciary Committee public meeting to order. This is a continuation from yesterday where we left Graterford Correctional Institution where we did hear testimony from those individuals who were inmates in the institution, and today we're going to hear from officials and other individuals across the City of Philadelphia dealing with prison health care.

I would like to call this hearing to order. I would like at this time to introduce the Health and Welfare Committee members and staff that are present and also other members of the Judiciary Committee that are here in extenso. The chairperson of the Judiciary Committee Representative Thomas Caltagirone, who will not be here. He did have a doctor's appointment and told us yesterday he had to leave for that and if he was not able to get back today it was because of that. I want to recognize our chairman.

To my left is Representative Babette Josephs, whose district we are in, and also a member of the House Health and Welfare Committee

and Judiciary Committee and the Appropriations Committee and Insurance. And to her left, Representative Kathy Manderino, member of the Judiciary Committee and Urban Affairs Committee and Tourism for the Commonwealth of Pennsylvania and also was present with us yesterday.

Mr. Phil Parrish, executive director of the House Health and Welfare Committee, and Mr. David Krantz is the executive director of the House Judiciary Committee. To the right of Mr. Parrish, Mr. Jawal Boyd, who is the legislative assistant and also research analyst for Health and Welfare Committee.

Mr. Sam McClay is here from the Department of Health for the Commonwealth of Pennsylvania sitting to our right. Mr. David Yurky, who has spent a lot of time in helping to prepare this hearing for us on health care, activist, and also a volunteer staff person for our office. We appreciate his efforts in helping to pull together these hearings. He has spent a lot of time and research hours putting together this hearing.

For too many, the issue of how a person received health care once they enter the

correctional institution here in Pennsylvania was a topic of general discussion. In fact, there seems to be an unwritten concept among the public that once a person is incarcerated they deserve the very worst treatment.

The purpose of this hearing is to hear testimony and have dialogue about the state of our health care delivery system as it relates to the Pennsylvania correctional system. We realize that there are some problems in that health care delivery system. We recognize that some of the problems have to do with overcrowding and recruiting health care providers. We also realize that other major problems are fragmented health care system for our correctional institutions and the lack of clinical leadership. One of my major concerns is how do we address the need for some coordination between the Department of Health, Department of Corrections regarding the provision of health care to the residents of these institutions?

In 1991, the juvenile and criminal justice international consulting service did a survey of three of the correctional institutions

in Pennsylvania. The recommendations made by this group would seem to have provided a guiding arm for how to improve our health care delivery system.

Another major concern is how do we integrate the health care needs of those who are incarcerated with the needs of those who are not incarcerated, but who have serious problems receiving health care services.

We must also realize that the issue of violence translates into a health care issue and afterwards can result in institutionalization. Most people have a hard time making the connection between the two. Let me give an example of what I am talking about. If a person has a bad encounter with a law enforcement officer and an altercation takes place, who pays for the medical treatment of the person who shows up in a trauma center or emergency room? In most cases, the hospital may have to eat the cost or pass the cost on to those who have the ability to pay. Another example would be if a person has an altercation while ingarcerated how can we assure quality care is provided expeditiously.

The whole issue of screening, diagnosis, and treatment of those with special needs, such as HIV, AIDS, or TB is also major areas of concern. Such cases may be first indicators of a major health problem within the system.

In closing, there are several issues that are major concerns of this committee and to the Judiciary Committee. Some of them I have outlined in this statement, but there are two that I purposely left for last; they are availability and training. I am very concerned that there may not be adequate medical staff to see and treat those who are really sick. And I am equally concerned that the training of some of our mid-level professionals need to be upgraded so that they can provide better treatment.

We want to hear your testimony and begin to resolve these very serious problems.

I want to say that we want to also thank Councilman John Street, president of city council, and the city council staff and the members of city council for the use of the city council chambers here today. We are most

appreciative to be able to be here.

I would now ask whether or not there is an opening statement. Representative Babette Josephs.

REPRESENTATIVE JOSEPHS: Not at this moment.

MR. CHAIRMAN: Representative Manderino.

REPRESENTATIVE MANDERINO: No. I'll pass.

MR. CHAIRMAN: We'll now start with the -- I understand that there was an accident with Dr. Chu Chu Sanders' son and that she is going to testify this afternoon. We'll then proceed with Scott Burris, Temple University School of Law.

Do you have written testimony? You don't have written testimony for the members?

MR. BURRIS: I only have the one copy. I'll use it first.

MR. CHAIRMAN: Why don't you identify yourself for the record then, sir, and then you may proceed.

MR. BURRIS: I'm Scott Burris, I am on the faculty of Temple Law School, I'm also

counsel of the AIDS and Civil Liberties project of the American Civil Liberties Union in Pennsylvania, and I'm a member of the AIDS Coalition on prisons in jail, a relevant organization of actions interested in improving the treatment of HIV in Pennsylvania's prisons and jails. I am the author of two books on AIDS in the law and public health law.

As a litigator, I have been involved in litigation against Delaware County Prison which resulted in the development of comprehensive public health policy with respect to AIDS and other communicable diseases. I'm also one of the attorneys involved in the case of Austin against Pennsylvania Department of Corrections, which is a comprehensive initiative confinement lawsuit brought by the ACLU International Prison Project, Institutional Law Project, and others against the Department of Corrections. I'm principally involved in the AIDS and public health issues in that case.

What I'm going to talk about today, however, is less litigation and how that can affect prison health care and, in fact, less -- not the health care that is provided in prisons,

but how prisons fit into a sensible effective public health scheme. My message is pretty simple.

If you just took down the prison walls and ignored the bars and just looked at prisons as little communities, little towns and cities and you looked at the health conditions and the population of that city and town, each prison, you would immediately identify those prisons as high risk areas as communities that had profound public health needs that had needs for prevention, intervention, that had need for diagnostic interventions, counseling, testing, had need for major education initiatives, drug treatment, things that could reduce the kind of conditions and behaviors that we can develop. You do that long before you thought about how many doctors they had.

The fact is in the outside world the best way to have a healthy population is to prevent people from getting sick in the first place. That's something we just haven't done with our prison population and we need very much to do.

Let me just explain why that is so.

Prisons serve to distill at-risk communities into hyper at-risk communities. All the conditions that make people sick are more present among those who are likely to go to prison. The population that is at risk for going to prisons is also generally the population at highest risk for being sick.

Disease in this society is not spread demographically. The poorer you are and darker you are, the more likely you are to be sick. Similarly, the poorer and darker you are, the more likely you are to be going to prison. That combination leaves the prisons end up holding a lot of the people that is most important to reach from a public health point of view.

For example, sexually transmitted diseases are strikingly more prevalent among minority populations in the United States than among non-Hispanic white majority populations. African-Americans, who make up less than 12 percent of the population, suffered 76 percent of the reported syphilis cases and 78 percent of reported gonorrhea cases. Hispanics, who make up about 6-1/2 percent of the population, accounted for 12 percent of the syphilis cases

and 5 percent of the gonorrhea cases. The prevalence of syphilis was 4.1 per hundred thousand for people with annual incomes less than 6,000, and almost four times less than for people with annual incomes of more than 15,000. The more likely you are -- The poorer you are, the more likely you are to be exposed to any of these diseases. The darker you are, the more likely to be exposed to one of these diseases.

It's also true of tuberculosis. Tuberculosis is substantially a disease that is spreading among people of color, particularly poor people of color. In 1990 almost 70 percent of all TB cases occurred among racial and ethnic minorities. Even more disturbing is I think the finding that 86 percent of all cases among children occur in minority groups. By contrast non-Hispanic whites account for only 30 percent of reported TB cases in 1990.

AIDS, of course, which came to notice in this country as a quote, gay plague, unquote has now become predominantly a disease of the poor people, poor people of color. 74 percent of the 18,000 women diagnosed with AIDS as of mid 1991 were non-white, primarily

African-American and Latino.

By 1988, you want to look at the time when the change really started to become clear. The cumulative number of cases per hundred thousand appear to be three and one half times higher among black men, two and a half times higher among Latino men, 14 times higher among black women than their non-Hispanic white counterpart.

Now, if black people, Hispanic people, poor people are more likely to get sick, they are also much more likely than other people to go to prison. The demographics of drug use are a big part of this, and I should say the demographics of drug use as it is punished. We have to recognize that it is much more likely as a drug user to go to prison if you are black or Hispanic than if you are white, if you are inner city as opposed to being urban. Most of the drug use in this country takes place among people who are non-urban whites. Most of the incarceration for drug use is among urban blacks. That's an anomaly, shall we say, of our justice system, but it is a big impact of who ends up in prison.

Only 1.6 percent of the white population is in custody or under correctional supervision by probation or parole, 7.2 percent of the black population. If you look at some of our worst hardest hit cities. The well-known publicized report of the National Center on Institution as Alternatives found that on any given day in Washington, D.C., 40 percent of young black males were involved with criminal justice system, and it's 70 percent of the black men in Columbia have been arrested by the time they turn 35. The most recent data indicates that less than half of the total state and prison population is white, non-Hispanic, with blacks constituting over 47 percent of the population behind bars. In state prisons, prisoners, black prisoners exceed the number of white prisoners.

Drug use is a big factor in leading to incarceration. The Department of Justice reports that well over half of all jail inmates had used a major illegal drug prior to incarceration. Over 13 percent of all those jailed committed their offense to obtain money for drugs. Nearly 80 percent had previously

used some illicit drug, such as marijuana. Between one-quarter and one-half of the jailed inmates were daily users of at least one drug prior to committing their offense and merely one-third were under the influence at the time of the arrest. In major urban centers, like Philadelphia, nearly 70 percent of all arrestees tested positive for one or more drugs. It's estimated by 1995, 70 percent of all federal prisoners will be drug offenders.

This means that we have in prisons a lot of diseases that poor people get. If you were to, as I said before, to look for a community that you want to intervene with or you want to have public health money being spent and public health officials doing their work, you look at places like Graterford Prison or any of the Philadelphia jails or Dauphin County jail or Centre County jail. You say, what we need to do is reach that population. Afterall, we know where they are. When a drug user is out on the street, that drug user may be very hard to reach with information about safe drug use or safe sex. That drug user may be under the influence. In prisons, that drug user is located in a fixed

situation, hopefully not having too frequent access to drugs. That's the time to reach that person.

Most people who go to prison or jail don't stay there all their lives. They are in there for a while, they are back in the community. They are part of the community from which they came and to which they will return. So any health problems that they have, any health threats that they face are part of the health threats of the community that they started with.

Unfortunately, we have a mentality and a bureaucracy developed that puts prisons separate from everything else. You have a health department that does health intervention, only rarely and only to a small extent does that health department go into the prisons and treat community prisons like communities that need health intervention. The funding streams are different. The concerns are different.

As we've seen throughout the state and throughout every state in this country, prison officials may often grudgingly be brought to provide medical care. They are not public

health figures, they are not public health officials. Their job is not to improve the health of the prison community or, for that matter, by improving the health of the prison community to improve health in the community to which the prisoners will return. That's a health department function.

What I'm recommending to the committee, urging you very strongly to investigate breaking down the walls between health work and prison work. I'm suggesting that you fund and help develop programs that make prison's key points for public health intervention. That means key places for AIDS testing and education. It means key points for identifying people with TB and treating TB. It means key points for providing drug treatment. You're going to hear that again and again. Among other things, drug use is a major public health problem that feeds other major health problems.

Prisons have got to become a place where that public health problem is addressed. You've got to see prisons as opportunity to provide care that you can't efficiently provide anywhere else. You got to see prisons as a

place to help change people's behavior, so that when they get out of prison they are healthier and their behavior will pose less of a threat to themselves and others.

Better prison health care is an important part of this. It's true. Certainly when we're talking about TB, which is very difficult to identify and to treat in many cases, especially among people who are marginally on society. At least in prison, they have a home over their head, they have three square meals provided, and they can be locked into a good health care pattern for a while before they leave. But I think to focus only on health care and to forget the fact that public health depends on not getting sick in the first place is to miss a major opportunity.

I encourage you to call upon the Health Department to put people into every prison in this state, not just the state prisons, even more important or just important to put them into county prisons. This happens on a limited extent. Some prisons we find public health nurses. There's been a pilot program to have Department of Health train people to do HIV

testing in a couple of the prisons in the state system. What you don't have is a comprehensive system that says there will be a branch of a Department of Health in every prison, there will be a public health nurse or a public health team going into every county prison and provide services.

Also, an important thing that you can do is to provide funding and to help break down barriers that prevent community-based organizations that do health work in the communities from expanding their work into the prisons in their community. This again happens in some counties. For example, in Delaware County, Pin Free, the Grant Program, the Ches Plan, employees of Delaware County Prison providing education and testing services and helping to ease the transition from prison back into the community when HIVs were being released, but that depended entirely on Pin Free. It is only happening because of the pot of money got devoted to that purpose.

Furthermore, there is considerable resistance among some prison officials from working with people from the Health Department

or people from community-based organizations. So that this resource that's there, people who are trained to provide these services are not able to get into the prisons to do the work. Again, this requires leadership pressed from funding from the top from Harrisburg, from the legislature to help create programs that will allow available services in the community to reach into prisons.

I think if you can do this, you're going to have two positive impacts. First of all, you're going to help prevent ill health in prisons, which will to some degree reduce the pressure of the strain medical services inside the prison. But even more importantly, you're going to help the health of the community to which the prisoner will return. You will have prisoners leaving prisons detox with some handle on the drug use with much better understanding of their risks for HIV or other diseases and, you know, while we're at it, maybe some job skills and some hope for the future to help keep good behavioral lessons learned being applied. Thanks very much.

MR. CHAIRMAN: Thank you very much for

your testimony. The Chair now recognizes Representative Josephs for questions.

REPRESENTATIVE JOSEPHS: I guess I really don't have a question at the moment, but I know where to reach you. I think your idea is just very sensible and stunning in its simplicity. I would like to be able to help in some of my capacities in Harrisburg to see some of that happening.

While I have the mike, I want to thank the Chairman of this committee and Judiciary Committee for holding these hearings. I think they are very important. I thank you for the opportunity to hear these witnesses and discuss these problems. Thank you, Mr. Chairman.

MR. CHAIRMAN: Thank you very much. Chair recognizes Representative Kathy Manderino.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman. Mr. Burris, you raised a lot of really interesting points, particularly in light of our tour yesterday at Graterford Prison. If you would to help me and maybe other members of the panel by way of maybe giving a little bit more detailed explanation, could you expound a little bit on your either observations or the

things that led you to the conclusion that there is resistance from within the correctional community to cooperate with the Health Department, other public health officials, and other possibility of community-based organizational involvement?

MR. BURRIS: Sure. I think that one I can refer you to is in my written testimony for some interesting general studies of prison administration and problems of how you bring about change from the outside in prisons. But I'll give you some personal experience on prison and jails in Pennsylvania from my work as a member of the AIDS Coalition and former member of the Department of Health and Private Sector Joint AIDS Task Force.

On the county level, the AIDS Coalition of prisons and jails has over the last six years done a three-statewide studies of county jail policies and practices with respect to AIDS. In the course of doing that, we have enacted all the local community-based AIDS health organizations in Pennsylvania and talked to them about their experiences working in the prisons.

What both, county and state, what we

found is a real patchwork. There is a tendency among prison officials whose job is custody and control to see everything through that lens. Outsiders can be threatening on security ground. It is an unnecessary bringing in of people who don't need to be there.

Of course, there is also the problem in dealing with AIDS or health care management generally that there may be some concern about the public learning, what is going on in the prison. Last, the worst conditions in prison, the more that they need the education and other interventions that outsiders can bring in, the greater the resistance to bringing in outsiders. Of course, outsiders is going to agree to report to everybody in the world. If conditions are bad, that's going to be embarrassing. I think we get some resistance on that level.

If we look at the specifics, we've had excellent intervention in Reading, Berks County, a lot of work is done, work done by Berks County. Testing and providing other assistance really helped the prisoners get the medications. In fact, there was a big flurry a couple years ago when several prisoners with HIV were

transferred to Graterford and just went through the roof because they had such good care with their certain partnership of prison health care and services, such an awareness of what they needed, when they got to a place where those services weren't available, there was some deep shock in their fear.

So I think there are some success stories. Certainly in Philadelphia you have a model program having the Health Department actually having employees inside the prison who are free to move through the prison by education. Having testing programs built right into the prison for HIVs. That's quite, as I say, unusual across the country as a model.

On the other hand, I dealt with some communities where the word is simply we won't let you in. Some of the state prisons where community-based organizations have tried to get in. For example, one of the strategies for keeping people out is require that any health worker goes in be on a prisoner's visiting list. You have to find people who will put you on the list. You can only see that prisoner. If you're on that prisoner's list, you can't get on

anybody else's list. If you are on that prisoner's list, you can't come more than once. That effectively prevents anyone from ever getting in on a reasonable basis.

So what I think as a coalition come to the conclusion, there was also the joint DOC, DOH task force and outside people in with the Department of Corrections and Department of Health and help on cooperation. What we found there is the sheer brick wall of prison bureaucracy, and the weight of prison bureaucracy was such that it was taking, you know, two years to implement a simple testing program in two prisons. I mean it's a good program, good idea, people were, I think, sincerely interested in seeing it carried out. But at that rate, we would be somewhere around the Year 2000 before testing would be available for every Department of Corrections in prisons. Since they are building so fast, we might never catch up.

I think it has to do with the fact that inevitably for correctional people health is a low priority. What I'm going to be asking for, really urging from people is health is a high -

priority, health officials and community health workers be allowed to get into prisons to do the work that is so important to them. We don't actually place it on the shoulders of prison officials, who are not trained to do it. They have enough to worry about. I'm really not saying that prison officials should become public health workers. I think I'm saying prison officials should get out of the way, they should see a niche for outside health people in prison health and public health and allowing those people to do their work.

REPRESENTATIVE MANDERINO: One other question, perhaps this is somewhat not necessarily for this. I would like your observations on the record. This is part of the larger scheme on our health care dollars in the Commonwealth and how everyone's health needs fit into the picture with regard to adequate health care.

One of the observations or myths, I think, that often I hear from the general public is that while the average working person is struggling to meet their health care needs, people who are incarcerated get free health care

and have everything taken care of. I wonder if you had any observations on that kind of dichotomy or that general theory.

MR. BURRIS: Well, there is an irony here. Because of the 8th amendment, government cannot deprive prisoners of medically necessary treatment. The level of treatment that's required by the 8th amendment is going to be very low. Nevertheless, it means in some sense prisoners are the only people in this country that have a constitutional right to health care.

I'm taking it a step higher, though, and say this, that one of the myths that's going on now broadly in our land as we talk about how to redistribute the $900 billion we spend each year on health care is the myth that access to health care is the same thing as health. Access to health care is not the same thing as health. In fact, health depends on many factors other than your health care. The most important factors are access to decent food and living conditions, access to clean and sanitary workplaces and so on, and freedom from the kind of desperate want that just drives people down into a state of ill health.

The record, the pictorial record as to the importance of improvement in the living conditions in improving our health in the last couple of years is just inconvertible. The problem with this myth is that it makes us concentrate on the end product of sickness when someone finally shows up and wants to go to the doctor. We will always have more sick people than care to provide. I don't care how you redo the system. If you concentrate on treating sickness once it's occurred, you're always going to be behind the ball.

The key to my saying is the insight of what is considered in one of the health circles and guided public health in the last hundred years is the best way to keep people healthy is to stop them from getting sick in the first place.

We're really concerned about stopping TB, for example. We can't just treat the people when they are getting it. We have to look at the fact that TB is spreading now the same reasons that it spread in 1920, because there is too many people that live in dreadful conditions who aren't properly nourished, who don't have

jobs, who don't have any reason to go to the doctor. TB is a disease of poverty, hopelessness, and poor living conditions. It's not a disease of the TB bacillus. There will always be plenty of bacilli. If we really want to stop TB here, constrict the supply of life as it is today.

So I think here when we talk about prisons, it's very much a social issue, as well as a medical issue. There are too many poor, drug using, hopeless, undernourished people waiting to get sick. It's really hard on the public health program to help those people stop being drug users, help them stop being poor, help them get into jobs, get into homes, roof over their head, help them get three square meals a day. Those people would be a lot less likely to get sick and less likely to need doctors.

Prisons have become a big housing program for us. They become the place we send people we can't treat anywhere else. Yes, medical care, it's absolutely essentially. It also helps them stop being so poor, help stop them being so desperate, help them stop being so

deprived so that they can be strong and healthy enough to resist the source of ill health, engage in behaviors that are safe rather than behaviors that are dangerous.

REPRESENTATIVE MANDRINO: Thank you.

MR. CHAIRMAN: Recognize the presence of Representative Harold James, who is member of both the House Health and Welfare Committee and also the House Judiciary Committee, serving as subcommittee chairman on Corrections and also serves as the subcommittee chairperson on African-American and Minority Rural Health Care issues for that committee.

Chair would like to recognize Representative James for any questions.

REPRESENTATIVE JAMES: Thank you, Mr. Chairman. I just have one question. If a prison official or correctional official was to say to you that there are no cases in TB in the institution, what would be your response?

MR. BURRIS: Well, I think it's conceivably true. I know that there is a terrible undercounting of HIV cases in our correctional system. With TB, we know there have been lots of people exposed. They could

easily have been exposed outside. Since the Austin preliminary injunction was granted last fall, there have been a consistent attempt to try and impose what is a good system of TB control in the Department of Corrections. I can't say at this point how successful it's been imposed. Assuming that it has been carried out, I think it's quite possible there are no cases at the moment.

The TB epidemic is getting a lot of media attention now. And it's certainly something that has to be seriously worried about. But it's still in the early stage. It's still in some sense stoppable. Certainly in Pennsylvania, we don't have the problem that they have in New York, where it's really getting to the point of being out of control.

The fact that they don't find any cases today doesn't mean anything in severity of the problem. Because TB is the kind of conditions that people are leaving from the communities when they go to prison are the kind of conditions that can really cause TB to grow. Furthermore, being in prisons, especially some of our poorly ventilated prisons, some of our

dormitory type setting, are also prime places to spread it once somebody has it. They may not have it today, but they can have it tomorrow, and day after tomorrow it can be a major problem.

REPRESENTATIVE JAMES: Just so that I can understand, because it brings me to another follow-up question. If someone is exposed to TB, is there a difference from someone being exposed to TB and someone who has TB?

MR. BURRIS: I'm not a doctor, I'm only a doctor of law. I know you can play one on TV. My limited understanding is that there are -- people who are exposed but do not develop the disease and then there are people who develop the disease. In fact, one of the key factors in terms of developing the disease is your overall health. That's why TB is a double threat to people with HIV. Not only are they more likely to die if they develop it, but if they are exposed they are more likely to develop it.

Anybody who would come from living out on the street in the rain for the last year or so may have enough of the compromise more likely to develop once exposure occurs.

REPRESENTATIVE JAMES: With your understanding as a doctor of law, so an official can say I don't have no cases of TB, but that does not mean that there are not cases of someone that's exposed, and if someone is exposed, are they on medicine, they are going to have to take medicine?

MR. BURRIS: Again, as I understand, people that have been exposed will have a positive skin test, and there is prophylactic treatment that can be given to prevent people from developing active TB after they've been exposed. That treatment, I believe, is Department of Corrections new TB protocol, which was imposed after the Austin decision last fall. So that should be going around. As I say, monitoring, testing, prophylactic treatment and vigilance is crucial right now to prevent ourselves from having a large outbreak of TB in the Department of Corrections.

REPRESENTATIVE JAMES: Thank you.

MR. CHAIRMAN: The Chair would like to recognize Mr. John O'Connell, who is the legislative research analyst for the House Health and Welfare Committee on the Republican

side, sitting to the right of Mr. Parrish.

Mr. Burris, let me ask you another question. My concern is that we had had a chance to visit Graterford yesterday, and it seems to me that the Attorney General's Office is very much concerned about the present lawsuit being filed by the ACLU with respect to health treatment and overall conditions that you brought earlier in your testimony.

Can you give us some idea as to where that lawsuit is now, if you have any information on it, and do you believe that this is something that will help correct the conditions inside the institution as you see it now?

MR. BURRIS: The schedule is roughly as follows, the discovery period, which has been over a year now, ends in the middle of May. There will be an opportunity for motions, such as motion for summary judgment, in June. The trial is scheduled to begin, I believe, in September and could continue for as long as two or three months, depending on what issues are made for trial.

Of course, we do believe that this will lead to a major improvement in conditions in the

Department of Corrections. Again, I think the brunt of my testimony is to say that even if there is good medical care provided through a court order or otherwise, even if we start to have enough room for all the inmates that we're sticking in prison, even if, in fact, we start to develop more alternatives to incarceration, the task remains to stop seeing prisons as different from communities and start to take the next step of realizing that these are people who need public health prevention and we need to provide them consistent across the board, not because it's a lawsuit, not because it's required by a judge or even the constitution, because it's the best thing, not only for prisoners, but for the entire population of the Commonwealth.

MR. CHAIRMAN: Let me ask this question because that leads me to further development of this area of questioning, that is, do you believe that there is a psychological deficiency with respect to those who work in the system who truly believe that the persons that are incarcerated are so low life that they don't believe that they have to give every respect or

care to those individuals in the system?

MR. BURRIS: Well, yes, that's a reprehensible view from a moral standpoint. I think also it partakes a throw-away society quality that we bring to this problem. We cannot afford to throw human beings away, and we can't use jails as garbage cans for human beings. We have to start reclaiming, recycling people that have gone backwards. We have to go back to communities that are producing. So many people who end up going to prisons and ask, wait a minute, they can't all be bad apples, they can't all be pathological killers. I mean, if you have 70 percent of the population being arrested before the age of 35, there's got to be a social cause going here, folks. They not all somehow just decided to be criminals.

What happens is you have a very unfair society and you have a great deal of injustice and you have the sources spread in a very uneven way. We've got to learn a lesson the way to give -- the way to have people behave the way you want them to behave as good members of society is to get them a stay, to give them a new chance so they can play. It doesn't take

much. At this point we're not giving anything. The health problem is they are making too many poor desperate people in this country. We got to stop making them.

MR. CHAIRMAN: We saw a gentlemen yesterday that had a skin disorder and started off very small in his joints and his arms and legs, now spread all over his body. He has yet to see, we were told, he was yet to see a dermatologist to deal with this particular problem. And since it spread all over his body he may go down the sick hall two and three times a week but he can see three or four different doctors and never be given a diagnosis as to what his actual problem is.

In cases like that, is there a better way to handle the kind of sicknesses that do exist where there is overt action that has not been taken to give in these times of severe health care problems that are pointed out that we know that there is a grievance procedure, it gets so comminuted with the long-needed process that the inmate could continue to suffer irreparable damage to their health unless they fall down and have to be taken out on a

stretcher? What do you see as a kind of molding, that type of health care that we believe needs to be added to the health care package that we're trying to put together for the Commonwealth of Pennsylvania?

MR. BURRIS: Short-term things like lawsuits can regress those problems to the extent that they arise from chronic shortages of qualified personnel.

MR. CHAIRMAN: Why do we always have to go to lawsuits? I'm here to inform you that if you look at me, you see I'm sick, and you recognize that there is a problem, why do I have to force a lawsuit to correct the inevitable? I mean, it seems to me we go beyond the scope of reasonableness, that we have to be forced by a court of law to do what we should be doing in the first place. That comes from the top.

MR. BURRIS: I agree with you. That's why I said short-term. A word of caution here, perhaps it's an analogy, you know, we haven't really succeeded in finding a way through law to eliminate medical malpractice. Only one in eight who are actually the victim of medical malpractice ever even sue. How do you have good

doctors on the outside? You have good doctors on the outside in hospitals and in practices where there is a culture of respect and concern for the patient and ethic and professional limits.

That's what we need in prisons. That's all that would work. We have to have medical providers and a system of health care and in hospitals and prisons that throws away that idea that you mentioned before, the prisoners aren't worth anything. These prisoners who are important, worthwhile people are as entitled as any other patient to good care.

How did you get that, sir? Challenging cultures requires about 50 things. It requires prison administration Department of Corrections that sets forth that as its ethic that embraces and encourages and requires that kind of behavior. It requires enough spending in obtaining and training of personnel that you have practitioners who are out of the caliber and are being taken to handle those attitudes. It requires an atmosphere in the practice in which you're not expecting one doctor to look at 500 people trampling by the sick hall and make

an instant diagnosis. And as an attitude we can't do everything, let's try and find the worst.

Certainly you can't have the kinds of limitations that often appear in prisons. We can't send everybody to a specialist or even send three people to a specialist a week or also I think a limit of it. Overall, I think, we can get a different set of doctors but it's not going to change unless the expectations change in every level.

MR. CHAIRMAN: One final question, Mr. Burris, that is, that we were told yesterday that there is a new concept coming from the Department of Corrections dealing with regionalism for letting RFPs for the purpose of being able to deal with the health care delivery system to the prisoners, it's going to be broken down into central region, eastern region, western region. 67 institutions each one of those will probably allow the health care provider or vendor to be able to deal with six or seven prisoners as opposed to individualized contracts for individual prisons as they are done now.

What is your feeling on the regionalization of the concept and you believe that that is something that will work without placing certain parameters at the level of at least the RFPs before they are met?

MR. BURRIS: Regionalization in theory, trying to at least reduce the number of different contractors and concentrate their territory makes some administrative sense. I think the larger problem is whether or not contract medical care is the way to go. What we are talking about here is HMO, we're talking about managed care. We are going to have, and we know from the outside that some HMOs can be really good. We also know that some HMOs can be dreadful.

I think that if we are going to have managed care in our prisons, we got to have some sense that the HMOs we're contracting with are really able to provide the care in a good way. Track record is one thing. We don't have too many HMOs of track record in the prison.

Are we going to let the same old people continue to form their little companies and contracts under another name or key players,

political connections that are sometimes involved in these contracts? All those have to give us cause as to whether or not the contract process is looking at the right thing. I'm doubtful, quite frankly, that the new system will get us better HMOs. So I'm not sure the regionalization will make any great difference. The problem will be easier to identify.

MR. CHAIRMAN: Thank you very much. We appreciate your testimony today, very valuable. I'm sorry. Mr. Parrish.

MR. PARRISH: Thank you, Mr. Chairman. Mr. Burris, I want to revisit your testimony for a minute. A couple of observations that you made that I would like to pursue with you. You made first the observation that while there were the consumption of drugs was one that was at large, there were more drugs being consumed by the non-African-American community than the African-American community, but conversely, most of the African-Americans who were in prison have some trail of drug use.

It seems to me that one of the things that is at the center of this is that drug use is looked at as a judicial issue rather than

looking at the cause of such drug use, as you pointed out later in your testimony when you spoke about economic deprivation and hopelessness as part of your cause for drug use.

My question then is, do we need a redefinition of drug use as a mental health issue rather than a judicial issue.

MR. BURRIS: I think absolutely. I would say partially mental health and physical health. Addiction is physiologic. I don't think we have to get into a fight over saying whether drug use is an illness, somehow condones drug use or supports drug use. There is no particular evidence in that in so heavily drug use.

Let's just talk to another practical manner. We know we have to have prisons where everybody tried to block out the war on drugs. We can't afford to keeping doing that. We know we can't afford to keep people in essence on prison welfare for the rest of their lives. What we need to do is take people who are now disabled for whatever reason and reenable them, help them find their own way.

Drug use is an illness, at least gives

us the responsibility and the opportunity for a cure. It's out there. Drug treatment works. Studies for the last 20 years show that drug treatment works. Drug treatment can very easily be integrated in the criminal justice system from arrest right through incarceration. It's only a matter of will and money. And it will work. We can guarantee it will reduce the number of people who end up in prison, back to prison, and staying in prison. It's not a complete solution. It will go a long way. Seeing drug use as a health matter is the first step.

MR. PARRISH: Thank you very much. Moving along to the comment you made about the 8th amendment and medically necessary treatment for residents of our correctional institutions. Is this an interpretation of the 8th amendment that we can make reference to or is this a personal interpretation?

MR. BURRIS: Well, the 8th amendment has been interpreted by the Supreme Court as cruel and unusual punishment. That's been interpreted in the health care area in court to serious medical needs.

Now, there is two parts to that definition of case law. One is the serious medical need. That has been by the Supreme Court. It doesn't mean just, and to lower costs, it doesn't just mean life threatening condition or very painful condition, it means actual noticeable serious medical need.

Ear infections, lots of things that cause serious discomfort and other complications are serious medical needs. That I think was fairly broad. The area we're running into trouble now is the first part of that phrase indifferent part.

Always it seems to suggest something more than mere negligence. Malpractice was not necessarily forbidden by the 8th amendment. It was inadvertent. So you had really terrible medical judgment being made. They would not rise to an 8th amendment violation unless they happened in such a pattern that it can be clear that the prison officials were negligent to serious medical needs.

In a recent case against Snyder, the Supreme Court has injected further levels of ambiguity in here, further weakened the

standards by saying the deliberate indifference is a subjective standard. In other words, we actually have to prove to get a violation, that establishes violation that the prison officials really knew and were really indifferent personally as it were. We're not sure what this means yet.

There is a fear that sends condolence letters to every prisoner saying, we really feel bad about the lousy medical care we're providing, we wish we could do better, we just can't. It might not be indifferent, because they are sad. They are not indifferent, they wish they could do better, they just can't. We're going to have to see how that plays out. I think Austin will be one of the early cases to test the meaning, new meaning of deliberate indifference.

I think it's always been the case to successfully litigate poor medical conditions you've got to have some funds, you've got to have a pattern of bad medical care. One or two incidents or complaints just won't do it.

Courts are reluctant to intervene in prisons. They want to see a real good reason.

So it's always prisoners are supposedly getting good medical care have to really being suffering in a big way for the courts to intervene that way.

MR. PARRISH: While you're here, with the indulgance of the Chair, I have one final question to pick your brain and ask you about two terms that have been kicked about as we've been going throughout the Commonwealth on this health care reform, inquiry and the term medical malpractice and tort reform have been banded about with regularity. We've asked a couple of officials to define for us or give us some parameters for the use of those terms.

In my estimation, I've come up lacking in terms of some specificity as to how the committee can then operate when it goes back to the drawing board. Could you lend us your talents and your observations with regard to what medical malpractice and tort reform would mean within the parameters of developing a legislative format?

MR. BURRIS: Well, the court system was developed as a way to deal with the assaults and batteries and trespasses. It's very odd that

we're still using the same system in the 20th century to regulate some of the most complicated highly technological behaviors we engage in.

My personal view, based on a couple of major recent studies that have been developed, come back to the system that it fails to deter bad medical behavior by doctors. It does not even identify malpractice victims or much less compensate the vast majority of people that are injured by that bad behavior, and it drives doctors crazy. And they have some large impact on the cost of medical care.

So I don't think -- When I hear tort reform and medical malpractice, I actually kind of think of -- I kind of combine the need for malpractice regulation before. In my view, we have to start grappling with the fact that everybody is right to some degree or another. The lawyers are right when they say a lot of people are being injured, and they need to be able to do something about it. The doctors are right when they say, to a certain degree, they are certainly right when they say they are very upset about malpractice.

The studies don't prove that, in fact,

malpractice suits are frivolous. As I say, the studies prove that probably there aren't enough malpractice suits. The bottom line is we ought to have a system that does better for the victims and doesn't terrorize the medical profession so much.

I don't think it helps you to say professional safety is to simply cap damages or to prevent contingent fee arrangement or something like that, that sort of tort reform. That's just a relevant act.

I also am not convinced that defensive medicine is the cause of the rise in our health care system. So I guess ultimately, Mr. Parrish, I sort of think that tort reform is the wrong answer to the wrong problem.

MR. PARRISH: Thank you very much, Mr. Burris. Thank you, Mr. Chairman.

MR. CHAIRMAN: Thank you very much. We appreciate your testimony here today. Chair would like to recognize the presence and absence of City Councilperson Herb DeBeary, who was here, wanted to recognize him and also his staff.

The Chair now will go back to

Dr. Robert Ross, the commissioner of the Department of Health for the City of Philadelphia and Dr. Chu Chu Sanders.

Good morning, would you identify yourself for the record, Doctor, and also those who are sitting with you.

DR. ROSS: Yes. Good morning. Thank you, Representative. My name is Dr. Robert K. Ross, Philadelphia Health Commissioner. To my right is Dr. Ronald Rahman, R-a-h-m-a-n, he is our Philadelphia Prison Medical Director. And to my left, Dr. Chu Chu Sanders, who is deputy health commissioner in Philadelphia County.

MR. CHAIRMAN: You may proceed, sir.

DR. ROSS: Thank you very much representative and members of the committee for allowing us to testify and present our thoughts and concerns on the issue of prison health. I have brought Dr. Sanders with me, deputy commissioner. She has oversight, just recently assumed oversight of our prison health care system. She is on loan from the Federal Center of Disease Control, is a nationally recognized expert in injury prevention, problems prevention, and preventive medicine in Atlanta.

She will be with us for a one to two-year period in leading us on those fronts.

Dr. Ronald Rahman, who is a former colleague of mine at the school of medicine. He's also well-known for his work at prison health, trained at the Hospital University of Pennsylvania in anesthesia and was the assistant professor of anesthesia and critical care medicine at Bunkers at Columbia University. He was also director of pulmonary laboratory and pulmonary consultant and has served prison facilities in both Pennsylvania and New Jersey for the last four years.

Let me begin by making a general statement about the health status and major health concerns of prison inmates in major urban centers, such as the City of Philadelphia, and that we see prison health as a microcosm of what is happening in health care in the general community, particularly urban setting like the City of Philadelphia, and that we know the health care is a national disaster, is a national crisis and everyone agrees on that from the President of the United States, who has taken that as a major policy issue, to the

physician communities to hospitals to health care experts. And prison health because prison inmates tend to come from devastating inner city neighborhoods, quite frankly, is not that much different from other communities.

I outlined essentially four major sets of health problems that are faced by prison inmates, particularly prison inmates that come from urban settings. Number one is substance abuse, number two is HIV disease, number three is turberculosis, and number four, serving a collection of chronic diseases, such as hypertension, diabetes, asthma, epilepsy.

Let me begin with substance abuse. Substance abuse I see as the major and number one public health concern of the last four decades of this country. There is no public health problem that had more devastating impact on neighborhoods than substance abuse. Substance abuse is the number one public health problem in this country right now.

To give you an example of the impact of crack cocaine. Since crack cocaine came on the Philadelphia scene in 1985, we've seen about a 60 percent increase in tuberculosis, we've seen

measles come back, which was previously irradicated, we've seen syphilis increase by 500 percent, we've seen infant mortality rate increase in some neighborhoods, and the low birth weight increase in many neighborhoods as well. So the introduction of crack cocaine into our city and neighborhoods has caused a tremendous impact on the health of Americans.

In prison health, it is also a number one health problem. In fact, a recent survey of detainees in intake screening for the presence of drugs in the urine in Philadelphia prison revealed that prison had the highest, the highest rate of elicit drug presence in urine than any other major urban city that was tested. And the state represented two years ago it was as high as 81 percent. Recent data revealed that in males, the presence of drugs in the urine, illegal drugs in the urine is around 75 percent, in females around 76 percent.

This does not mean that 76 percent of all inmates coming to Philadelphia prisons have a hard core drug addiction problem, but it does mean that at least three-quarters of our inmates have abused an elicit drug in some recent time

prior to their arriving to the prison health system. It's a white problem as well.

We see an optimal drug and alcohol program in prison health as consisting of five basic components. Number one, the importance of having adequate intake and screening facility for all physical health issues, not just drug and alcohol. We can't determine a drug and alcohol problem until you have a good physical examination and evaluation by physicians.

Number two, adequate detoxification facilities so that intoxification and quality of manner within a short period of time of the inmate arriving to the facility, we know that about 1 percent of all prison inmates will need immediate detoxification from a hard core drug problem.

Number three, the presence of a therapeutic community in a facility to provide 24 hour a day treatment within the walls of that prison facility.

Number four, the importance of therapeutic groups for counseling and support so that both recovering addicts and addicts who are in the early stages of recovery and treatment

can support one another inside the prison facility. Prison facility is a community as well. We need to recognize that.

And finally, the ability to move clients into community-based, neighborhood-based treatment programs which have adequate support and case management services. Recognizing that these inmates may be in detox and treatment facilities, they are not going back to the community once they came. We need to have those support mechanisms in the community.

The second major health problem, health concern is HIV disease or AIDS. These are the components of important and effective HIV education counseling treatment programs. Many of which are up and running in the Philadelphia prison system now.

Number one, as on the outside, importance of education and counseling to every single inmate and every single inmate, because these are persons that are coming from high risk neighborhoods and have high risk behaviors, whether it's drug use, intervenous drug use, or other high level behavioral issues, but every single inmate must be receiving education

counseling on the issue of AIDS, as well as voluntary screening. We don't mandatorily screen everyone, but everyone gets offered voluntary screening. Therefore, to be very effective, we screen as many as 2,000 inmates every year in our system for HIV.

As in substance abuse and as in TB, there is an even higher rate of HIV positivity due to population and the population on the outside. It may be as high as 5 percent. That's what our data shows, as high as 5 percent in most urban prison settings. In addition to the opportunity for education and counseling for every inmate and voluntary screening, optimally there should be prison facilities and HIV specialty clinic on site. The purpose of that HIV or AIDS specialty clinic would be to institute protocols for treatment and management of the disease, to begin the appropriate prophylactic treatment, for example, the use of ADT, and also to follow these patients that have a variety of chronic health problems, to follow a patient's medical services, to make sure that they are receiving quality health care.

The third major problem, certainly

potential problem in prison settings is turberculosis. As all of you know, tuberculosis has gone through some of the resurgence in urban setting. New York has it severe right now. The City of Philadelphia I would not qualify as an epidemic or even an outbreak, but it is in danger of becoming epidemic.

We do not have at this point hard data on the rate of TB in our prisons. We are collecting that data now. I can give you some information to give you a ballpark of where we are. We know that in the general population -- And again, let me just make sure that we're clear on terms.

When I talk about screening for TB, I'm talking about putting a skin test on someone's arms and waiting 48 hours to see if your arm swells up the appropriate amount, we call that a positive skin test or positive converter. That doesn't necessarily mean that that person has active turberculosis. It means that at some point in their life they were exposed to the bug, that their immune system has reacted against it, and further evaluation from the department to see if they have active TB.

Fortunately, the rate of positive TB screens are much, much higher than the rate that goes up after disease. In the general community, the screening positivity rate for TB is about 8 to 10 percent. In the inmate population, we believe that figure is as high as 20 percent. That figure has been corroborated by some data that came from Graterford Hospital and the study that was done in Montgomery County Health Department there and prison department. Our prison is the same way. Somewhere between 10 and 20 percent of all inmates are going to screen positive for TB. Right now we have very few, less than three active cases of TB identified in Philadelphia prisons, but again, this is a population that is at great risk.

We are finalizing our comprehensive TB plan for the city, but the major components of prison, of effective prison tuberculosis initiative include the following, number one, screening of all new prison detainees for TB by skin test or perhaps even a chest X-ray; secondly, to screen or review the TB status of all current inmates, making certain that they've had certainly in the last 6 to 12 months a TB

screen test; thirdly, immediate hospitalization of any detainee or inmates suspected of having active turberculosis, which we do right now; fourthly, there should be an active infection disease nurse specialist on the ward of prison facility system to identify and follow suspected cases of TB, as well as the establishment of a TB specialty clinic in the detention center or somewhere in the prison facility; finally, the establishment of clear treatment protocols for the administration of anti-TB medication with emphasis on compliance and DOT. I can't underscore this final recommendation any more fully.

The problem of tuberculosis is those individuals that are at risk to get TB come from a list of persons of HIV disease, homeless individuals, prison inmates, those that are at drug and alcohol treatment facilities or addicted to drug and alcohol. That is a population of individuals that are not known for being fully compliant. Perhaps with the medical system, we tend to disfranchise poor, we tend to be black. Now we are asking these individuals to take a medication or two or three every

single day for a period of 6 to 12 months, because that's what the treatment for TB looks like. That has posed a difficult problem for public health in this country. We'll be wrestling with it now. We'll be wrestling with its runoff.

Certainly in the prison facility we do have the opportunity, to use the phrase in deroggatory fashion, counter population. We have them in our facility. There is no excuse for not getting that person's medication on a timely basis of providing quality care.

Very clearly those folks would screen positive for TB, being treated for tuberculosis, you need to get their medication every single day, we need to have that documented, need to be observed. That treatment takes up to 12 months.

Finally, the last group of health problems I will term as chronic diseases. And those chronic diseases which affect poor people, African-Americans, and the general community, such as asthma, hyperextension, diabetes, epilepsy. Those focuses are very high risk in African-American communities, minorities. Our education of the patient, health promotion

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activities change behavior, close medical follow-up, administration of medication.

Every once in a while we'll be in some prison facility, doesn't matter if it's Philadelphia or other urban centers, an inmate will die because they didn't get their hypertension medication. There is no excuse for that. We know that happens. It should never happen. Certainly, we should be doing close follow-up of medical care and getting that medication.

So in summary, at a time when health care in this country is a national crisis, and health care industry, communities and neighborhoods is a national shame. Actually, a prison facility, this may be the first time that many of these inmates have access to consistent and appropriate and quality medical care on a timely basis and consistent basis. And the companies at our prison facility, we see them as our patient and they should be getting quality care, just as our citizens in the community should be getting quality care as well.

We think it's an opportunity for the first time for inmates to get quality preventive

care and managed opportunities. So at this time I'm open to any questions. Both Dr. Rahman and Dr. Sanders here as resource persons in case anybody has any more detailed questions. Representative, we would be glad to answer any questions you have.

MR. CHAIRMAN: Thank you very much, Dr. Ross. Chair would recognize Representative Manderino for questions.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman. Dr. Ross, if I may, before I start asking questions, ask for a little bit more information from you with regard to Drs. Sanders and Rahman and yourself, how everybody works together. If you heard part of the last person's testimony, I was left with an impression that here was the public health official and here were the prison health officials and there wasn't too much kind of coordination between. I guess before I start asking questions, how is it working in Philadelphia?

DR. ROSS: Basically, the prison health services in the City of Philadelphia is provided according to contractual basis. The delivery of

those health systems in Philadelphia is Correctional Health Systems. They provide direct health care delivery to the inmates and have done so since 1989. However, the oversight in management of that contract rests with the responsibility of Philadelphia Department of Public Health and is under my jurisdiction and is ultimately my responsibility.

The way it works is that we hire, we have a prison medical director from the Health Department that oversees the contractor and makes certain that effective communication is going on between the City Health Department and the contractor who provides the health services, That person as the director is Dr. Rahman. He reports to Dr. Sanders as deputy commissioner, who has other responsibilities. And Dr. Sanders in turn reports to me.

Both Dr. Rahman, whose only been on board two months or so, Dr. Sanders has only been on board with prison health a week, we are just pulling this, actually significant reorganization in the department. Part of that reorganization is with the intent to improve the quality of prison health services and to improve

the emphasis of prevention in prison health services, which we think is important.

REPRESENTATIVE MANDERINO: So that the coordination that you described in your testimony and that we're seeing right here is a new kind of coordination, we should expect things from the future, or were these positions in this type of system in place for a while?

DR. ROSS: No. The positions have been in place for a while, the persons are new. In addition, for example, our AIDS unit in the health department known as the AIDS activities coordinating office, we provide on-site counseling education and screening of inmates for HIV disease. We also do -- We're working with our new TB control director that came on the Health Department recently. He will be working constantly with Dr. Rahmen to make sure the tuberculosis protocols and the management of that program is well coordinated.

So I think there is some legitimate criticism that prison officials and public health officials have not been working hand in glove. I think that's legitimate criticism, maybe not just in Philadelphia, major urban

settings. We're trying to improve that with time.

REPRESENTATIVE MANDERINO: Let me move on to a few specific health areas that you touched on and that I am concerned with based specifically on what I saw and heard yesterday at Graterford.

One of the things you talked about was the TB program for prevention and treatment and in your comments talked about the need for taking of the TB preventative or prophylactic treatment of the TB through medication and problems with compliance by the inmate population. Yesterday I heard a little bit different story, which was of numerous people in the inmate population who wanted to comply and didn't have the availability of the medication as it was necessary and would go for days and even weeks knowing that they were supposed to be taking daily medication and never having it available for them, even though, from their side of the story, they reported every day to get it. I guess I want to know if, A, you were aware of that, and B, if there is some problem that we're working the glitches out of.

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DR. ROSS: I'm not fully versed in any detail on what is going on in the Graterford Prison. I can tell you that I would not be surprised if there were occasional complaints from inmates about our own prison system, I know that we've had in the past inmates not get their medication on a timely and daily basis for a variety reasons.

I'll give you one example of a case we had, it was about a year ago, where an inmate was on a medication for a chronic condition. The inmate didn't like to take the medication. He was a diabetic, was getting insulin. And the inmate would get a pass to come down to the medical clinic to take his insulin, the inmate would get the pass, leave his cell, and not show up at the clinic, would probably take a walk around the prison facility, and then come back. That inmate went several days without getting his insulin and suffered from a complication of diabetic shock and subsequently died.

What that particular case showed us was the number of places and number of opportunities for the system to break down and someone to get their medication, whether they want to get it or

whether they don't want to get it. One of the things that we're trying to work on in the Philadelphia Prison System is to institute a system that essentially fool-proof and human-proof, that the system is effective enough and well enough established that anyone who gets their medication gets it.

There is a whole host of reasons why they might not get their medication. Sometimes there is a lockdown. If there is a lockdown, as I understand it, Dr. Rahman can talk more about this, we think there is no excuse for a patient not to get their medication if there is a lockdown. Sometimes a lockdown, medication, the med line, as we call it, is not held and prison inmates don't get their medication. So there is a whole host of reasons and opportunities for inmates not to get their medication.

I think as a physician and as a public health practitioner that there is really no excuse for it. It really should never happen. We're aware that it does happen, whether at Graterford or our own facility. We need to continue to improve the system.

REPRESENTATIVE MANDERINO: I appreciate

the story that you did relate because it does show some faults in the system. However, it doesn't point to the potential fault in the system that I was trying to get to, because that is an incidence of non-compliance or non-willingness on the part of the inmate.

My concern is when an inmate is willing and the medication is not available, and one of the real concerns I have in probing this issue is, and we talked about contracting out and contracting services with medical providers and even in the private health care delivery community, we know that there are good managed care providers and have managed care providers and availability of all the treatment that you need if you're with a good provider and maybe sometimes the reason we define bad providers because you're not getting what you need.

I'm wondering whether or not part of our problem when I hear stories about medication that just isn't there to be taken, if it has to do with how we've structured our contracting, how the contractors get paid, what kind of profit margins they are looking for, and if they really have a medication shortage that's tied to

the way we've designed and contracted out our health care delivery in the prisons. That's really the core of where my concern is coming from.

DR. ROSS: Well, let me answer the specific question first and then the general one. In the circumstances of medication not being available for an inmate, I would have to look at that on a case by case basis. Maybe the medication was there, somebody didn't have the key or the key was missing. Maybe they actually ran out of that medication, maybe the pharmaceutical dispensing was not well done. I'm not sure why that inmate didn't get that medication. I'm sure there's a reason for it. It's probably not an acceptable reason.

In general, in terms of the provision of quality medical care in prisons, I don't know, maybe Dr. Rahman can put his comments in, but I do know enough about it to say this, it is very difficult to deliver health services in prison centers. It's not easy. There are a whole host of issues from the population that you're dealing with, which can often mean difficult problems to the circumstances of

providing medical services.

Sometimes there are issues for the medical provider that are out of their control, such as reliance on the guards, such as reliance on the transportation of inmate from one facility to another, from one hospital facility, from a medical setting, from outpatient specialty provider, activity on prison facility.

The real bottom line in delivering quality care in prison health services is total commitment from the top of the prison facility administration right on down to the prison guards and to the folks who mop the floors. If you don't have that total and complete commitment, the system will break down somewhere. And the medical provider may be trying to do the best job they can in providing quality service, but if the prison guards are not being fully cooperative, they can't do their job.

I don't know if I'm answering your question. All I can say is it takes a total commitment from a good quality provider and health department in our case that is totally committed to oversighting the contract serves as

a provider. Dr. Rahman, do you have anything?

RRPRESENTATIVE MANDRRINO: As a matter of fact, I would like to ask Dr. Rahman a couple questions following up on that. Dr. Rahman, have you in your oversight of the Philadelphia County Prison System noticed any systemic problems or glitches that might need to be worked out with regard to, following on that same train of thought, with regard to the availability of medication that's already been prescribed and needed by inmate population, and if you are aware of any problems, explain to me how it occurs and what we can do to fix it?

DR. RAHMAN: We have looked at these issues that you're now mentioning, in fact. The difference between here and what you probably saw on the state level was that we in Philadelphia tend to have what we call a stock of medication as a reserve in case there are problems at the pharmacy. There are times when the pharmacy itself may have trouble receiving medication from its distributor, something of this nature. Once a prescription is written, it is processed in a timely fashion. Because we do use this stocking procedure, we rarely have had

a problem, such as you're describing, particularly on something as readily available as INA.

REPRESENTATIVE MANDERINO: Again, I may be asking beyond your knowledge, whereas we have this coordination between our city health deparment and our county prison system, do you feel that, do you know whether that kind of coordination is lacking at the state level, and do you have any comments about whether or not that would -- what the coordination you have here would facilitate maybe the concern that I was just expressing when it comes to our state prisons?

DR. RAHMAN: Are you asking me for an opinion regarding what we do in Philadelphia, would it be applicable to the state level?

REPRESENTATIVE MANDERINO: Yes. I'm really just looking for some advice. I recognize you're relatively new there, but I would love to hear it.

DR. RAHMAN: I think what Philadelphia does is actually, I believe it is very beneficial of public health people overseeing the contracts. What I mean by that is, it's

very difficult for people who are non-medical and who don't know the real public health concerns to oversee the contracts. I think that the concerns that the public health department have frequently are different from the concerns, for instance, the state may have. I believe that the public health department has a better overview of what the real concerns of the population at large are. I believe they have the expertise to monitor the contracts appropriately.

I think that what is being done in Philadelphia points directly to that and the fact that you can bring up many problems that are not clearly delineated to the health care provider, but they will understand it better coming from another physician or for someone who they respect as authority and realize that the interest is their interest as well as the people at large. So I do believe that this will be very helpful to you on the state level. But just my opinion.

REPRESENTATIVE MANDERINO: Just so that my questions aren't inappropriate. I realize I started off with a wrong assumption in my head

perhaps. No one here that's testifying to us at this particular time, none of you doctors are specifically involved in provision of health care at the state prisons, we're talking just city and county prisons right now?

DR. ROSS: Dr. Rahman was formerly with the Graterford Prison system and has recently left that system to join us. Basically, we stole him.

REPRESENTATIVE MANDERINO: Dr. Sanders, if I may. A person, an inmate within the prison population has full-blown AIDS where they are exhibiting outward signs of the disease or maybe --

Let me ask you an even more basic question. When we say full-blown AIDS as compared to someone that is HIV positive, what health symptoms would be exhibited by an active full-blown AIDS case and in the case of a prisoner that has it, where should that person be, in terms of in the prison itself?

DR. SANDERS: I think Dr. Rahman would be better at answering that question.

REPRESENTATIVE MANDERINO: Whoever is appropriate.

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DR. RAHMAN: Let's understand that when the initial screening is done, this is done by AACO, A-A-C-O is their abbreviation, and those inmates receiving a positive test are then referred to the medical department. Now, when you say full-blown AIDS, I assume you're speaking of someone who presents with an opportunistic infection.

REPRESENTATIVE MANDERINO: I guess what I'm asking you is, when somebody says full-blown AIDS in the medical community, what does that mean?

DR. RAHMAN: That usually means for us that his CDC comes below a certain level and that he has the potential to exhibit any of the opportunistic infections most commonly associated with very, very low counts. Now, in the community, however, when someone says full-blown AIDS, they usually mean the wasting syndrome that is seen. This is a subjective type of thing. You see someone who looks debilitative and who is not able to really ambulate very well, he may have non-specific complaints. Pretty much you can identify them because of the wasting more than the internal

infections.

REPRESENTATIVE MANDERINO: If I as a lay person see somebody in a wasting condition, it's very likely that this person is in active AIDS state, correct?

DR. RAHMAN: I don't know if I would say that. AIDS is still a relatively rare disease. Tuberculosis will present like that. If you are untreated, you get a tremendous wasting. They are both defined as debilitative disease, even the cariconomas that are presenting. Anything that obstructs your ability to consume food or forces you to have a high metabolic rate would give you this. I wouldn't say that. In this society right now, if you look like you lost a little bit of weight, that's what the overall thing would be.

REPRESENTATIVE MANDERINO: Within the prison community, to the best of your knowledge, what is the standard operating procedure, in terms of where prisoners are housed when they have an active case of AIDS and are not just testing positive to those symptoms?

DR. RAHMAN: We do not segregate prisoners on this basis. What we're really

talking about is blood and body fluid proportions. That is to inform the inmate not to use someone else's razor, ask them not to engage in activities, such as sharing needles, et cetera, that would compromise others or expose others to blood and body fluids.

It's really a counseling to the inmate themselves, because we really can't control that level of individual activity. But if you can counsel them and let them know the risk involved to those in association with, usually they will cut back their activity.

REPRESENTATIVE MANDERINO: But there is no policy that the person with an active AIDS case should be in the medical part of the facility, they should be in the regular general population sharing cells with other people?

DR. RAHMAN: Let me explain. The people that you're describing are usually too debilitating to be out in the general population, so they would be housed in our detention center, medical facility. We have a large infirmary there.

Where someone is housed depends on their ability to handle the normal circumstances

that they are required to do in a prison setting. They must be able to go get their trays, they must be able in a timely fashion to go to the front of the line, to go up and down stairs. There are certain requirements that people with chronic disease, some of whom are not able to do. Those situations they are housed in a special area.

REPRESENTATIVE MANDERINO: Thank you.

MR. CHAIRMAN: Chair recognizes Representative Josephs.

REPRESENTATIVE JOSEPHS: Thank you, Mr. Chairman. I'm very encouraged to hear of the way the public health folks in the city, yourselves, are overseeing the provision of medical care in the prisons here. And I think to follow-up on Representative Manderino's part of the questions, it would be very helpful for me, and I think for all of us, if we could have something in writing that sort of described that model, a narrative or a chart.

Because like Representative Manderino, I'm not going to be sure what we're doing on the state level. If I had a better idea of what is going on here, I could ask some more intelligent

questions of our public health officials and Department of Correction officials on the state level. If you would be able to forward something like that to the chairman of the committee, I would appreciate it very much.

DR. ROSS: Sure. We would be glad to provide you with written copy of my testimony, as well as what we think a model system should look like. Let me just go on record by saying that we do not believe, and we, the City of Philadelphia, yet have a model prison health system. We have some pieces of it that are very good and some other pieces of it that need a lot of work. My role here is not to say that we're doing better at Graterford and come and see what we're doing. I think that we want to be a good model of excellence on prison health service delivery as a city. Obviously, we would like to see the same for our colleagues at Graterford. If we could work together, that's fantastic. We historically had some problems with our own prison health system. We're trying to make some changes to get to a model of excellence, and we're not there yet.

DR. SANDERS: May I say something?

REPRESENTATIVE JOSEPHS: Certainly.

DR. SANDERS: Dr. Rahman and I are committed to -- I should say we're in the process of putting together a standardization manual that we would like to put in place. We would be happy to share that with the committee when that is completed. We don't expect it to be completed until sometime during the summer. We would be happy to share that with you.

REPRESENTATIVE JOSEPHS: Thank you. I would be happy to get that and anything else you have before that. I do understand that these systems are not perfect, we're getting there. I would like to know what is happening in Philadelphia just the same.

I also would like to know very much what your model system would be, because that would be the kind of thing that we could use as a guidepost on standards when we're asking questions and doing investigations and passing legislation, appropriating money and so on.

I'm also very interested in what you are able to do. You touched on this just a little bit in the way of preventive, intervening them in the prisons, and what you would like to

be able to do and what that involves. And specifically, among part of your answer, if you would tell me what cooperation that you have with community groups that are interested in providing health care or counseling or some steps in integrating of Pennsylvania. I guess anybody on this panel or all of you who have an answer to that we would be happy to hear from anyone.

DR. ROSS: An excellent question. Your question points to the mission of public health in general, that is to access more prevention and education to prevent these diseases. The key to public health in this decade or the '90s is going to be connecting with individuals and families and communities to ard (Phonetic) themselves the ability to managerial health through behavior and public health and has not done a very good job of that in the past 40 years. We're trying to do better.

We see opportunities. Although we don't have such programs, we see opportunities. We have them in bits and pieces. We don't have a real consistent basis. The opportunities for model programs that can be done within the

prison facilities. For example, we know that a lot of inmates smoke, we know that a lot of individuals who are, I've never met, I used to work at a drug treatment program in Brooklyn, I never met a recovering addict who didn't smoke. They all smoke. There may be one or two out there, I just haven't met them. A lot of them have particular personalities, and they smoke cigarettes.

Why couldn't, I'm not saying this isn't happening, Dr. Rahman is relatively new to these situations, why couldn't the inmates themselves organize or be trained to organize smoking cessation courses or support group within their prison facility? That could be run by the inmates where the inmates are actually educating and training each other. We see that for other health issues as well.

Why couldn't all the diabetics in the prisons organize themselves as support groups or where everyone has HIV disease should have these kind of support groups on the outside for HIV disease get together one or two nights a week and support each other and educate each other? That can be done inside the prison facilities.

These were the kinds of programs that don't take a lot of money, are effective, it's important for behavior, that improve quality of life, that could carry over to inmates once they leave the facility. These we see as kind of model components for model program. I think that's some of the reasons why Dr. Rahman in his opinion, and I agree with that opinion, says public health should have a strong presence in the administration oversight of any prison health program because those public health issues need to be emphasized.

REPRESENTATIVE JOSEPHS: Our community groups, I did ask for some comment on that.

DR. ROSS: It happens. It happens on a spotty inconsistent basis. For example, drug and alcohol treatment, we do have programs set up whereby an inpatient that has been intoxicated or has been into the therapy community inside the prison walls, they get released. We try to make certain that they are released to a program that is based in a neighborhood, for example, someone who is Latino. Philadelphia Prison Facility has a drug problem, is in recovery, Progresso or some other

Latino Philadelphia politically-based organization may have a support group or counseling program for addicts who are recovering. We try to lead them to that program so once they leave they can immediately go to someone who is in the community and can support their recovery process for them.

REPRESENTATIVE JOSEPHS: I think I maybe didn't make myself clear. I was thinking more of groups that come into the prison and ideally, as Mr. Burris described, were allowed to perhaps help inmates to set up smoking cessation programs and so on. Is there anything like that, how --

DR. ROSS: I'm not aware that we're doing anything like that right now. Dr. Rahman or Dr. Sanders, if you're aware of any. I think it's an excellent recommendation.

REPRESENTATIVE JOSEPHS: My last question. I am always interested in women. I know that the population of women inmates is rising without any sign that it will cease to accelerate. I know that women's health concerns are very much different than men's. And it was pointed out at another hearing that we had on

health, people on the outside that women, for instance, don't have one primary care physician. If we could afford it, we have two. We have a gynecologist and we have a general person. Women come to prison, not only the substance abuse problems and all of these diseases, but they come pregnant or they come at risk of pregnancy.

And I would like to know where your thinking is around the special needs and very important needs of women because it seems to me if we're talking about taking better health habits and better knowledge about health from the prison to the community, that a prisoner that's going to do that is probably going to be the woman prisoner.

DR. ROSS: I'll make a brief comment and Dr. Sanders and Dr. Rahman a comment. Clearly, and this data has been verified in urban centers as well, the likelihood of a female prison inmate having a drug problem or alcohol problem is higher than that of male inmate population. We also know there is some hard data to support this. But also, if you've ever had the opportunity to talk to a drug

counselor counseling female addicts, there is data that reveals that a significant proportion and some counselors tell me as high as 75 or 80 percent of the women in their drug program have been sexually or physically abused at some point in their lifetime, which means that there is probably a greater need for ongoing mental health counseling and support services. I'm not familiar with --

Come back to what we're doing in Philadelphia, I can tell you that I agree with you because there is a great need in those two areas, both in drug and alcohol treatment and counseling support, there is a tremendous need for women in the prison system to get those services.

I will now invite either Dr. Sanders or Dr. Rahman to comment what they feel is going on, in terms of women's health services in Philadelphia or elsewhere.

DR. SANDERS: I'll just say that I agree with what you said. I think one of the reasons that it's so is because there's not been enough women to advocate for women's health issues surrounding them. I think one of the

positive things that has happened in Philadelphia is that I am now responsible for prison health. Another positive thing is that there will be a standardization manual and that will be in place.

Let me just say to you that we are very aware of that. We are planning to fix that. As Dr. Ross has said, even though Philadelphia does have some pluses, it does have some minuses. That's one of the areas we're really concerned about fixing.

REPRESENTATIVE JOSEPHS: If I could just with the indulgance of the Chair, you reminded Dr. Ross I was about a year and a half ago at a symposium or conference or something about one of the prisons and an expert got up and started to describe an incidence of violence and sexual abuse and so on. In the background . . The typical woman prisoner. And a woman in the back stood up, raised her hand and stood up and broke into the presentation and she was a volunteer at a battered woman sheltered and she said that sounds just like my clients.

Thank you, Mr. Chairman.

MR. CHAIRMAN: Thank you. Chair recognizes Harold James.

REPRESENTATIVE JAMES: I thank you, Mr. Chairman. Just a few questions. Let me thank you all for being here to testify. Dr. Rahman, is that right?

DR. RAHMAN: Dr. Rahman.

REPRESENTATIVE JAMES: What is your area of specialty?

DR. RAHMAN: I'm an intensivist.

REPRESENTATIVE JAMES: That means what?

DR. RAHMAN: Intensive care is my area I have special interest in. I also have special interest in pulmonary disease, HIV, and tuberculosis. Correctional medicine.

REPRESENTATIVE JAMES: You were at Graterford, you were working for the state at that time or were you working for independent vendors?

DR. RAHMAN: Yes, I was working for independent vendors.

REPRESENTATIVE JAMES: Would you say that maybe -- If I had the opportunity to work for an independent vendor or a state and Dr. Ross called me to work for him, I would go

with Dr. Ross. Aside from that --

DR. ROSS: That's your opinion.

REPRESENTATIVE JAMES: Aside from that, would you or could you say that maybe one of the reasons you left Graterford because you saw a frustration, in terms of improving health services there within an institution either by administration or by government?

DR. RAHMAN: I'm not sure.

REPRESENTATIVE JAMES: You're not sure why you left?

DR. RAHMAN: No, I'm not sure that my response will be helpful.

REPRESENTATIVE JAMES: It would be helpful if you said that yes, that would be helpful.

DR. RAHMAN: I left Graterford because I was asked to do something that I thought required my skills and abilities more so than what was currently occurring at Graterford. I thought that the need was in Philadelphia City, there was an opportunity for Dr. Ross's desire to actually really turn the system over and you see, by bringing in quite a few new people. I believe that his intentions will actually occur.

I believe that this will actually be a model system in one year for the entire country. That's why I came.

REPRESENTATIVE JAMES: Thank you. I'm trying to get an understanding of sometimes in bureaucracy of administrations, sometimes administrations don't like to admit about some of the problems they may have.

In discussing TB in the institutions, what I'm confused about is I heard yesterday that Graterford, that one of the officials said that there were no cases of TB and yet I heard from inmates that said that they were exposed and that they knew of cases and that they knew of someone or some number of them, a small number that may be isolated.

So I'm just wondering, in terms of administrative response from Graterford, not from you presently, if a person is exposed, does that not count as a person that may have TB? You, as an official, you would say that person is not. If I just came up to you and said, do you have any TB cases and you know of four people that are exposed, would you say you don't have any TB cases?

DR. RAHMAN: I would ask for a more careful definition. If you were to come to me and ask me that question, I would ask you to be more specific about your request.

REPRESENTATIVE JAMES: My request would be, do you have any TB cases in Graterford.

DR. RAHMAN: You're not framing the question such that it can be answered.

REPRESENTATIVE JAMES: We need to be taught how to frame our question to get the appropriate response from officials.

DR. ROSS: If I can interrupt for just a second. We're having council hearings in this very room in about two weeks to talk about our TB plan. Part of it is the use of phrases and terms and language, and we all know people play games with language.

The correct question would be, are there any active cases of TB in the prison. The question then is, is anyone in the prison right now that you know of that is sick, that actively has TB, is in danger of spreading it in a facility that has historically poor ventilation those living conditions, that kind of thing.

Almost by definition, I may be giving

away a potential trick of some trade, but you need to be able to ask the right questions. Almost by definition, no prison official or prison health official would ever say yes to the question, do you have any active TB in your prison, because if you know you have active TB in your prison that guy shouldn't be there. He should be either in isolation or in a hospital getting treated.

Almost by phrasing the question, do you have any TB in your prison or active TB in prison, the answer should always be no. It's like saying, did you beat your wife this morning, because anyone who has got active TB shouldn't be in the prison... They should be out of there. So maybe the question is, are you aware of any cases of active TB, and then the answer should be, well, this past year we identified five cases of active TB, and all of them perhaps were treated.

So when Dr. Rahman says, learn to phrase the question, that's the way the question ought to be phrased. I can tell you that this year in Philadelphia prison over the course of this year we identified very, very few active

cases of TB either in detainees or prison inmates. I'm sure it's less than five, somewhere between two and five. However, we do know from the Graterford data that as many as one in five inmates screen positive on a TB test at some point during their lives.

So I hope that clarifies a little bit to get some sense of the appropriate question to ask and how to ask it. The appropriate question might be, how many active cases of TB have you identified in your prison in the last year. That's a very different kind of response than do you have any active cases of TB in your prison right now. That answer should always be no.

REPRESENTATIVE JAMES: Thank you. Then the follow-up would be, if, in fact, let's say so there is no prison facilities that can have any prisoners in isolation with active TB, they don't have the facility to house?

DR. ROSS: There are some, and again, I invite Dr. Rahman to expand on this. We are looking at for Philadelphia prison systems, we are looking at a device whereby a prison cell can become an environmentally controlled cell. There are a couple of things you can do with

patients who either have active TB, meaning that they are infectious, they can spread TB to other inmates or other persons, then there is someone else who not only has active TB but is very ill, not only do they have active TB, but they may need oxygen or may need some other kind of intensive therapy. Okay.

For patients who we suspect may be active, have active TB, meaning we suspect they might be able to spread TB to another person, but they are not sick enough to be in a hospital, we would like a facility or a group of rooms in a prison facility that we can put them in where the air flow is controlled, where the air is exchanged six times an hour, where they are not capable of spreading TB to another inmate.

There are now devices on the market, we're looking at purchasing some of these devices now, we can turn a prison facility into one of those rooms without having to have to completely overhaul and revamp the entire ventilation system or an entire prison system which can take lots and lots of money.

I suspect that Dr. Rahman can answer

this, the state correctional institutions are looking into this kind of devices as well.

MR. CHAIRMAN: Excuse me just a moment. I would like to recognize the presence of City Councilperson Herb DeBeary, my councilman, and also the chairperson of the public safety committee here, city council, and also to recognize the presence of City Councilperson Michael Nutter, since we are in the chambers, make a lot of sense to recognize these two gentlemen, 8th and 34th districts, and also Councilperson Manderino. Glad to see you here.

DR. ROSS: Dr. Rahman, do you want to comment on the issue of TB?

DR. RAHMAN: Since you did visit Graterford, you are aware that they do have negative pressure rooms and also at Camp Pendleton institutions they do have negative pressure rooms that can be used to isolate respiratory-wise, isolate inmates until such time as a diagnosis is achieved without hurting the remaining inmates with the possibility of spreading of this infectious disease.

REPRESENTATIVE JAMES: So if I was an inmate and I tested positive and then you would

classify me as being exposed, would I still be in population?

DR. RAHMAN: Anyone who gets a positive -- What I mean by positive, positive can be defined in many ways. Let's assume for our intense purposes this means that the individual has a significant reading and has the TB germ in their body. This individual then receives a chest X-ray. The chest X-ray is pulmonary tuberculosis, active tuberculosis is present. It's not 100 percent, but it's at least 99 percent.

At that point if the chest X-ray is negative, the individual is usually sent to a tuberculosis clinic. He is seen in a clinic by a physician that is very familiar with tuberculosis. At that time, the inmate, the entire history is obtained as to when he first turned positive. It could have been 20 years ago when he was first tested and he actually turned positive. Once you're positive, you're positive for life.

REPRESENTATIVE JAMES: Good. What about positive s-p-u-t-u-m-s?

DR. RAHMAN: Sputums?

REPRESENTATIVE JAMES: What are they?

DR. RAHMAN: Let's understand we have to be -- - Again, once we get into the medical side of it, it has to be very specific. Sputums are obtained in a setting where, for instance, someone has a positive skin test and chest X-ray. Sputum is secretions from the bronchial.. We don't want spit from the mouth, we want it to come from the bronchial trach. This is mucous that comes up that is basically by the lining cells of the respiratory trach.

We obtain this and look under it at a microscope. Tuberculosis has particular staining characteristics, which I won't go into. For all intense and purposes, what we test for, we obtain the sputum. Sometimes we'll do it randomly. For instance, if someone has a positive skin test and a negative chest X-ray but he's coughing, he might be that 1 percent of people who has a normal chest X-ray.

We'll do a sputum and we'll smear it first to see if there are organisms present just by looking at it. That's to smear. That's what is done in this country. We use the smear to determine how active someone is. If the smear

is negative, meaning that we don't see any individual germs on the smear, we still culture it. The culture takes six weeks sometimes to come back, even eight weeks. So that this individual is essentially not isolated.

This is one of the hardest parts about treating tuberculosis. There are many people who are asymptomatic, you have no real way to know, other than to wait for the sputum culture to come back. But we do know that this individual, it is very unlikely that this individual will infect anyone. You have to put out a certain number of germs to actually infect someone. By rule, it has been shown that it takes months of contact within a given facility or in your own household to actually transmit this germ. It's a very special germ, very special.

REPRESENTATIVE JAMES: That is certainly good to hear, because I was concerned because what I was hearing was that you could be on the subway and somebody sneeze or cough and we can be in a room and the same thing happening somebody could be infected. Of course, in the prison population it would be worse. That's

good to know.

DR. ROSS: Let me interject for a second because we have our council hearings here in two weeks. It's going to be a source of -- It's going to be an important piece, because TB is a significant public health problem, in terms that a level hysteria that may be generated that may be unwarranted does not occur. TB is a contagious disease. There are varying degrees and levels of contagion with contagious disease.

For example, the measles is one of the most contagious diseases known to mankind, such that if you were not vaccinated against measles or you never had measles, you never seen the measles virus before, if you walk into a room a half-hour after a kid with measles had been in that room and that kid is gone, that kid has been out of the room for a half-hour and you walk into the room half-hour later you could get measles. Measles is that contagious. TB is contagious in stages but not as contagious as measles.

Is it possible in the realm of possibility, is it possible to get TB at a subway stop or bus stop? Yes. It's also

possible you can walk outside and get struck by lightning. We're talking about that kind of -- those kinds of odds. If you live with someone whose got TB, those odds go up dramatically. If you live with someone that's got TB and you have AIDS, those odds go up much more dramatically. So that there are levels.

It is possible to get TB at a bus stop, it is very unlikely that that is the way that you'll get TB. We have about 350 applications in the City of Philadelphia, most of them fall into the category of either health care workers who have been exposed, persons with HIV disease, homeless individuals, persons who have drug and alcohol problem. Most of them are at risk and disenfranchised employee. If you happen to have a decent place to live and happen to have a decent level of health care, you're probably not going to get TB. That's sort of a general rule.

REPRESENTATIVE JAMES: Thank you, Dr. Ross. The same thing the previous doctor of law said, that one of the causes of TB was related to a lot of conditions. Of course, we always can count on you to kind of put the record straight. I really appreciated that.

I can note, because of you, the Philadelphia prison system can be ahead in terms of if that happens. I would ask that the testimony you're going to present to city council in a few weeks that if a copy of it can be sent to our chairman of the Health and Welfare and the Judiciary Committee will be appreciated. Thank you.

MR. CHAIRMAN: Thank you very much. Very quickly, Mr. Parrish has a question. It looks like we're going to be working through lunch.

MR. PARRISH: The Chairman has put the onus on me to be brief. Dr. Sanders, my question primarily was for you. I do have one question of Dr. Ross. Dr. Ross, could you tell me what the average cost of a resident of Philadelphia prison system is per year?

DR. ROSS: The average cost per inmate in the Philadelphia prison system, I can give you an approximate number and come back to you with an exact number of how much. Prison's health cost is approximately $12 million. We have approximately 5,000 inmates in our system. So if someone is smart enough to divide 12

million by 5,000, we could figure that out. Probably around 2-1/2 thousand dollars a year per inmate. Roughly $2,000 per inmate per year, maybe a little bit more. We can make sure we get back to you on that, Representative, with that exact number.

MR. PARRISH: Thank you very much. Very quickly, Dr. Sanders, welcome to the City of Philadelphia. I understand that you have come with a great deal of information and direction when it comes to translating the issue of violence into a health issue.

Could you as quickly as possible for the committee give us some background as to how we can view violence as a health issue and what are some of the parameters on structuring that view?

DR. SANDERS: Well, the mission of public health is to prevent unnecessary morbidity and mortality. We have come to the recognition that violence or death due to violence or sickness or injury due to violence is a preventable process, that we can prevent that through public health strategies and promising strategies that we know of.

The reason we got this issue was because of the fact that more than 50,000 people lose their lives as a result of violent abusive behavior in this country each year. The other factor you have to remember is that 3 million people each year suffer some sort of restricted activity as a result of violent behavior.

Because of this and because of the epidemics, we've decided we're going to get on this bandwagon. We do realize that this is a complex psychosocial issue that's going to take complex multi-disciplinary solutions. But we believe that a lot of the solutions are promising and we can prevent a lot of this. That's why we're in this business. Does that answer your question?

DR. ROSS: Let me just say. We're trying to put together a plan for violent prevention. Dr. Sanders is chairing that. The problems that we think of public health and public health problems doesn't necessarily have the answers. We think that part of the answer, part of the plan is recreation, employment, and mentoring and jobs and role models. I don't think the public health has all of the answers

within our own fields.

What is going to be important about this plan is making sure the entire community is committed top to bottom in every neighborhood to the issue and trying to get committee input and the plan, as well, don't have that many in short.

DR. SANDERS: Their community input does not necessarily mean creating just a portion of us, it means all of us as a community. Because we have researched and we know geography, there is no rational ethnic which lives within the confines of the United States that is immuned to it. We all need to get on board.

MR. PARRISH: Just as a very quick follow-up. We understand that the Secretary of Health has also taken this on as a priority issue within his own agenda. We would ask that the city officials of Philadelphia cooperate with the Health and Welfare Committee and hopefully Judiciary Committee as we develop a mutli-dimensional or dynamic plan for the Commonwealth of Pennsylvania. This is something that needs to be addressed. Thank you very

much.

MR. CHAIRMAN: Thank you very much. We want to thank all three of you, Dr. Ross, Dr. Rahman, and Dr. Sanders for being here today. A number of areas of concern that we're going to tackle. I hope that we will be able to get you back again, particularly Dr. Rahman, we talked a little bit about Graterford. I really need to talk to you about the whole state prison system from your perspective, in terms of how that works. We'll have some person from the Department of Corrections to testify right after you.

But also we get a better prospective from you, Dr. Sanders, with respect to this overall issue of health and how it's really going to meet with overall universal health care plan for us and the Commonwealth of Pennsylvania, which is why we're doing prison health. We think that's also tied into universal health care plan no matter what is put together in Washington, no matter what is put together by the government. We as legislature have a responsibility to our constituents and also we want to also get your best reading of

that. Because we believe it dovetails to our overall plan.

You, Dr. Ross, were out of town, you were not able to be here when we had it at the University of Pennsylvania. I mean at Children's Hospital. I wanted to pursue that with you. We'll hopefully get a chance to do that at a later time. Thank you all of you for being here this morning.

DR. ROSS: Thank you, Representative, for hearing for prison inmates being a forgotten population and forgotten community. It's really wonderful to see someone paying attention to this issue.

Second is the issue that a legislator may want to pursue, that is, the cost of prison health is going to continue to be burdensome, particularly we have no more prisons. The cost of care is going up. The cost of treating TB, treating AIDS is expensive. We're going to try and find ways to stretch our dollars to go further.

One of the things I have as a special concern, I understand most state prisoners do not qualify for medical assistance coverage.

There may be one state where prisoners may qualify for medical assistance reimbursement. We assume all those costs, as you know. We as a City of Philadelphia and us as a State of Pennsylvania.

I would like to know why is it that we cannot have prison inmates qualify, to qualify for medical assistance on the outside, qualify for medical assistance reimbursement on the inside. I would be happy to sit down with you, Representative, at any time to take that discussion further. That is going to be a clear issue of burden for all those jurisdictions, whether state or county, in the provision of quality on medical services.

MR. CHAIRMAN: We'll approach that with Representative Caltagirone. And Representative Manderino is also a member of the Judicary Committee, she can probably go back with one of the discussions that needs to be had. And also, Representative Babette Josephs sits on the Health and Welfare Committee and Appropriations Committees.

With all that in mind, we'll have an opportunity to sit down hopefully for the end of

the fiscal year to approach that. We appreciate it very much. Thank you. We will take a short recess.

(Recess)

MR. CHAIRMAN: The time of the recess having expired on our short break, we would like to call the hearing back to order. At this time we would like to recognize the presence of Ms. Diane Marks, director of Health Care Services for the Department of Corrections. And if she's going to have someone sit with her, choose to sit with her, would you identify yourself, Ms. Marks, and identify counsel for the department?

MS. MARKS: Yes. Good morning. Thank you. My name is Diane Marks, as Mr. Chairman said. I am the director of the new bureau for Health Care Services, Department of Corrections. Joining me at the table is Ms. Sheri Young, chief counsel for the Department of Corrections. They are located at Central Office in Camp Hill, Pennsylvania. I have a prepared statement to read you today, which I understand has been distributed to you.

MR. CHAIRMAN: You are in order. You

may proceed.

MS. MARKS: This morning I want to provide a brief overview of some of the changes the Department of Corrections is making with regard to prison health care. Unfortunately, given the Austin class action lawsuit and the ongoing litigation with the former provider of health care services at the State Correctional Institution at Camp Hill, which involves the death of an inmate, based upon the advice of legal counsel, the scope of my participation at this hearing must be limited. I am restricted in what I am able to both offer and respond to Nonetheless, the department intends to cooperate with your inquiry concerning health care within the state prison system. Because this public hearing is informational in nature, my remarks will focus on what the Department of Corrections is doing today to improve its health care delivery system.

The Department of Corrections has recently established a new inmate health care bureau with direct line authority to the health care administrators in the institutions. The bureau position complement is provided in the

attached table of organization. The bureau is directly accountable to the Commissioner of Corrections.

The department's health care delivery system has been divided into three regions with eight state facilities per region. Two institutions in each region will be designated as the primary and secondary health care facilities. Three assistant directors have been hired to supervise operations in each region.

Medical services and operational procedures will be standardized in each facility statewide. Dialysis service and a Hospice program will be centralized for the entire system.

A statewide quality assurance plan, developed cooperatively by the bureau quality assurance chief and National Capital Systems, Inc., and an infection control plan developed by the bureau infection control coordinator will be implemented.

A centralized quality assurance committee will be established to review monitoring results, formulate corrective action plans, and provide physician peer review of

clinical practice. The bureau is also developing procedures for the monitoring of vendor contract compliance in accordance with the National Commission on Correctional Health Care Standards.

The changes in our system will provide us with an enhanced capacity to manage the functions more efficiently while continuing to ensure that quality care is provided to those incarcerated.

And again, I regret not being able to respond to specific questions today, but I do want to assure you that the department will work closely with this committee in its review of our prison health care delivery system. Thank you.

MR. CHAIRMAN: What do you mean that you're not able to respond to specific questions?

MS. MARKS: As I had indicated in the statement, because of our ongoing litigation and based upon the advice of legal counsel, I am not able to respond to questions here today. However, any specific questions can be forwarded to the department through Scott Lawrence's office for review and response.

MR. CHAIRMAN: Let me just say this. Evidently -- How many months have you been with the department?

MS. MARKS: I've been with the department for two years and specifically in this position three months.

MR. CHAIRMAN: Three months. You were advised by counsel that you do not answer any questions relevant to what?

MS. MARKS: Relevant to the status of our litigation in the two cases that I mentioned.

MR. CHAIRMAN: So other questions that this committee has relevant not to concerns of the litigation are certainly subject to mutual respect?

MS. YOUNG: If I may. The scope of the Austin litigation, as we have discussed previously, is very broad. To the extent that it involves the provision of medical services to inmates, it covers the entire delivery system in every aspect. That is the case that the gentleman testified about earlier where we are still in discovery in that particular litigation. That discovery process will close

in mid May.

The other aspect to that concern is that the federal court upon the filing of this lawsuit by ACLU imposed a protective order by order of Judge DuBois, who is sitting on this case, neither of the parties can disclose information absent Court approval. That is the nature of that Court Order.

To the extent that the department has invited the committee to submit any questions or concerns in writing, that is so that we may review those inquiries, determine whether or not they are covered by the scope of the protective order, determine whether or not they are issues that actually are in litigation and to the extent that we can respond provide those responses.

But because of the fact that in this particular lawsuit we have been in discovery since 1991, it would be very difficult, I believe, for any one of my clients to extemporaneously say that particular question is or is not covered by the scope of that litigation.

We are also in active litigation with a

health care provider, a former health care provider in Camp Hill. That is pending before the state courts. There is no protective order in that particular case. But again, when matters in litigation, I'm sure the Chairman and the other committee members appreciate, it is not unusual to limit responses that are made publicly, and that is the nature of the department's concern.

MR. CHAIRMAN: Well, I'm glad that you have taken a position. What I will say to you is that then we will put forth any question we want on the record today and will indicate that you are sitting here and that you choose not to answer. The scope of my question was going to be relevant to the new proposal in organizational charts to go this way by regions and the regional health care. Is that a question in litigation you can't answer?

MS. YOUNG: Can we take it one question at a time?

MR. CHAIRMAN: That's what we're saying. We are a Health and Welfare and Judiciary Committee, we are the House of Representatives. I don't know who has advised

who, whether it's the Attorney General's Office that was impeding us yesterday or the Department of Corrections that deal with a major health care problem we have in the Commonwealth of Pennsylvania and for the department to take position that pieces under litigation, which we have not raised subject before they were raised, to say that you can't answer any questions. I just find that to be awful stringent.

Not only do we submit persons at a subsequent later time, but there are other major issues that we encountered yesterday, aside from the litigation, are subject to some response by the department with respect to what we observed, what we saw, and what we are dealing with as legislators. And to say that they cannot answer them till we put them in writing, I think it ludicrous.

I went to Superintendent Vaughn yesterday, and there was a gentlemen who had symptoms of a hernia and he should be seen right away. If that is something that you can't discuss in terms of health care overall for inmates in general and the way we should frame our direction futuristically, I don't understand

why there would be a reluctance on either one of you to deal with something that you have been in for three months so that we can't even have a feeling for your direction for the health care system for the Commonwealth of Pennsylvania for its prison system.

MS. YOUNG: If I may, Chairman Richardson, I'm not in a position to speak for the Attorney General's Office, as I am not an employee of the Attorney General's Office. However, I can say to you that the department in no way, shape, form, or fashion has any intent to impede this committee's activities. But as I indicated, we also have no intent to violate the order of a federal court judge. We cannot do that. That is the advice that I have given my client, that is the advice that the Attorney General's Office has given my client.

And absent the time it takes to analyze the wealth of information and wealth of issues that are on the table in active litigation, so that we don't jeopardize our position in those ongoing lawsuits, which, in fact, if we lose, you will be appropriating a great deal of money for.

MR. CHAIRMAN: Unfortunately, because we shouldn't have to go that way in the first way.

MS. YOUNG: We did not initiate the lawsuits.

MR. CHAIRMAN: I know that. It's unfortunate that the Commonwealth of Pennsylvania citizenry always has to file suits against the Commonwealth of Pennsylvania in order to get action taken. Therefore, if it had been preacted as opposed to being reacted, you would not be in this position at all. That is the case, I'm not going to go through that.

Chair recognizes Judiciary Committee in the presence of Representative Manderino at this point.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman. First, let me say that I'm disappointed in the least by the position taken by the department. And to the extent that that was advised by the Attorney General's Office, I'm doubly disappointed.

My experience with litigation is that while individual case matter and individual cases of individuals that might be subject to a

lawsuit might understandably be off limits with regard to questioning, particularly in light of a court order, I see no reason that that should maintain with regard to both general practices and procedures of our Department of Corrections at the current time, as well as practices and procedures with regard to future plans.

With those remarks being made, I would like to ask at least a few questions that I have, and if counsel so sees to it to advise Ms. Marks not to answer, then certainly that will be part of the record.

MR. CHAIRMAN: You're in order. You may proceed.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman. Based on what I heard and learned yesterday at Graterford about the proposal by the Department of Corrections to regionalize, to divide the Commonwealth within regions for the purposes of providing health care, I think we raised some concerns yesterday about whether or not regional RFPs that serve six to eight institutions each would improve the delivery of health care systems. And my concerns are even greater today than they were at the beginning of

yesterday.

And I guess my first question is, what is it about the regionalization of health care that the Department of Corrections believes will result in the improved delivery of health care to the prison population?

MS. YOUNG: If I may, Representative, that is one of the areas that is currently in litigation. As I suspect, this is not a surprise to you, as we talked about this at length yesterday.

REPRESENTATIVE MANDERINO: You're instructing Ms. Marks not to answer the question?

MS. YOUNG: Yes.

REPRESENTATIVE MANDERINO: Thank you. My second question is, with regard to the regionalization of contracts, can you explain to me how, whoever is the successful contractor, how they are proposed to be paid for the services rendered to the prison inmates?

MS. YOUNG: Your question is how will the vendors be paid?

REPRESENTATIVE MANDERINO: Yes. For example, will they be paid a particular lump sum

for the institution based on the number of inmates in the institution, will they be paid for each health care need met? And if that's the case, how will that be documented. Will they be paid in addition for the provision of medicines or will the cost of medicines be included in an overall package, those kinds of issues?

MS. MARKS: I can answer that question. They will bill monthly, first of all, the department monthly. It will be based on physician hours. There are certain salaries that are set for physician services per hour and the amount of hours that is put in based on need. So that, in fact, if we inform a particular vendor that -- In this particular region, as I said in my statement, we will have dialysis. For that particular vendor, they know up front that that is a service that we plan to centralize and that is in their particular region. So unlike the other two vendors, for example, they would have to supply us with proposed costs to deliver the dialysis services.

Given that then, in addition to regular, say, general practitioners, their

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salaries per hour, we know that in that particular region that our costs vary because in that region we have dialysis. When we tell the vendors or those interested vendors in this region we're going to have centralized whatever service, they must provide that, that that is how we want it set up. So they will bill monthly based on physician time and hours put on in. However, those hours put in are based on the needs that we have determined.

REPRESENTATIVE MANDERINO: Let's use your dialysis example for further exploration. If in the eastern region you determine that dialysis service is part of the package on which they are bidding, did you in your RFPs give them a particular number of estimated patients on which for them to base that cost, and if that's what you did, how did you come up with the number of people in need, and what flexibility, if any, is built into the contract if the need is determined to be greater or lesser than that outlined proposal?

MS. MARKS: Yes, we provide statistics to the -- Well, we did to the region. Using dialysis in the east, we most certainly would

provide them with that data. We do know how many people are on dialysis, we know how many inmates came into the system on dialysis, those that went on dialysis while incarcerated, and those with chronic renal disease that there is an anticipation without improvement that they will also go on dialysis. That provides us with some projection to give us those costs.

REPRESENTATIVE MANDERINO: My second part of the question had to do with once the contract is let, if the demand is identified by the health care contractor to be greater or lesser than what it is, how could the payment then happen?

MS. MARKS: It is established and set up in such a fashion that with the understanding that, obviously, our need will change, so that what you see now -- And then the vendor -- That's how they negotiate with any potential company that's going to provide a dialysis service. They know that our need will change and will vary. And then again, based on the numbers that we gave to them with the ones with long-term renal disease, they know that based on that number that at some point in time those

gentlemen or women are going to need that service.

REPRESENTATIVE MANDRRINO: The way it's proposed for the future to contract out such specialty items like you just said with regard to dialysis, is that a continuation of the way it works in the current system or is that a change, and if so, if there is a change, can you explain how it changed?

MS. MARKS: That is a change. Presently, each institution who may have an inmate in need of dialysis, the individual vendors in those institutions are responsible to find dialysis units, freestanding community units to provide that service. So that presently through our system we have inmates among our institutions receiving that service in various centers.

The reason for centralizing that particular service, number one, coincides with our plan for the standardization approach. Number two, we do believe that, and from some preliminary discussions, that it will be more cost efficient to use one center who will on a regular basis have available beds for us,

because when it's determined that someone needs to go on dialysis, they need to go on quickly. We will have that assurance that we can provide that service quickly and that it will be an ongoing service available. And of course, as I had indicated, that it has preliminary discussions shown to be more cost efficient.

REPRESENTATIVE MANDERINO: So under the current system where each individual contractor vendor within an institution would recognize a need and send the person out somewhere else for the treatment, who pays for that, does that come out of that contracting vendor's contract with the state or is that something additional over and above what they now get paid that the Department of Corrections picks up the cost of sending them out?

MS. MARKS: The situation has been up until this point that -- Well, it's two-fold. Number one, the vendor is responsible for any service that an inmate needs. And the reason I say up until this point, in that up until about six months ago, perhaps, I believe, maybe a little longer, the Department of Health had been paying for a portion of those costs through the

rehab division, long-term renal program of the state. However, there has been changes made in that -- The Department of Health has made some changes in that and that they are no longer going to be paying for that component. That does not change the fact that the vendor still is responsible. Previously a portion was made by the Department of Health program and the vendor paid the balance. But the vendor would still be responsible totally.

REPRESENTATIVE MANDERINO: So if I'm interpreting what you're saying right, right now in the Commonwealth of Pennsylvania we have structured our system such that there is an economic disincentive to our vendors to provide necessary care -- Let me strike that question. Let me just make it a statement. I don't really want you to answer it and then get into trouble with your counsel. And I could see I was leading that way.

For the record, my concern is that whenever you're in any type of vendor situation, and I say this in full recognition that across the Commonwealth, whether we're in our correctional institutes or otherwise, we are all

grappling with controlling health care costs and that's a part of reality of our budget. But my concern is that when we contract out vendor services we lose additional control with regard to the provision of necessary services.

And what my concern is that if we're saying to vendors, this is the fixed price of your contract to provide, using the example you were using earlier, dialysis services and we've pushed the whole responsibility onto you on this fixed cost, that what we in essence have just done is created a system whereby I'm going to identify less of a need that there is or I'm going to ignore health care problems that might exist because my contract, there is a disincentive in my contract to identify those needs and pay for them, because then I won't have any money left from which to have made a profit.

So to the extent that that is something that has happened in our past contracting practices within the Commonwealth, I hope that it's something that you're aware of in trying to change when we're letting new RFPs and changing the way we have health care delivery being done

within our correctional institutes.

I guess my second question along that line with regard to our current practices and our future practices deals with the dispensing of medicine. As it is right now, the cost of medicines within our correctional institutes, is that a cost that's bore by the vendor within each institution based on a lump sum or is that something that the Commonwealth picks up the tab separate from the cost to the vendor? Is my question clear?

MS. MARKS: I think so. I think it is. The vendor will be paying that cost. Up until this point, the state was paying that cost.

REPRESENTATIVE MANDERINO: So up until this point, if I am working on an assumption or at least if I'm working on an assumption that there have been instances or a pattern, whatever, if I'm working on an assumption that there have been cases where prescribed medicine was not available, am I correct in assuming that the problem lie not with the -- and if I assumed that the medicine wasn't available because no one had the money to pay for it or for some cost reason as compared to some ordering problem,

that that cost responsibility fell on the Commonwealth, our Department of Corrections and not on the vendor?

MS. MARKS: Payment to a medication has been the department's responsibility.

REPRESENTATIVE MANDERINO: How about ordering the medicine?

MS. MARKS: Ordering the medicine, obviously, a physician must write the order. However, nursing staff processes that order to the company.

REPRESENTATIVE MANDERINO: And that's Commonwealth people, not vendor?

MS. MARKS: That's Commonwealth nursing staff with the exception of two institutions, as I mentioned yesterday.

REPRESENTATIVE MANDERINO: I guess with the indulgance of the Chair, one final statement for the record. In your opening remarks, Ms. Marks, and I recognize that you are new, but I think it's important to point out that we talked about changes in the delivery system, not only to deal with management efficiencies and oversight, but also to assure the continued quality of health care delivered to the

prisoners. That's my paraphrase of your opening remarks.

I guess my concern is that I have real questions about the quality of health care we've been delivering and so I hope that any change in the system will not further compromise that but will truly enhance that delivery. Thank you, Mr. Chairman.

MR. CHAIRMAN: Chair recognizes Mr. David Krantz.

MR. KRANTZ: Ms. Marks, my question is since we're going to a health care provider, and I was under the impression that prior to that we had individual physicians, why don't we go back to individual physicians where the state can -- they might be able to, the cost might be a lot less than going to a provider that has to deal in the proper.

MS. MARKS: I would like to offer clarity before I respond. In that, presently, we have contracts, when I use the word individual, I mean --

MR. KRANTZ: Institutions?

MS. MARKS: Yeah, institutions. Each institution has a contract with a company.

MR. KRANTZ: I mean, prior to that. In other words, at one time I'm sure the systematic individual physicians were on the state payroll, no?

MS. YOUNG: On occasion, but very little.

MR. KRANTZ: I thought it would be a lot easier to employ individual physicians, state physicians, I guess you would call them.

MS. YOUNG: In my experience with the department, I've had more than Ms. Marks, so I will explain that history to you to the extent that I can. There have always been the contract arrangements to provide care to inmates, simply because of the numbers of physicians that you need, the types of services that you need provided, and whether or not the agency can provide those services inside. So contractual arrangements are nothing new.

MR. KRANTZ: Do you know if other states in the country, are they all contracted, do any of them have individuals?

MS. YOUNG: I couldn't respond to that.

MR. KRANTZ: Thank you.

MR. CHAIRMAN: Mr. Parrish.

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MR. PARRISH: Thank you, Mr. Chairman. Two very quick questions. Ms. Marks, in the past from all of the material that I have been able to peruse, staff turnover has been a major problem within the Department of Corrections. In your estimation, with this new plan that's being developed, will this reduce or enhance staff turnover in your estimation?

MS. MARKS: I've been advised by my counsel not to answer the question. I'm sorry.

MR. PARRISH: One of the issues that the Chairman raised yesterday, and I don't know that anyone took the time to read his opening statement that was just entered into the record, if my recollection serves me correctly, was the issue of fragmentation.

The LPNs as it was described to us yesterday are employees of the Commonwealth. Those people that keep records for the Department of Corrections with regard to medical services are staffed to the Commonwealth of Pennsylvania. The doctors are, for the most part, I guess, employees of the vendors who have contracts with the Commonwealth of Pennsylvania. That to me is a highlight of fragmentation in

our system.

How does -- Let me try to get around Ms. Young's advice here. How does one propose to undo the fragmentation that the Chairman highlighted in his statement yesterday?

MS. MARKS: I've been advised by my counsel not to answer.

MR. PARRISH: Thank you very much. Thank you, Mr. Chairman.

MR. CHAIRMAN: Thank you.

Mr. O'Connell.

MR. O'CONNELL: No questions at this time.

MR. CHAIRMAN: I want to put on the record that after yesterday's meeting with the department there were a number of concerns that were raised by individuals of whom testified before these respective committees that you're before today. And I want the record to reflect that I'm now directing that you take back to Commissioner Lehman that there was some major concerns that should not have been answered and questions that we believe that were relevant to our scope of work to deal with health care for inmates in the Commonwealth of Pennsylvania.

And since you're not permitted to answer these questions, you can take back this information to the commissioner, and I expect an answer for Representative Caltagirone, chairperson of the Judiciary Committee, and to the Health and Welfare Committee, myself, and we will disseminate it to the members of Health and Welfare Committee.

There were a number of complaints that were raised, in terms of medical conditions of the following persons. I want to first list the names of the individuals and their numbering. And I want to indicate that for the record upon meeting with the Judiciary Committee and Health and Welfare Committee members that were present that no punitive action be taken against these individuals because they cared about their health and had the fortitude and the stamina to come before our committee and at least share these concerns with us, which should be a concern of yours if you want to be the Bureau of Director for Health Services for this Commonwealth.

I do not take lightly the health conditions and concerns of those individuals,

whether they are staff or inmates, and that our committee is very committed to doing whatever it is necessary to assure the safety and the health of those individuals inside of the institution.

One is Mr. Lonnie Roberts, 8R5804; Mr. Jerry Rice, AS1796.

I want to point out for the record I specifically spoke to Superintendent Vaughn about this gentleman who had a hernia diagnosed over three years ago, no corrective surgery despite constant pain and the fact that he had numerous times been called down to sick hall and he gets different diagnosis frequently. That is a concern that I ask to have taken care of immediately. I do not even want to see anybody play with someone who has either symptoms of or complaining of what they believe may be a hernia and was diagnosed by a doctor that he did have a hernia but then was counteracted by another doctor saying he didn't have one. That's just playing games with people's health.

Mr. Eugene Watson, AM7601; Mr. Donald Reel, R-e-e-l, AF7267; Mr. William Warren, AM5892; Mr. Laurence Quinn, AS2761; Mr. Geary Turner, that's G-e-a-r-y, Turner, BS2748;.

Mr. Allen Young, AY5037; Mr. Theodore Schell, S-c-h-e-l-l, AF7923; Mr. Wayne Thomas, AP9127; Mr. William Saab, S-a-a-b, AF1902; and Mr. Grover Sanger, S-a-n-g-e-r, AH8015.

I want an immediate response to those inmate's health conditions. We will submit for the record and to the Commissioner other names. These were the worst case scenarios. We pulled out a list of many health concerns at the institution. Whether or not they are real or unreal is sort of like in the eyes of the beholder and some of those individuals that testified before our committee yesterday, there is some truth to some of the concerns that were raised, and that's why we're raising them with you so that corrective action can be taken.

Relevant to the RFPs, reform proposals for the Commonwealth of Pennsylvania, regionalization concept by the department, I would raiterate the discussion that I had yesterday, which was an informal discussion and not on the record, that my overall concern is the fact that in many of these institutions across the Commonwealth of Pennsylvania, as the population of African-Americans, Hispanics, and

other minorities that represent a disproportionate number of individuals that make up the entire Commonwealth of Pennsylvania, particularly by the location of the institution and their locale of where they may be presently in the Commonwealth of Pennsylvania.

With that in mind, it would seem to me that one of the overall concerns of any request for proposals would be the fact that those kinds of quality assurance piece is indicated. For example, where applicable and where pushed, we should be seeing that African-American doctors, physicians, dentists, and other technicals, psychologist and other services that can be rendered should be at least sought.. Where there are female prisons, there should be female doctors sought to take care of those inmates in those institutions where we have women incarcerated.

That overall contracts, in terms of what is meant, whether it is done by joint venture or subcontracting out, consideration should be given to African-Americans and minorities for opportunities to receive those contracts. What we have found is that many of

these contracts continue to follow the old boys network, take care of my boy, you take care of your boy, and I'll take care of them in the east, you take care of them in the west. They are all the same people. Most of the time what happens is that the people who needs to be rendering the service are not concerned about the service but are concerned more about the dollar profits and profit motives.

Our concern, Representative Manderino was trying to raise with you was the fact if we're going to overhaul the system and we're going to change it, then the compassion at the top has got to be in such a way that it doesn't seem to always be a punitive type of action that has to be taken because somebody says I'm sick. It's almost like because you locked up, boy, you stay locked up. Just because you say you're sick, I ain't got time to see you today. I think that's a nasty attitude. If that is one that permeates throughout the system, then it needs to stop and needs to be changed.

I think that Commissioner Lehman needs to hear that from those individuals who are raising, because if you can cover up or simply

feel that you're covering up or hiding or shielding or protecting those individuals who are not given the kind of treatment that they are supposedly seeing, then we're doing something wrong.

I would hope that since you have been silenced here today that perhaps maybe when you're unsilenced that we could really get into the depths of the health care delivery system for inmates in the Commonwealth of Pennsylvania that will have a tremendous impact on our direction as legislative body and as state employees who work for the constituency here in the Commonwealth of Pennsylvania, which is the people of the Commonwealth.

And finally, I would indicate that the questions that will be submitted, will be jointly submitted by Representative Caltagirone and myself to the department dealt with by staff and other concerns that may be raised and would hope that there would be placed a time limit with respect to when the questions are submitted in a timely fashion to have those questions responded back to me within a two-week period. It seems to me that that should be ample time to

respond to the questions that will come out from our respective committees.

I am upset. I hope that the message will be taken back to Commissioner Lehman that the committees both are upset that this was the course of action that legal counsel advised the Department of Corrections to respond to and that we want to get on with the business of the Health and Welfare Committee to try to place what we thought was a vicious and eager way to try to see how we could shape health care for all of the citizens, whether they were indigent, whether they were incarcerated, whether they were long-term care residents, AIDS victim, whatever they were, to put together our own universal health care plan, and we run into a snag with our own Department of Corrections to try to get that vital and necessary information to shape that for the Commonwealth of Pennsylvania.

I'm just mainly concerned that that is the position and hope that after these hearings that people who will read this testimony will have the availability of the department to share on the record the concern that we raised today

about humanity, compassion, and understanding. Those individuals who normally don't have anyone to defend themselves or fend for them because of the way they are. If we've gotten so big and so uppity and some capricious in our thinking that we don't have any human compassion in our heart anymore, aside from what legal says to us, but our own ability to be able to respond and see how we want to deal with our own population of those who are incarcerated, I believe that we are in a sad state of affair if we cannot get to that human side of element. So this would not have been necessary. We just had a few open dialogue because many of our members, just like anybody else, they know that there is a problem. All we want to do is correct the problem with that.

Recognizing that we appreciate your presence of you all coming down here today, but the commissioner should have just said, I ain't testifying, and I would have understood that much better than wasting your time having you come back to answer these questions and not having answered the questions. With that in mind, you're excused. We hope that you take the

information back.

MR. CHAIRMAN: Mr. Gene Boyle, I hope that you will be able to talk to us. You're the last person to testify and then we're going to take a quick break out for lunch, then we're going to come back. Just quickly. That's all.

For both of you gentlemen, since I know you best, Sam McClay, why don't you identify yourself for the record and then ask Mr. Boyle to identify himself and then both of you will be in order to proceed.

MR. McCLAY: Sam McClay, policy coordinator for the Secretary of Health, Commonwealth of Pennsylvania.

MR. BOYLE: My name is Gene Boyle, I'm with the Office of Drug and Alcohol programs, Pennsylvania Department of Health.

MR. CHAIRMAN: You're in order. You may proceed.

MR. BOYLE: Good afternoon, Representative Richardson. As I said, my name is Gene Boyle, I'm the director of the bureau of program services, and I'm here this afternoon representing the Pennsylvania Department of Health Office of Drug and Alcohol Program.

Representative Richardson, Deputy Secretary Peterson asked me to give her regards. She would have been here this afternoon, however, due to a conflict she could not.

MR. CHAIRMAN: Thank you for that.

MR. BOYLE: I am pleased to be with you and have the opportunity to provide comments to the committee. As we continue, and we're all aware that to combat the substance abuse problem we have to realize that if we are going to be successful we all must work together, all agencies of government, agencies of government with local communities, and certainly bringing it on down the grass roots organizations.

Serious drug use continues and certainly heals other criminal behaviors. Drug addicts, for example, are involved in approximately three to five times the number of crime events as arrestees who do not use drugs. And they have a significantly greater number of arrests than non-drug involved arrestees.

Following conviction, the overwhelming majority of substance abusing offenders are put on probation in their community under supervision. Those recognized to be more

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serious offenders are incarcerated. It is clear that for some offenders incarceration is necessary, for others regular supervision may be a very appropriate sanction. For many more substance abusing offenders, however, the choice between incarceration or probation is not sufficient. A range of programatic options must be offered.

Pennsylvania Department of Health, Office of Drug and Alcohol Programs has and will continue to impact upon this problem. Today over 750 prevention, intervention, and treatment facilities provide services statewide. I will attempt this afternoon to focus on some major issues of mutual interest.

Our enabling legislation in Pennsylvania Drug and Alcohol Abuse Control Act 63 of 1972 as amended essentially requires the department to have coordinating responsibilities for all drug and alcohol prevention, intervention, and treatment services. Our charge is universal for Pennsylvania citizens. It includes responsibility to insure that services are provided to persons who are under the primary jurisdiction of other state

agencies. To formalize this process, to provide for this process as well, that coordinated responsibility we have put into what we call memorandums of agreements, which recognize that the primary responsibility for identifying and providing needed services belongs with that state agency. The principal responsibilities of the Office of Drug and Alcohol is to offer technical assistance in determining service needs, recommending service models, and in the instance of treatment, visiting those programs annually as a part of licensure review to ensure conformity with our licensing standards.

The Department of Health, Office of Drug and Alcohol is a single state agency designated by the Governor to receive and disburse, not only the state funds, but the federal funds in addition. Generally, the department's philosophy is that the service needs and funding priorities should be determined at a local level. And we have accordingly developed decentralized system which we call single county authorities.

It is important, also, to note that our funding is based on annual appropriations and is

not entitlement funding. It is also important, I think, to state that a third primary funding source in addition to the state and the federal government's funding stream is Medicaid dollars, which are administered through the Department of Public Welfare for hospital-based, residential, and outpatient care.

Recent passage of Act 152 has allowed us to expand Medicaid coverage services to include today beyond hospital-based residential care settings in certain counties in the Commonwealth.

For the adult offender population, the department offers assistance in four primary areas, first dealing with the state correctional institution. Beginning in 1973, the department helped establish a therapeutic community program which was designed to provide intensive drug treatment for acknowledged drug abuse offenders and in that case in SCI, Camp Hill.

Over the past five years, ODAC has provided the Department of Corrections with $6.5 million to expand these services throughout other state correctional institutions. Therapeutic communities now exist at Graterford,

Crescent, Huntington, and Muncy.

We also provide funds to the Department of Corrections in the last two fiscal years to hire 45 drug and alcohol trained staff personnel to provide drug and alcohol treatment services throughout the SCI system. Over 535 inmate clients received services in therapeutic communities last year. This number does not include the number of inmates who received drug and alcohol education, intervention, and/or treatment provided by the above-mentioned treatment specialists in those 45 physicians.

We know that the number of inmates that can benefit from drug and alcohol education and counseling services is quite large. Our mutual resources may not be sufficient to meet the demand. However, much of the programming that we have been involved with is still new and we must together do more evaluation to determine its effectiveness and to determine what more needs to be done.

Presently our major concentration in working with the Department of Corrections is in the licensing of the five therapeutic communities and working also with the department

to establish appropriate treatment relative to their boot camp initiative. Our respective staffs have been working together for more than a year in the Department of Corrections Licensing Policy Manual. And our site visits are expected to begin sometime in June of this year.

The department also hopes to collaborate with the department to respond to some federal funding initiatives provided through the center for substance abuse treatment in Washington to provide additional dollars for initiatives for the incarcerated population.

A relatively new development is the creation of community correctional facilities, mostly operated by the private sector, mostly through contracts with the Department of Corrections. The facilities have significant cost savings potential for the correctional system, and we are trying again to work cooperatively with the department to ensure that proper treatment services are met based on licensing standards.

In addition to working with the Department of Corrections, we have been involved

with the Bureau Board of Probation and Parole through a joint funding initiative, which provides over $600,000 to our single county authorities here in Philadelphia and in Pittsburgh. The initiative is to provide for inpatient and outpatient funding for treatment services.

The project also allows in particular from the Board of Probation and Parole an intensive program of supervision to parolees who have had a history of drug dependency and who are considered to be of high risk through the use of the board's client assessment process. Last fiscal year over 1,172 clients in Philadelphia and an additional 461 clients in Pittsburgh received such services.

Treatment alternatives to street crime is the third area that I wish to discuss with you this afternoon. Task, as it is commonly referred to, is a project designed to be a catalyst between state and county criminal justice agencies and drug and alcohol treatment services. It is to reduce substance abuse related crime and criminal recidivism among the drug and alcohol abusing offender by providing a

mechanism for assessment referral and monitoring.

Currently, there are 12 Task programs in 13 counties throughout Pennsylvania. In 1991-'92, 4,943 evaluations were completed for individuals to enter Task and over 2,000 individuals received treatment as a result of those coordinated efforts at the local level. ODAC is currently working with the Pennsylvania Commission on Crime Delinquency to expand the number of counties presently providing Task.

The Pennsylvania Commission on Crime and Delinquency also provides from their block grant funds in conjunction with us what is called the drug control systems improvement initiative, whereby ODAC and PCCD jointly fund programs at the local level. Grants that go to develop comprehensive prison overcrowded reduction programs and have hopefully an impact on individuals, both not only at the tail end of incarceration, but also at the front end. These dollars have allowed 730 individuals to receive again either inpatient or outpatient treatment services last year.

In closing, I would like to thank the

commission for allowing me the opportunity to be here today and for your continued efforts in leadership in addressing the challenges that we face in dealing with the criminal justice population. Thank you.

MR. CHAIRMAN: Thank you very much. We appreciate your testimony. Chair recognizes Representative Manderino.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman. I just have a few questions. As a baseline, maybe it would be helpful to me to know what responsibilities does the Department of Health have with regard to hospitals and clinics and other health care providers outside of the prison system, in terms of licensing or looking at the care that's being given there.

MR. McCLAY: Mr. Boyle can comment on the responsibilities with drug and alcohol. But they are very similar to our other responsibilities in general. There are some exceptions. But in general, the department has been given the statutory responsibility to license certain health care providers, hospitals, nursing homes, drug and alcohol treatment providers, and so forth. It is a

licensing, in some cases a certified responsibility.

REPRESENTATIVE MANDERINO: When you're licensing or certifying those kinds of institutions, what are you measuring, what are you looking for?

MR. BOYLE: In the institutions, we just began to develop those processes. It was up until right now it was never -- Let me step back. We started about two years ago to work with the Department of Corrections to begin licensing. It was always a question whether or not we had the right to license another state action. Typically, we were licensing providers, drug and alcohol community providers.

It was agreed by both the Health Department and Corrections that we would begin licensing about a year ago. Part of that licensing process at this point where it was at was they needed to develop a manual for us to begin to review based on the types of services that they were offering. We are at that state right now. We are also going to move forward to developing, I think, your question specific standards for correctional institutions which do

not exist now.

REPRESENTATIVE MANDERINO: You're talking about with regard to provisions of services for drug and alcohol treatment?

MR. BOYLE: Yes.

REPRESENTATIVE MANDERINO: Heretofore there's been no oversight, can I take it from your comments, or responsibility by the Department of Health with regard to standards of provision of health care within the correctional institutes in general, general health care?

MR. McCLAY: General medical care, we do not license the state or the county prison facilities.

REPRESENTATIVE MANDERINO: Do you license as an entity their contracting service for vendors of providers?

MR. McCLAY: The individual physicians licensing is done by the Department of State as with nurses and mid-levels.

REPRESENTATIVE MANDERINO: That's my license to practice medicine.

MR. McCLAY: If they are contracting with a Health Maintenance Organization, that Health Maintenance Organization must be licensed

and is licensed by the Department of Health. If they are contracting with an individual doctor for a service that is not licensed, there is not a specific license for that, the Department of Health is involved.

REPRESENTATIVE MANDERINO: You were with us yesterday, sir. Do you see any value in the future to us as a Commonwealth looking at whether or not the Department of Health should have a more active role in licensing the general provision of health care services within our correctional institutes?

MR. McCLAY: I would say several things. One, that the relationship between state health departments and state departments of corrections vary from state to state. There are generally two broad models, one is where they are separate and where the prison system is responsible for those services and the health department is in an advisory capacity without any official jurisdiction.

The other is where the Department of Corrections in certain states are not responsible for the management in the development of health care services. So there

is a range throughout this country between those different relationships. I would say that in Pennsylvania, the Department of Corrections has been in contact with the Department of Health over a variety of health care issues, Tuberculosis, AIDS, and so forth. I would say that over the past several years, since at least Secretary Noonan has been with the Department of Health, there's been a very active dialogue back and forth between the two departments.

It affected itself in two ways. One, they are asking us for our medical expertise, and two, they are using the information when we give it to them. Unfortunately, I can't say that's always been the case that I've had reported to me that's not always been the case. This has been a very instructed improvement. I do not mean to say by that that they are mandated to have to accept our price. That they are not.

REPRESENTATIVE MANDERINO: Thank you, Mr. Chairman.

MR. CHAIRMAN: Chair recognizes Mr. David Krantz.

MR. KRANTZ: I don't have any other

questions.

MR. O'CONNELL: No questions.

MR. CHAIRMAN: I just want to approach with you this discussion around regionalism for a minute. What is your feeling about the Department of Corrections going to a more regional system on the delivery of health care services for inmates in the Commonwealth of Pennsylvania?

MR. McCLAY: The mechanism which you contract out for services, via health care services or other, should be weighed against what is the actual provisions of services, specifics of the contract. First, the request for proposal that's being administered and is being led out for review and then bidding, and then second, the actual provisions of the contract.

I think you all have just naturally because of the way the demographics of Pennsylvania exist, you will have in some areas where you will have an easier ability to find providers than in others. You will have areas where costs will vary from one point to another. With both of those differences, you can still

accomodate contracting, as well as individual contracting.

The guts of what the tests that you value yourself is what will the service be to the consumer. It's going to be the end consumer of that service, what is going to be expected of that provider, whether it is the state agency that contacts directly with Dr. X or whether it is the state agency contracting with a management organization. The trend around this country, as I'm aware of, is to have a more managed approach. That's why you do have some of these national organizations, and the one the Department of Corrections uses at this moment is nationally based out of St. Louis. They are a national buyer for health care services. There's been a growing trend to that. I think in part the difficulty is in finding a provider. They can subcontract out physicians and health care providers usually in that local community if they can find them.

There are also varying degrees around the country as to what level are those employees, are they employees of the system or are they private individuals who they then

contract in? Again, whether they are state employees or the department of corrections or whether they are private individuals who contract with the department and, as you heard yesterday, there is a mixture, and the state is moving to make more of them, state employees at the nursing level, not at the physician level.

MR. CHAIRMAN: You believe that the correctional institutions in the Commonwealth of Pennsylvania with respect to the numbers that we have inside these institutions will ever really get to qualitative assurance in health care for inmates in Pennsylvania?

MR. McCLAY: I think that's probably a relative question, in that will it be quality compared to what?

MR. CHAIRMAN: Compared to nothing.

MR. McCLAY: Compared to where they are?

MR. CHAIRMAN: Compared to where they are. I don't want to say nothing. Strike that. Compared to where they are now and where they should be.

MR. McCLAY: Again, I think that ultimate test of that, the ultimate answer to

that is what is it you're requiring them. What are they requiring in this case they are contracting out to their provider, and two, do they have the resources, literally the individuals to do the watchdog to make sure the providers provide that service.

I thought it was very encouraging what I heard the last couple of days to hear that the department is starting to create positions to do watchdogging. I think the whole idea of Bureau of Health Services has never existed in the Department of Corrections before and to have it at that level and then have staff meetings at regional levels. They don't provide any service. All they do is watchdog to make sure that those services are there. It at least has the potential, greater potential than I've been aware of in the past. But, of course, ultimately the legislature has the ultimate oversight.

MR. CHAIRMAN: Mr. Krantz has a question.

MR. KRANTZ: Thank you, Mr. Chairman. Can you tell me, the Department of Corrections mentioned that inmate health services cannot be

paid for by federal funding.

MR. McCLAY: Federal assistance.

MR. KRANTZ: Is that a decision by your department or by the United States or what?

MR. McCLAY: The restrictions for that is both a state law and in federal law. Federal law would supersede. The state couldn't override it. But the Commonwealth adopted also the restrictions that exist, not just in Pennsylvania, but around the United States.

There is a case pending relating to Texas that's been pending for a couple years regarding this matter, but that is correct, it is federal.

MR. KRANTZ: Across the whole country, the public assistance cannot be used to pay for health care services for any inmates?

MR. McCLAY: Not public assistance in the meaning of taxes, but medical assistance for medical health care in an institutional residential setting. That's right, be in a prison or be in our state mental hospitals, although there is some suits filed regarding mental hospitals.

MR. KRANTZ: Yet the federal government

will pay for an individual off the street?

MR. McCLAY: That's correct. They make a clear distinction.

MR. KRANTZ: Would you find it advisable for the states to put together a class action suit against the federal government to provide those services?

MR. McCLAY: The Commonwealth has filed, I believe, I haven't been involved, I believe that they had filed an amicus brief, as well as other states, on the Texas case. They have joined in in support of the State of Texas in that suit.

MR. KRANTZ: Thank you.

MR. CHAIRMAN: Would you send the committee that brief, if you can?

MR. McCLAY: I'll see -- The Department of Health did not file that that I'm aware of.

MR. CHAIRMAN: Just tell us where we can get it. We need it.

MR. McCLAY: I'll try to assist you in entertaining that.

MR. CHAIRMAN: Thank you very much. Appreciate your testimony here today. Send our

regard back to Secretary Noonan, Anderson, and Deputy Secretary Reese. We will now break for a half-hour for lunch, give our stenographer a break, and we'll have a quick lunch and be back with Dr. Lewis Polk.

(Recess)

MR. CHAIRMAN: The time of recess having expired the Health and Welfare and Judiciary Committees will come to order.

For the record, Mr. Bill Faust, F-a-u-s-t, Alliance for the Mentally Ill, could not stay. Therefore, he has submitted testimony. The following document was to be issued into the record and that we indicate title concerning violence and relationship to mental illness by Madeleine Goodrich, forensic executive committee, and has a start and end to it. That's the only thing I would like to have submitted for the record.

(Submitted testimony of Mr. Bill Faust, Alliance for the Mentally Ill)

Dr. Lewis Polk, director of the Gordian Ehrlacher, public health administrator, Bucks County Health Department.

Would you gentlemen identify yourself

for the record?

MR. POLK: Yes. I am Dr. Lewis Polk, the director of the Bucks County Health Department. With me is Mr. Gordian V. Ehrlacher, E-h-r-l-a-c-h-e-r, the public health administrator in Bucks County Health Department. I have an opening statement, if I may, sir.

MR. CHAIRMAN: Please proceed.

MR. POLK: In my opening statement, I will focus on why we believe that the health services that we provide to the inmates of the Bucks County Prison are of good quality. Mr. Ehrlacher in his opening statement will focus on why we operate our prison health services ourselves and have chosen not to privatize it. He will also discuss a number of measures that we have taken to control the costs of the program.

In the fall of 1987, just about one year after I arrived to lead the Bucks County Health Department, we had a site visit from representatives of the National Commission on Correctional Health Care. At the end of a multi-day inspection, the visitors from this national accrediting organization gave us a

verbal report of their findings. The terms they used included, quote, the Bucks County Prison Health Program is the state of the art, closed quote. And it is at the, quote, cutting edge of excellence, closed quote. When the official written report arrived, it did not include those exact words. However, to describe our present health program, it did use the words, quote, fine, closed quote, and, quote, outstanding, closed quote.

I said that we were inspected soon after I started working in Bucks County, because I wanted you to understand that I was not attempting to take the credit for the excellent evaluation since the Bucks County Prison Health Services was already in place before I got there. However, Mr. Ehrlacher had already been working with the Bucks County Health Department for about a decade and a half by then and he does deserve credit for helping to make it a program of superior quality.

The Bucks County Prison Health Program had been inspected and accredited a number of times prior to 1987 and has been inspected and accredited a number of times since. To date, we

have been accredited for a total of 14 years.

I have chosen not to stress the opinion of those of us who work for the Bucks County government that we have a good program. Instead, I emphasized a formal evaluation by an outside agency and national accrediting body for correctional health care that the Bucks County Prison Health Program is a quality operation.

Now Mr. Ehrlacher will give you his opening statement.

MR. EHRLACHER: Thank you. Very simply, my statement will focus on two things. We had the opportunity to privatize several years backs and opt not to do so, and also I will share with you some of the things that we have attempted to do to reduce costs in the prison health system, which is a major concern, but also to maintain a level of care that we have consistently provided since we've been in the health care business in the prison.

The Bucks County Prison is a two-segment vehicle. It has approximately 550 inmates in the prison structure itself but also has a rehabilitation center that houses 250 plus inmates. We are responsible for the health care

for that total population.

November of 1989 we had brought in a private contractor who specializes in prison health services. We asked them to do assessment of our program and to provide us with cost estimate of what it would cost to privatize the program. He came back to us and he gave us an estimate of our program that would run about $1.6 million a year. We were currently spending a little over $1.6 million at that time ourselves. His proposal, however, would reduce the number of staff that was going to be used in the health care system and would also reduce somewhat the type of services that we would and could provide, such as methadone clinic and things of that nature. Subsequently, we opt not to privatize it. And the reason being that all the other arguments for privatizing did not fair with our system, because the county had seen the wisdom of turning the health care services on the prison over to the health department.

Subsequently, our philosophy of care, our tradition of dealing with low income minorities and population based that helped, we were probably a better system of looking at

these people and providing them with the health care they needed and did not get involved in who is in here for what and all the other things, the arguments we talked about.

At that point in time we made the decision we would not privatize and then we began looking at our own system, and we have what we feel is a quality system. We're still able to do a quality system but we're still cognizant of rising costs.

Some of the things that we have done, we've established a prison health advisory committee, which is made up of administrators from the correction system, from the health department, and most of all employees either under the contract or of our agency who provide the hands-on care to the inmates. We meet quarterly. We discuss policies, procedures, and, of course, we also look at the costs of the operation.

In doing this, we're able to communicate between the correction system and the health system, minimize all the problems that come up when you have different people working within an organization. And we made

recommendations to the commissioners as to where we should be going and how we should deal with the situation.

Out of this committee has come a number of things, we have a very astute quality assurance program. Our medical doctors and our nursing staff review all the medical records or most of the medical records which are randomly sampled of the inmates. They make sure that the inmate is getting the type of care he or she needs with the medical problem that's addressed, they make sure that the pharmaceutical regime is appropriate, they make sure that the person has been seen by appropriate specialist. And it's also another factor, we want to make sure we're not doing overkill either. It's worked quite successfully. The number of errors you come up with has been very minimal, mostly in the recordkeeping.

The other factor that we have been able to do as a result of that committee is that we initiate a pharmaceutical formula, which means that the doctors can only prescribe medications at the lowest cost unless they justify doing otherwise. The reason for this is the cost of

pharmaceuticals are very expensive, and there are a number of drugs on the market that are just as suitable for the inmate. However, no inmate is denied the drug that medical protocol requires just to save money. In other words, if the doctor can substantiate that this is the drug that is going to give this person the relief to correct the situation and give him the comfort that he or she needs, that will be the drug they will get. In implementing that, we were able to substantially save I would say in the area of 80 to $90,000 a year in drugs alone.

We also brought in mobile X-ray units, which cut in half our X-ray services by costs of the X-ray itself and the reading. In addition to that, we've eliminated the need for two prison guards to transport an inmate to a local hospital and bring them back and that cost factor.

And last, but not least, I've already mentioned the quality assurance program, but the quality assurance program is not a cost program, it is a medical health care program. We are very cognizant of treating the inmates the same manner that they would be treated and maybe even

a little bit better, depending where they come from, as if they were outside the prison walls. We are in the business of health care, we are not in the business of correctional care. Thank you.

MR. CHAIRMAN: Thank you gentlemen very much. I appreciate your testimony. In the 550-person inmate population that you have in your system, how many are women?

MR. EHRLACHER: I think right now we are close to 60.

MR. CHAIRMAN: Can you give us a racial breakdown of African-Americans, Hispanics, and other minorities in the institutions in Bucks County?

MR. EHRLACHER: I cannot give you an accurate breakdown at this time. I could get that information for you. I could give you an estimate. I would say approximately the Afro and Latino would be about 33 percent of our population.

MR. CHAIRMAN: Are these inmates that are in Bucks County because of the nature of physically the locale of Bucks County, persons who are incarcerated who live in Bucks County?

MR. POLK: No. That really explains the difference in the racial and ethnic make-up that Mr. Ehrlacher said. These are people that have been either arrested and cannot pay bail or have been convicted of crimes that took place in Bucks County and that they do not necessarily live in Bucks County. Bucks County's own resident population is somewhat different racial and ethnic make-up.

We also have some people in our county prison who really have been convicted of state crimes that either through plea bargaining or other arrangement have been set up to serve their state service here in turn in the county jail. We even have at times some federal prisoners that end up spending some or all of their sentence at that time.

As you know, typically, the people in the county jail would be usually short-term, short sentences. People usually stay over two-year sentences usually end up in the state institution for the reasons given before. Some of them who really should be in the state institution end up in ours and even some in the federal.

MR. CHAIRMAN: Can you give us a breakdown delineating separate from the federal and state, what is your average net for the stay of inmates in Bucks County?

MR. POLK: It's probably less than six months. That's sort of not precise, but it's less than six months. So we're dealing with people with basically short sentences. This, of course, makes the problem of giving health services to people who are in for a relatively short time even more complex than it would be in a state correctional facility where you know the person is going to be there a longer time and even to follow up with certain tests and follow up with certain things from a standpoint of making sure the person is still there when you have to do the next step in the process is a little bit easier in that sense in the state institution than it is in ours, particularly since some of ours, as I mentioned, are there because they can't make bail. If they later make bail, they can be out quickly. The tests you do on them today, you want to see them in two days, they aren't there sometimes in two days, they are out on bail by then or whatever.

MR. CHAIRMAN: You raised this point. With respect to the number of inmates, how many doctors then are servicing the 550 inmates?

MR. POLK: Again, we have a total of -- First, I should say all of them are part time, we do not have any full-time prison physicians. They don't spend 40 hours a week in that role. We have in essence four physicians who focus primarily on the main jail and the other physician spends his time currently primarily in what we call the work release or rehabilitation, where the person goes out to work at a job in the community and comes home -- comes back to the correctional facility at night to stay. We are talking about four part-time physicians focusing on the main prison where people don't leave, and then the fifth physician is focusing on the rehabilitation slash work release.

Some of the people in their work release program are able with permission to even go to their usual physician out in the community, some of them have that ability financially and other ways, and with permission are able to get their medical needs taken care of that way. Those who either have no such

source of care or choose not to use it are getting their medical care in the work release facility through our fifth physician.

MR. CHAIRMAN: The absence of full-time physicians, you have full-time nurses?

MR. POLK: Yes. We actually cover, we have seven day a week, three shifts a day of nurses, and we have primarily full-time nurses. We have some nurses just for scheduling standpoint who are less than full time. They may work two or three or four times a week. Our typical nurse will work a full five-day week. Because of seven-day coverage, that five days may not necessarily be for a given nurse Monday through Friday. We schedule it, as I said, to have full-time coverage around the clock. And during the daytime hours, we have more than one nurse on duty.

MR. CHAIRMAN: Final question. How does the normal routine of the day -- Let me do it this way first. Make it two parts. What does your system do when an inmate first comes in the institution?

MR. POLK: All the inmates come in and they get a screening by the nurse, they get a

battery of tests, which includes a tuberculin test and other tests. If indicated, they will be signed up to be seen by a physician to follow-up what the nurse has seen. They have the sick call, so that an inmate can request to be seen after they are in the correctional facility and the nurse will see them and can either handle the problem following standing orders and written in advance protocols or they can be seen by the physician.

MR. CHAIRMAN: Now, you used the word screening. You're a doctor. You used the word screening as opposed to examination. Is that the same thing?

MR. POLK: Again, you're quite right. These are technical terms. The nurses sometimes use the term assessment. A nurse, unless she's a nurse practitioner or unless we would have and we don't have physician assistants, don't do a complete physical as a physician would do. But they do check and they are qualified to do so, things like heart and lungs and blood pressure and on and on. Obviously, there is a difference between the physicians and the nurses. And again, since we do not employ nurse practitioner

or physician assistants, all of our nurses are RNs, registered nurses. We do not use in that setting licensed practical nurses or nurses aides. These are all licensed registered nurses, and they are qualified and legally able to do what a licensed registered nurse can do, which, as you correctly pointed out, is somewhat different than what a physician is licensed and legally able to do.

MR. CHAIRMAN: How many do you have?

MR. POLK: May I ask -- We have ten full-time RNs and four part time. Again, that is we're able with that combination to schedule the seven day a week, three shifts a day coverage. And on the daytime shifts we have more than one nurse present.

MR. CHAIRMAN: How many African-American or Hispanic nurses and doctors?

MR. POLK: None at this time. The staff more accurately reflects the population of the county. The county at this point in the 1990 census was 95 percent white. It had been between 1 and 2 percent Hispanic, between 2 and 3 percent African-American, and the rest would be made up of Asian and Pacific Islanders. So

people who work there or those who live somewhere in the general area are more likely to be taken from the pool of people that live in the county while the inmates are those who would be those who committed crimes or are accused of having committed crimes in the county. And therefore, there is somewhat different ethnic make-up.

MR. CHAIRMAN: With 32 percent, if I heard you correctly, African-Americans and Latino and Hispanic individuals in the institution, in your overall care of delivery, particularly for psychiatrists or sociologists or some other that may have a particular understanding of one's particular ethnic background versus another background, particularly since they are in a different environment, since you've already indicated there, Bucks County, they are not too far from, have any thoughts or consideration by you or Mr. Ehrlacher, have either thought or viewed the opinion of whether or not it would be a necessary or consideration for the institution?

MR. POLK: We certainly have thought about it. Again, I don't have the advantage of

having heard the testimony which I understand was earlier today, as well as yesterday, but while we are able to staff our facilities with people we hire as opposed to privatizing the cooperation, recruitment, and it varies at different times, nurses and physicians and other health professionals to work in a prison setting is not easy.

We certainly will give additional consideration. We do attempt in our work with the people who staff the operation, attempt to do what we can to increase their sensitivity to people of different backgrounds than themselves. But there is a very real recruitment problem of getting people who might be from a racial or ethnic make-up closer to the mix of the inmates. It would possibly mean people having to come from other geographical areas and the increase time and so forth.

Particularly, for the physicians, who I mentioned are not full time, it's difficult to ask somebody to drive an hour or more for a job which on that day may only be a two or three hour assignment. But that's certainly something which we have considered. At the moment we are

doing our best to try to increase people's sensitivity, even though they themselves may not be of the ethnic or racial group that a very significant proportion of the inmates are.

MR. CHAIRMAN: This is my final question. Have you been accredited by any national or statewide commissions that give accreditation to standards and where you stand, in terms of other county facilities throughout the Commonwealth of Pennsylvania or throughout the country?

MR. POLK: Yes. Actually, I believe I mentioned in my opening statement that the National Commission on Correctional Health Care, which is a national accrediting body, which has many sponsoring organizations, both in the medical and the correctional and the criminal justice side has been repeatedly checking us not only on a paper evaluation but an on-site, more than one day visit maybe, with a very thorough check and they have been accrediting us approximately every two years for the past 14 years. We have been continuously accredited by this national accrediting body for prison health services and we are currently accredited and

have been continuously since 1979.

MR. CHAIRMAN: Are you given points?

MR. POLK: Points. I don't believe it is done so much with a point setup. They break their standards into essential and important -- And you have to have, I believe you have to have -- you have to be in compliance with all the essential criteria or standards, and you have to have, I believe, 85 percent of the important standards. And we have met those percentages and those criteria, and thus, we have been accredited and still are.

MR. CHAIRMAN: Thank you very much gentlemen. Mr. Krantz?

MR. KRANTZ: No questions, Mr. Chairman.

MR. CHAIRMAN: Mr. O'Connell.

MR. O'CONNELL: No questions.

MR. CHAIRMAN: Mr. Boyd.

MR. BOYD: Just one quick question, Mr. Chairman. This is in reference to you used a couple of technical terms, assessment or examination of inmates. After the initial entry examination, how often do you examine the inmates thereafter?

MR. POLK: May I just have a fast consultation. Mr. Ehrlacher has reminded me that even though we are primarily a short-stay institution, as we discussed before, since we may have some county people who will be there a period of time or, as I mentioned, the federal or state people, we do have a pattern, as I was just reminded, that someone who is there a longer time will be rechecked, to get away from the other technical terms, on an annual basis. Again, the overwhelming majority of our folks are not going to be there that long to need or to get an annual recheck.

MR. BOYD: Thank you, Mr. Chairman.

MR. CHAIRMAN: Chair recognizes Mr. Parrish.

MR. PARRISH: Thank you, Mr. Chairman. Gentlemen, could you tell me how much it costs per resident for health care?

MR. POLK: Again, I will pass this on to our money man, Mr. Ehrlacher.

MR. EHRLACHER: I didn't understand. Our per cost per resident, my last figures were $5.40 a day.

MR. PARRISH: $5.40 a day.

MR. POLK: That's just for the health, not the total correctional.

MR. PARRISH: With regard to your part-time physicians, how many of them are primary care physicians and how many specialties do you have within your universe of physicians?

MR. POLK: The basic answer there is the physicians we have are the ones that come that are on-site and handle the physicians sick call. They are all primary physicians in the sense of either general physicians or internal medicine physicians. We do, however, have a network of specialists available either through a nearby hospital or through contractual relationships with specialists in various forms.

So if someone needs a cardiologist, someone breaks a leg or sprains an ankle badly, you can see an orthopedic specialist and on and on. Someone that is very seriously injured can be hospitalized or transferred to a medical school teaching hospital, if indicated. But the physicians on-site are primary care physicians, but they do refer. That's, obviously, one of the things that make our costs where they are, because things that require further specialty

care will, in fact, be referred to the specialists.

MR. PARRISH: My last question has to do with quality assurance. Could you tell us what model you followed in developing your quality assurance program?

MR. POLK: The model we use is one of the standards. I mentioned the National Commission on Accreditation Health Care as one of its standards relates to quality assurance, and spells out the criteria that a system of quality assurance should be. We certainly set up a model that we, in fact, have been approved by the accrediting body as meeting their standards.

Basically, it is a pattern, if I would like to go into it a little bit, where we every month pick a sample of the patient's charts. We do it in two ways or three. One, we pick a certain fraction, like every tenth chart; two, we pick every patient that is referred outside either admitted to a hospital or to see a specialist; three, we have a disease or condition of the month. One month we might take everybody with a diagnosis of hypertension or

high blood pressure, another month we may take someone who has diagnosis of diabetes, another month everybody who has a diagnosis of epilepsy.

We have those charts reviewed first by our head nurse to go over to make sure that the various things are there, that all the blanks in the forms are filled out, that the chart is legible, that if somebody ordered a blood test that it was done and the results got back. Then we have each chart that was to be reviewed reviewed by a reviewing physician. Physicians rotate in rotation pattern, and each medical chart is reviewed to make sure that the overall history and physical findings are in line with what the diagnosis was felt to be, what the follow-up in the way of tests or further treatment, rather the thing made sense. We do that for all the charts that are selected out by the various methods that we choose.

Then we have the results of these monthly quality assurance reviews tabulated and computed, and they are then reviewed at the quarterly correctional health care meeting, multi-disciplinary meeting that Mr. Ehrlacher spoke about previously. And we in a formal

sense go over those every quarter and make sure that a group as a whole agrees with the findings and see if there is any systematic or institutional problem for any ongoing type of concern which needs special follow-up.

MR. PARRISH: Last question as an addendum. You mentioned that you decided not to privatize. Was that an individual county decision or did you have discussion with other counties and decide that you would use your right of first refusal to not privatize?

MR. POLK: Well, we did send our head nurse for the whole department and supervising prison health nurse to several nearby counties which did privatize. And we got, again, in very indepth discussion with them and on-site visit to these other places.

We then, as Mr. Ehrlacher said, requested a proposal from a national firm which provides this service. Then we analyzed this, and again, was totally up to Bucks County government. As Mr. Ehrlacher mentioned previously, both on the fact that the economics would not lead us to wish to privatization and that the quality of care in the sense of the

level and number of staffing we thought that we were doing was superior to what the proposal from the firm was offering. So we would not save any money. In our judgment, we would get a lesser level of staffing and a lesser volume of staffing than we had. So we felt there was no advantage to us to privatize, and therefore, we chose not to.

MR. PARRISH: Thank you very much. Thank you, Mr. Chairman.

MR. CHAIRMAN: Thank you gentlemen very much. We appreciate you being here and your testimony.

Next person to testify will be Dr. Gary Carbone. Identify yourself for the record, sir.

DR. CARBONE: Dr. Gary Michael Carbone.

MR. CHAIRMAN: You're in order. You may proceed, sir.

DR. CARBONE: Good afternoon. I was asked by your administrative assistant to appear today. I don't have anything prepared, sir. I was asked by your administrative assistant to appear today perhaps to be of some assistance to the investigation.

I was employed at Graterford Prison for

approximately four or five months two years ago. Based on some of the conversations that I had with your administrative assistant, at that time he thought I may be of some help to you, and I'm at your mercy.

MR. CHAIRMAN: At my mercy. Okay. Let me ask this question, sir. In your employment with the Graterford Prison, how did you find the health care to be?

DR. CARBONE: Poor.

MR. CHAIRMAN: As a result of your activities, were you able to document this poor health service, delivery service?

DR. CARBONE: Document in the sense, where I had written down on paper, yes, at one time. However, it's been two years since I've been employed at Graterford and had no reason to keep any further documentation, although I do have specifics that I will never forget up inside my cranial vault. I'll be more than happy to pass that along to you..

MR. CHAIRMAN: Let me do it this way, so we don't have to be real lengthy about it. Why don't you give an example of what you encountered and what you saw as being part of

poor health care.

DR. CARBONE: I think, first of all, since I've been here, I've heard a few terms that I thought were the problem, that is privatization brought up by the distinquished gentlemen that just left this table. I think overall that might be the root of all of this. I think once you privatize health care, it becomes a matter of economics for the people whose company it is that is supplying health care to any institution, not just in medicine, but as a general principal. I think that health care is something that is best left to the physicians.

The privatization of the organization that they had at Graterford was a private organization that was headed by two non-primary care or headed by one non-primary care physician who hired a non-primary care physicians as part of their administrative team. Both of those individuals were psychiatrists, who hired an anesthesiologist, Dr. Rahman, took him in as administrator.

Although our licenses as physicians in the State of Pennsylvania states that we are

eligible to practice medicine and surgery, which it says directly under physician's license to practice medicine, I feel that in a case where one of your family members had a sore throat, would you send them to a psychiatrist; or one of your family members had a heart attack, would you send them to an anesthesiologist. I was one of the few primary care physicians that they had there, although I know there had been other people there who were primary care physicians.

But the administration of this system they had there, private system were non-primary care physicians. These are the people that were dictating the policy of health care in institutions. Now, on the other hand, I just heard testimony from this gentleman here who gave testimony on the institution that comprised 5 or 600 individuals, 5 or 600 inmates. Graterford Prison is the seventh largest prison in the world, on any given day can have anywhere from 5 to 7,000 prisoners. It's ten times the size of this previous man we just heard.

I do not have a lot of nice things to say about the system in general, the medical system, as far as the medical care in general..

MR. CHAIRMAN: How would you describe the attitude of the private vendor who had the health care services at Graterford over all?

DR. CARBONE: To make money at the expense of common health practices, I was hired to administer health care for a large population of the prison. I ran the sick hall system, as well as the various subspecialty clinics which were in my specialty, some of which were not in my specialty. I worked full time. I think I was only one of two or three full-time physicians that were working there at the time. But I think to answer your question, to characterize it, I think to make money it costs to make money.

I think -- I may have this wrong. I'm not a businessman. But I think if the budget is $8 million per year and you spend $2 million on health care, then your net profit is going to be $6 million, and that's what I think is the bottom line in health care.

Let me just make my point a little bit more clear for you. I was dictated policy by two non-primary care physicians who were psychiatrists. I was hired by them. As a

physician running a tuberculosis clinic, every inmate that was processed through the Graterford system coming in had a tuberculosis test. To me, in my medical training, if someone had been considered a recent converter, which means if they had a tuberculosis test at another institution six months to a year prior and had a negative result, came to Graterford, and it was interpreted as a positive result, those patients were to be X-rayed and then treated with prophylactic, anti-tuberculosis medications. Recent converter status requires treatment of at least one medication.

Just before I came down here, I made a stop at the chairman of the Department of Infectious Disease at the medical center to review this. This may be something that I bring up. Please let me. As of 1993, what is the current treatment modalities for patients who is recent converters of tuberculosis testing. It's exactly that. In 1993 what I just described. They are recent converters, those patients require at least one medication.

Now, at that time in a forthright manner, I was referring these patients for

X-rays with the idea they may indeed have tuberculosis. As far as the non-primary care physicians dictating policy to me, I was then instructed by them not to write that on the charts anymore or there would be investigation as to why we have so much tuberculosis in Graterford Prison. I don't know if I can substantiate that. But from the bottom of my heart, I'm telling you the truth not to document that information any further.

There have been cases there that were out of my control. I ran the sick hall at various clinics, and I was basically under another physician, Dr. Rahman, who was, I believe, the person who ran the infirmary. And on various occasions when I would have very, very sick people asking to go to sick hall, I did indeed admit them there only to find out the very next day that Dr. Rahman had sent them back to the ward, to their respected prison cells.

It was unfortunate that my hours were from 8 o'clock in the morning till 5 o'clock in the afternoon, and Dr. Rahman's hours were whatever time he got there in the morning, he would leave about 1 or 2 o'clock in the

afternoon. So I was there at least three or four hours after Dr. Rahman had left and seen very few sick people in my sick hall that I had been admitted to the infirmary that I found out Dr. Rahman came in the next day and discharged them back to the general population regardless of whether they had a very acute onset.

I've had many discussions with the director on this subject who thought perhaps if the communication was a little bit better between Dr. Carbone and Dr. Rahman. And on those occasions then after that I had to admit those patients back there, I would speak with Dr. Rahman on the phone and everything would be all right. The next day I would come back and find out those patients were discharged back to the general population. Whatever specific illnesses they have, severe enough I thought they needed hospitalization, it just didn't occur.

MR. CHAIRMAN: Why do you think he did that?

DR. CARBONE: I think Dr. Rahman is a company man. I think Dr. Rahman at the time was making a statement that he will run the

infirmary the way he sees fit. Now, Dr. Rahman is an anesthesiologist by training. He might have had one year of internal medicine training, if I'm not mistaken. It's easy to find out. By trade, he is an anesthesiologist, which is not a primary care specialty in medicine.

As far as I'm concerned, he has no business taking care of people who are genuinely sick with diseases unrelated to what his specialty might be. He's not a general practitioner, he's not a general internist, he's an anesthesiologist.

I ran the hypertension clinic. Everybody knows that if you have high blood pressure you should be on a salt-free diet. I wrote salt-free diets for a lot of patients who were not controlled very well on medicines. Dr. Rahman came by and discontinued all of those because it cost too much, that the prison system is on low salt diet for everybody in the prison system. We ate the same food as employees as the prisoners did, believe me, it's not a salt-free diet. Some of the things I had happen.

There have been cases where people have

actually died as a result of gross negligence on the part of some of these physicians that were working there. At the risk of slandering some of them, I will give you the specifics if you want the physician's names.

MR. CHAIRMAN: We wouldn't want you to slander physicians. What we would like to do is have you at some point share some of those with us so that when we do begin to look at this more in depth. One of the concerns we have now with this pending lawsuit that seem to be very comprehensive with the whole prison system, that perhaps maybe some of those other points need to be brought out, too.

DR. CARBONE: I would be more than glad to.

MR. CHAIRMAN: Chair recognizes Mr. Parrish.

MR. PARRISH: Dr. Carbone, are you familiar with a Robert Washington?

DR. CARBONE: Yes, sir, I am.

MR. PARRISH: I have a chart here that indicates some of the reasons for some of these inmates no longer being with us. I notice on this chart that Mr. Washington is listed under

the death category as unknown. Could you shed any light for us on this particular and what might the causes of death be?

DR. CARRONE: I know what his cause of death is, sir. This is probably the most despicable example that I can bring up. I was going to wait on the invitation of Honorable Mr. Richardson to explain.

Robert Washington was a patient of mine who I seen in the clinic on various occasions for his complaints of asthma. Mr. Washington also had hypertension and HIV infection with clinical AIDS. He was an older man, probably in his late 40s, seemed to me, anyway, although I can't remember specifically. But we indeed had a relationship where I was caring for him with his asthma, as well as his other medical complaints.

At one time he had an acute exacerbation of his asthma, and I sent him to the infirmary, which had a small emergency room from my sick hall room for specific bronchial dilator therapy. It seemed to me that despite a lot of these standard modalities that we use to break bronchial spastic disease, he was

refractory and required stronger and stronger medications, which I couldn't get to him on a timely basis.

As an example, when he came to me with a sore throat on Friday and I prescribed for him penicillin, he wouldn't get the penicillin until Monday night because of the system of having to write down the prescription, submit it to the pharmacy nurse at the institution, pharmacy nurse would then take it to the pharmacy, the pharmacy was closed until Monday. That's on a weekend.

On a regular weekday, if J was to give you the same prescription for penicillin, you still won't get that medication until -- If you came to me today or early this morning, I would fill the prescription, you wouldn't get that medicine until tomorrow night. So it's a horrible system. To get someone medicine urgently was difficult. Medications that were required in many cases weren't available, although they had emergency medicines in the emergency room.

It was my judgment that it was in this patient's best interest to be hospitalized in

the infirmary. I did that. The next day he was discharged back to the general population. I saw him again in sick hall, he was worse. Again, I admitted him to the infirmary with specific orders of intravenous medication, IV, oxygen, supported measures, and he started to improve. I got paid till 5 o'clock. I stayed with that patient one day until 7 o'clock, 7:30 until he improved, knowing I wasn't getting paid for it, and walked out knowing I did something for this guy. Next day I come back, he's discharged back to the general population.

Finally, I think he became so sick that it was obvious to any of the primary care doctors that he indeed required hospitalization but he wasn't getting the medicines that I had him on, he wasn't getting intravenous steroids, he was only getting oxygen. Robert Washington then realized what he was doing. I don't know if you've ever had any experiences to see somebody with bronchial spastic disease or asthma, but they truly suffer, if you're not giving them any medicine.

As a result of that, Robert Washington had an attempted suicide in the infirmary. He

tried hanging himself and then he got loose and tried to set fire to the oxygen hose that he was connected to. On the basis of those acts, they thought he was psychotic, admitted him downstairs where they kept criminally insane and psychotic people in a room where there was no hope and that man died a miserable, miserable death.

And it's listed here that he went to Suburban General Hospital where he died. I know he died in that unit. He may have been taken to Suburban General Hospital that night to be pronounced dead. I think that form is misleading saying he died in the hospital. He died by himself.

That is one example, sir, of what I can tell you about the system of privatization in health care. I will never forget that as long as I live.

MR. PARRISH: What were the general conditions under which you practiced medicine while you were in the employ of the institution at Graterford?

DR. CARBONE: Many cases that we had seen come through my sick hall room were nothing

more than sore throats, bumps and bruises, and the like. There is a huge population of potential patients there who potentially can walk in with anything. I had seen quite a lot. I had seen people with an ear infection that I had treated with antibiotics. I had cultured some of these, some of the material that was coming from the infection in the ear and found that it was a Pseudomonas organism, which is resistant to many antibiotics except for one. I'm talking oral antibiotics, antibiotics you can take by mouth. The sensitivities for this organism, various intravenous antibiotics is quite good. However, this was a newer antibiotic and probably cost about $8 per pill. It at the time had been the only oral antibiotic that was of any use for patients with bronchitis from the Pseudomonas organism. To get that medication for this person almost took an act of God.

These gentlemen who preceded me were saying that if indeed a physician deemed a more expensive medicine necessary or another evaluation by a subspecialist it was done. It had to be documented. Documentation did not

suffice with this organization, and these patients, obviously, did not get the antibiotics that I, as a physician, prescribed, knowing in my heart of heart if I could have used another antibiotic I most certainly would have. And I wasn't there to become more difficult, I wanted a specific antibiotic, and it was very difficult to obtain.

Subspecialty care was close to impossible to attain. Patients with hernias, these patients, no elected procedures were done in my stay there. If an elected procedure was scheduled, these patients were put on a list. They had no general surgery there.

They had a person who was their general surgeon who had one year or two years in general surgery residency training and then obtained a license to practice medicine. The State of Pennsylvania requires that you have two years postgraduate medical training and approved residency training program and then you're eligible to be a licensure. You need to have completed five years of residency training in the subspecialty of surgery. This person did not. That was the general surgeon that we dealt

with.

When I had sent patients to this person for simple procedures, like removal of a mole or evacuation of hematoma, bruise, it was done by her. The idea then that later on someone told me that we were not to send these general surgery cases to her, she wasn't a general surgeon. It goes on and on.

MR. PARRISH: Thank you, Doctor. Thank you, Mr. Chairman.

MR. CHAIRMAN: Thank you very much, Dr. Carbone. It seems to me you definitely could go on and on. Perhaps maybe we need to have staff get with you to gather more information to deal with these other issues that certainly are unanswered.

DR. CARBONE: At your convenience, sir.

MR. CHAIRMAN: Thank you very much. Next person to testify is Minister Rodney Muhammad, Nation of Islam.

Would you please state your name for the record and your title, and then you may proceed with your testimony.

MINISTER MUHAMMAD: Thank you, first, let me say in the name of Islam. I am Minister

Rodney Muhammad, I'm here representing the Honorable Lewis Fercott from here in the City of Philadelphia and Delaware Valley. I'm minister of Number 12 here in Philadelphia and I'm also the president and director and chief executive officer for Respectful Life Institute for Human Development. I currently have a ministry, prison ministry at Graterford right here in the State of Pennsylvania.

Let me start by opening that I have before me the book of scripture of the Moslems, and in it, as I paraphrase, it states that a messenger would be risen who would recite to people who are in pitiful condition messages and also to purify them. The question would be why would they be in need of purification. It is because of the state and the condition that mandates a messenger being raised. Any time one wants to know or one determines, let me say, what type of society one wants, that will be the determining factor for the educational system that is built. Because the end product of educational system, of course, is to produce the type of person that you want to build the kind of society that you want to have.

Of course, the universe, which is the overall society of God himself, is a universe that seems to achieve a perfect state of health. Everything that goes incorrect in this universe, if it is set back right, it will correct itself. We should know that no doctor has the power to heal or to cure. But what a doctor does have is the skill to know how to arrest an acute situation to allow the healing and to cure the process to take place.

In a society where every 60 seconds every crime conceivable to man takes place, we have to see that, as the Pharaoh says, we are really suffering from something much longer than the prison situation. But of course, we don't want the prison situation to seem as something that is totally outside of the society itself. It is a facet of society that seeks to correct those who we say have gone against or made some infraction towards the laws that govern our society, but society has said to be trying to achieve a perfect state of health. And what we need as members of society is what picture it is that we are seeking, what it is that we so desire that we are trying to achieve.

If we look at the Flinstones and the Jetsons, we could see that one could look at how it was in the beginning one would like it to be that way in the end. Because in a society that's called the melting pot where you have virtually almost every ethnic group known to man on this planet, the Flinstones does not reflect this. If you look at a society that's known as the melting pot with every ethnic group known to man, the Jetsons does not reflect this. So you look in the beginning, you look in the end, and you see what comes from the mind of someone, how they will generally like the society to look.

So now we have a disproportionate number of black males in particular that our housed now in prison institutions throughout America. This issue of health, I had wondered today if I should really be here, because as a minister, I am seeking for health, but I am seeking for a perfect state of health through spiritual development. Right now prison life is a life that has been proving itself to be a deplorable life. It costs an estimated somewhere in 35 to $50,000 per year to house an inmate and $8,000 or less per year to house a

young black male in a college institution in this land.

Anyone that is seeking cost efficiency, it would say that it's more productive for us and more cost efficient for us to house a young black male in college than it does to house him in a prison institution. However, we are going against the grain of any desire to be cost efficient when we look at the numbers and the epidemic proportions that our own black males are going into the prison institutions.

The word institutionalize comes from Latin, which means to establish or ordain. This suggests that when someone goes into a prison institution, when they go through the process, and they do the time that they are set up to do, they are supposed to be a totally repaired human being that comes back out into the general society, able now to get back into the mainstream of society and live a productive life.

However, institutionalize does not mean to repair an individual so that an individual moves outside of the institution where they have been housed for a protracted period of time, but

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institutionalize means that one now leaves the institution but the institution does not leave them. This means that the individual comes back into the general society with the expectations of everyone but themselves that they are going to make it in the general society when no means have been given to them to do this.

If there was ever any credence given to that saying that the criminal always returns to the scene of crime, then we can understand why many who leave jail end up right back in jail. Because the very place that is supposed to help in the repairing and the reforming of the individual can actually be seen now in many, many cases at the scene of the real crime. An individual now is almost doomed to repeatedly come back again and again and again to an institution.

The word rehabilitate comes from the Latin word habilitate. It means to supply with the means. Of course, when you say you're going to rehabilitate someone, re comes from the Latin word again. So you're going to rehabilitate, you're going to once again habilitate this person. That means once again you're going to

supply this person with the means. The means to do what? The means to live a productive life, the means to live with a state of dignity. But that is to suggest that they already had the means before whatever took place that landed them in the prison institution, that this person was already in possession of this.

So again, as I'm talking, I hope that you can follow me, because I'm speaking more in concept now. In short, many times when we cite certain things as a problem, we look at someone's records, we look at someone's background, we look at someone's life that they have led up to the point, and these things are cited as the problem rather than the result of the problem.

I have in my briefcase an article from the Wall Street Journal that talks about the current commission report that America is moving toward two societies, one black, one white. This is the current commission's report after an exhaustive study of what caused the cities to erupt back in the '60s. Now, this, of course, suggests that there may be two standards set up in America. If there are two standards set up

in America, then you would find a standard that suggests now that if the color of someone's skin is white, that the conditions may be more favorable coupled with someone's skin other than white, the conditions may be less than favorable.

I'm only springboarding from the current commission's report now. The report suggesting that America as a result of this could be moving toward two societies and splitting that we would have a dichotomy of race in this country with the gap so wide that we can never hope to bridge this gap. If this is so, and we cannot say and should not think that the prison institution would be exempt from any biases that are in the current society that we live. There are economic bias in the general society we live and there will be economic biases within the prison institution. If there are political biases, if there are cultural biases within the general society, we can expect these biases to exist within the prison system.

I am suggesting that in general we spend too much time trying to clear up cobwebs when the real pain should be not to clear up

cobwebs but to kill the spider. Some years back, if we just look back historically at the birth of this nation, this nation was born by Adrian going into the prison system, opening up the jails and allowing the people to come out. Please do not think that I am suggesting that we do this.

But England did this and sailed the people from one side of the Atlantic, where they could have been dangerous criminals, to the other side of the Atlantic, where they took on new status and sons of liberty and states and they built one of the most powerful nations on earth and one of the most respected nations on earth.

If this is to give us any indication of what people incarcerated can do, then we need to be taking a more serious look at the prison program that we currently have. I will say this before closing now, of course, that the Honorable Elijah Muhammad, who is a man that began the work of Islam in North America in the 1930s, was incarcerated in 1942 because they did not want Elijah Muhammad teaching young black men that they had no part in World War II after

the bombing of Pearl Harbor. The Honorable Elijah Muhammad went into jail. They, of course, experienced now the teaching of Islam within the prison system. As a result of this, Islam has been a factor inside the penal institution and it will always be one. It is a factor that is not going away.

I am suggesting that we need to consider some things, particularly in the institutions that house many of our young black neighbors, that the Honorable Lewis Farcott has a great impact on the prison community nationwide. It makes no difference whether they are Catholic, Protestant, Moslem, whether they consider themselves atheist, Pan-Africanist, Socialist, indifferent or whatever, the Honorable Lewis Farcott has a great impact on nationwide.

We have a study course called self-improvment, the basis for development. Out of this course, we have had a follow-up program that has proven effective that when a young black man who has invested himself in this program comes out of the prison institution doing time either on parole for good behavior or

either serving out the rest of the time that has been given him through the course of law that these young men have shown up in the service to help the Honorable Lewis Farcott in helping him proving to do more to help themselves than they ever have in their life. These men move on to do productive things into society. We are watching other programs to look at the success ratio of what they are able to produce, in terms of the real rehabilitation of the human being.

As I said before, I have gone into Graterford Prison the latter part of 1991 and have been working there going maximum of one time a week, and we have built a considerable community there at Graterford. There have been several young black men that have come out of Graterford doing time that have shown up under my leadership here in the City of Philadelphia are now living productive lives.

What we are saying is that so much money is thrown to agencies and departments and centers and things that many times through the bureaucratic quagmires, things may get past us. This is our focus. Our focus is our people. Our focus is bringing people back to a state of

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health, knowing we did not have this power but if we can just set the individual right, that's what the doctor does. If he sets the individual right with the right set of circumstances, and they are truly supplied with the means, which the word habilitate means, to supply one with the means. You can't say a young black man is suppliad with the needs when he suffers from substandard education, you can't say he's supplied with the means when he only has out before him role models that are already crime figures themselves, you can't say that he's being supplied with the means when he comes from a poor family and then ends up in prison for 5 to 10 to 15 years or more and he's virtually at the mercy of the state.

A state that, as I just heard some speaking before us, they have a facility that may have 33 percent minority or combination of both Hispanic and black, but Bucks County does not have that kind of composition. Because Bucks County does not have this kind of racial component, then the medical staff that treats this 33 percent black and Latino people do not reflect this black and Latino people. So you

may be representing Bucks County, but you're certainly not representing the prison that's in Bucks County. But the people are being brought from other areas would suggest to me this is more big business than anything.

So long as this kind of attitude is prevailing, at least I don't see that anything meaningful is going to be done, and what we're doing is people are going into deplorable conditions because you need health to be liberted. If a person is going to be liberted from a life of crime, if a person is going to be liberted from a life of breaking laws, they must begin to achieve a state of health. If the United Nations just came out of the conclusive statement that the stress is the diversion, that means that none of us are exempt and without our health we really don't have anything.

So I'm saying that just as the little girl was away from home, which is just like anyone being taken from home being put in prison to do time before they can go home again, little Dorothy ended up in a land of Oz. But there was no way Dorothy could get home until she got a brain, there was no way Dorothy could get home

until she got a real heart, and there was no way Dorothy could get home until she had enough courage to live her own life that was free of influences. The Wizard couldn't take her home. All she had to do was come to herself and she was at home again.

I'm saying that if a young man or a young woman, anyone that goes into a prison institution cannot experience that which is helping them to get back to a perfect state of health, I mean in the wholistic sense of the word, then you cannot expect that individual to have really come home, but what you really have is a body that has come home but mind is still in that institution. It's only a matter of time before they do something to land back in that institution again. Thank you very much.

MR. CHAIRMAN: Thank you very much for your testimony. Chair recognizes Mr. Boyd.

MR. BOYD: Islam. Thank you for your testimony. Minister Muhammad, could you talk about, just give us some specifics, in terms of how you support the inmates at Graterford and talk about some of its successes? As the state is gearing up to look at, to organize its

establishment as a more regional focus, could you talk about how there may be a need for your operation to do the same, if it fits a certain successful train?

MINISTER MUHAMMAD: I'm understanding you to say if the state sets up a --

MR. BOYD: The state correctional institutions are starting to look at establishing its health care delivery system in a more regional focus, meaning not only looking at Graterford as a delivery system but the whole eastern region, which makes up about seven additional institutions. Your primary focus is Graterford?

MINISTER MUHAMMAD: That's correct.

MR. BOYD: Could you talk about some of those programs and its successes and just expound on that?

MINISTER MUHAMMAD: Yes, sir. Thank you very much. Number one, going into Graterford, there were a number of problems that I had to deal with with the inmates. We had to get what little community was there when I moved here organized. As we worked toward that, and that took a lot of spiritual counseling, I was

going up, and I go up every Friday generally, and I spend maybe anywhere from one to two and a half hours up there with the inmates. Usually the time that I go up is time spent in the chapel.

What we have done, I didn't want to start anything without first helping us to secure a good spiritual underpinning. This is the wisdom that we have learned from the Honorable Lewis Farcott that we should never start off on economic thrust until we first make people honest. Because if we start out in economics with dishonesty still in our heart and not rooted, then we'll just have a dishonest economic system pretty much like a lot of what we see today.

So, we spent a number of months just working with spiritual development. I can't say a lot about that other than we did counseling, we did speaking to the larger communities that we had set up. Then we began to devise programs. The programs that are devised that we have in operation right now, many products now that are wholesome products are moved throughout the prison facility by the Brothers that belong

to our particular community.

So we have newspapers, we have books. Because it has always been my feeling that people who read more and learn more are liable to do a whole lot less destructively as we're constructing them better through reading. It makes a person to feel more powerful and more confident, hopefully even more responsible. So books are being moved, tapes, videos. And there have been several programs that the Brothers have put on.

One of the most recent projects that they have engaged in is a little black girl that lost the kidneys, and she's going to need a kidney operation, as I understand it, a transplant and the Brothers have raised nearly $2,000 right there in Graterford Prison toward this effort, and we've had people come onto WHAT and other talk shows and newspaper, public service announcements to help promote what the Brothers are doing.

I was very careful on the outside not to try to steal their thunder but to always direct all the news media to them and what they are doing, not so much what us, what we were

doing. We were just communicating to the outside community what they are doing right there in Graterford. So they wanted to target a case of someone that they could help.

This black woman was a hard working woman. She had to leave her job because the child required so much care. Even as much as a scratch on the child could be devastating for her. So the mother literally was not able to work now. So she can only live on the love and support on anyone that donates now. So they are trying to raise up the monies for the operation that is needed. There are other projects that are coming.

One of the things the Brothers do is they built good economics, they are building a good economic base for themselves right now at Graterford. We hope to in the future secure some contracts of good wholesome food that they can eat. I am not aware of the total dietary program that is there right now, but I know that in time you're dealing with rising costs on health care. It's either one of two things, somebody is just rising the costs and doesn't need to rise, or we're becoming unnecessarily

unhealthy. And if the latter is the case, then some dietary considerations could help to reduce costs in health care.

Now, with respect to the second concern that you raised about moving regionally. I don't know. I haven't studied the health care system, in terms of its costs, which is more cost efficient. But I would think this, whether they use the current system or whether they have a portable system, I think the real key thing is who is in control of the system now. Do the people who are in the institutions have enough voice, even if it's not a voice where they speak, I just don't think you should have an institution that should has 33 percent black and Hispanic and then have a totally Caucasian staff of seeing after them and their needs. I think that there are economic biases and political biases and cultural biases in the larger society, you're going to witness the same thing right there in the prison institution.

I remind us that we may think of it in light, in terms of cultural biases, but there was a black man that was diagnosed as mentally retarded who discarded this diagnosis and went

on to earn a Ph.D. in social psychology and he produced an exam. They went into WATTS, where most of the children have failed the standardized American test. He gave them the same standardized American test, but he reworded the questions to reflect the culture expression of those children right there in the community at WATTS. When the test was reworded to express the cultural expression of those children within their own areas where they live, they understood the questions more. And when the questions were understood more, 98 percent of those children passed those standardized tests.

So this issue of cultural bias and the cultural misunderstandings that can exist and prevail, they have a great impact on the quality of service that someone can receive, because it has a lot to do with the patient's level and all of that. So if the thing is mobile, I don't know enough about it to know if it would be more cost efficient. But you don't want to, when it comes to health, you don't want to look to cut costs if it's going to cut the chances of people being more helpful and then you run a greater risk of people being less healthy.

Now, if the state is in control of this or federal government is in control of that, I don't know which one can make it worse, but I would think that if it's mobile and it's over on this part of the state today, and this is the only unit you have to deal with, somebody gets sick over here at the same time, I don't know that you have somebody that is, what we would call an adequate staff to deal with that situation.

So I would think that before they implement something like that there should be a lot of considerations that are taking place. But, of course, if it's going to do something that's going to end up either spending more dollars or rerouting and redirecting more and more dollars that already are not getting to the people whom the dollars were first raised for or appropriated for, then I'm certainly not for it. We need to scrap it and look it over and see about some other approach.

MR. BOYD: Thank you, Muhammad. One final question, what has, if I could, Mr. Chair, what has been the relationship between your organization and the Graterford administration,

in terms of receptiveness and assisting you in establishing this kind of network?

MINISTER MUHAMMAD: Glad you asked that question. In some respects the relations, I won't say they've been good, but they haven't been bad. I haven't had as much contact with the administration, other than by letter, to make a formal request of our desire to set up ministry there at Graterford. We did not request this when we first went in, we first went in to begin to work the community.

However, we did contact Graterford administration, and we were told to contact Harrisburg I think Chaplain Mayo was the one I was told to contact, who would authorize this and get me set up with the State of Harrisburg -- through the City of Harrisburg for the Commonwealth of Pennsylvania, to work not only Graterford, but many other institutions throughout the Commonwealth, because I'm getting letters from everyone that wants me to come in and set up these programs.

The thing that, I think at least one of the things that I was led to believe was preparing our efforts to get this done was that

they thought the Islamic community already had a chaplaincy set up. We reminded them that we had more than one faction there at this line and that we felt it should be recognized. We did not request this before coming in. We requested this long after we came in to give them evidence of the other community and to give them evidence of our intentions. I don't think that they can say that we're serving ill motives when we have law abiding members in our community. They can't say that the members who represent the Honorable Lewis Parcott there at Graterford, they can't say that these people are giving them problems now. They bring the papers in, they bring the tapes in, the books in, and they are trying to be upright. That's what we teach, that's what we subscribe to.

So it's kind of been back and forth between Harrisburg and Graterford. When I contacted Harrisburg, Harrisburg wrote me back saying that the chaplain at Graterford saying they are already set up, but they are not set up to service our community, they are not set up for counseling, they are not set up for helping us to build a stronger community, but they force

us to work out through the office of our financial transactions and things like that. Of course, this doesn't give our community a sense of dignity and independence to be able to work. We don't mind working in conjunction with another community, but this is not working in conjunction, this is just working in suggestion to, in my judgment.

If we can recognize under the Christian boundary, if you will, that there is a Catholic priest there, there is a Protestant chaplain there, there are members of the cloth of other religious denominations, I think that we can all go back to the creation of man. We did not see all these religions. All there was -was man and God and man was nominated and now man denominated himself. He is expressing himself through a lot of religious denominations.

So if this is going to be the case, then we feel that our community is legitimate and that it should be recognized and that we should be able to set up in Graterford, as well as the other institutions throughout the Commonwealth of Pennsylvania that are communicating with me right now even as I speak.

MR. BOYD: Thank you. No further questions, Mr. Chairman.

MR. CHAIRMAN: Thank you. Mr. Parrish.

MR. PARRISH: No questions. Just glad to see you, my Brother.

MR. CHAIRMAN: Brother, Minister, we thank you very much for coming here today. Thanks for your testimony.

Mr. Michael Ruggieri.

(Recess)

MR. CHAIRMAN: The time of recess having expired, committee meeting will come back to order. The next person to testify will be Mr. Mike Ruggieri.

MR. RUGGIERI: Good afternoon. My name is Michael Ruggieri.

MR. CHAIRMAN: Would you spell your name just to make sure we have it correct on the record?

MR. RUGGIERI: R-u-g-g-i-e-r-i.

MR. CHAIRMAN: Thank you very much.

MR. RUGGIERI: We the People Living with AIDS, I'm on the board of directors, also write a monthly column for We the People Living with Aids. I'm on the board of directors of

17 Aids Coalition Prisons and Jails in Pennsylvania. I work as a teacher for the faculty in educational training center in Hahnemann University, Pennsylvania State Education, representative treatment action work project of San Francisco. I'm contributing owner to Path. I'm real involved in AIDS advocacy, also great, great, great, great grandson of Zachary Taylor, 12th president of the United States and James Madison. My family has been involved in the politics for quite a while.

My reason for being here today, Mr. Boyd had called me to your aid and asked me to come speak today on testimony on health care in the prison situation. I was diagnosed with AIDS in 1986, which I probably had for at least two years before that. I had it for about nine years. I was diagnosed in prison. I was put in the hole, kept in isolation. I was in Chester County Prison, I was in Dauphin County Prison. I had state sentence, spent most of my state sentence in the county prisons. My laundry was burned, I was discriminated against, confidentiality was breached, suffered cruel and

unusual punishment, I filed a lawsuit.

I suffered while I was in prison. I had dietary problems, I had holes in my esophagus where I couldn't eat solid food. More or less, the attitude in prison was that it was my own stupid fault for getting AIDS, I should have thought more about it before I got it. I was just to deal with it. When I told the medical staff I was sick, they told me we won't be able to deal with these, what do you expect us to do, you're in jail.

I didn't feel like being denied health care should be part of my punishment. I could deal with the punishment, but I couldn't deal with being denied health care, especially at the time I was diagnosed. I was scared, I didn't know a whole lot about AIDS. Pretty much in shock at being put in the hole. Started reading the bible a lot. They told me I had six months to two years to live. They would do what they could to get me out of prison. Nobody did anything for me. I put in numerous sick call requests, I wouldn't be put in. Things were really bad.

There was a lot of inmates that were

not real literate. I was more articulate, so I started writing letters to elected officials, churches, and outside agencies, as far as to try and get some help. Newspaper picked the story up, came into the prison. I started to get some publicity, things got a tiny bit better.

The health care at that time, Prison Health Services was out of Wilmington, Delaware, was the health care provider at the prison. They had a budget that consisted of $5.86 per inmate per year with a sealing for insurance between 15 and $25,000 a year for catastrophic illness, accidents, and single injury or AIDS.

Most of the doctors that worked there were retired and their medical training was probably 40, 50 years ago, and they weren't really aware of what was going on with AIDS. They weren't infectious disease specialists.

We had a four-bed infirmary. You were shackled on your stomach on all fours, no TV, no smoking, no bathroom door. There was a shower, nobody got to use that. This was for men and women. Four-bed infirmary. Their diagnostic equipment consisted of paper thermometers, blood pressure testers, stethoscope, and tongue

18 depressers. That was about it. The cure for everything was generic Tylenols that crumbled after half the time. It was really poor.

I had several problems, especially with my dietary. My mouth was ulcerated real bad. Other times they would say we don't have the medication, we don't know what to do. They have to write to the main company and get permission to do tests that I needed. See, I couldn't swallow. I couldn't swallow.

Pretty much in the county prison situation, they figured you're either going to stay or get out to keep costs down unless you get so sick they are afraid you are going to die in prison. Then they would start to speed up your release or parole or whatever. A lot of people saw, especially when dealing with AIDS, don't want to speak up because of the discrimination and fear of harassment and whatever remains. So I, more or less, did a lot by like breaching my confidentiality that we're talking about.

I did start getting medication after a while. One prison I was in, I had to wear a red arm band to disclose to anybody. Everybody knew

that people that had AIDS was more or less let it be known. There was a lot of problems.

I was from Prison Outreach. I get letters from inmates from prisons all over the State of Pennsylvania and other states. And I contact a lot direct treatments and sometimes I have some success in helping get inmates treatments, sometimes I didn't. Sometimes I like to bring the attention the Policy 5.03 or Policy OM, PA pursuant to Section 681. These are policies dealing with terminal illnesses in prison like AIDS.

While infirmary and prison can't really take care of the medical needs of the inmates, they can petition the judge for reconsideration sentence and the judge can write a court order, move an inmate to another facility subject to the court for treatment. There is a lot of problems in this because after a judge sentences an inmate, after 30 days he loses his jurisdiction. The state parole board assumes your jurisdiction. They aren't very cooperative in dealing with an inmate until he comes up with minimum sentence for parole. Then they do paperwork and all that.

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In the meantime inmates are suffering. They aren't getting the right attention. The overall cost reduction is they don't take inmates and put him in the real hospital, and people in the medical department don't really no how to deal with the major terminal illnesses. There is not much sympathy for people with AIDS, homosexuals, drug addicts, prostitutes, and whatever. There is a lot of moral judgments.

But the thing is a lot of opportunistic infections associated with AIDS are contagious, such as tuberculosis, which is airborne. A lot of people come down with tuberculosis now. It isn't just a problem with people in prisons that you can get rid of the lower eschelon criminals. These people are having visitors, guards working there, administrators, faculties, they are giving it to their children who bring it to school through the adult community and giving it to other people. Problem is going to escalate like the national deficit. It's got to be dealt with.

A lot of these private health care companies, their goal is cost reduction. They, more or less, train people to work for them, not

write anything in the records that they can be held criminally liable for unless they take it to court. U.S. Supreme court in the recent, they are taking for 1983 Civil Rights petition filed against where they subpoenaed the medical records. So they write things that are very big in medical records so that they can't be held criminally liable. In effect this is what they are doing, being negligent with people lives, trying to keeping costs down.

County prisons might have a smaller budget than someone in the state prisons. They don't have as much money to work with. When they have been on a contract for $6.1 million, they have a year to work in that budget. If they have a couple of people with AIDS, they are costing a couple hundred thousand dollars for health care, they wipe out the budget. Everything is all involved in that budget.

People are getting minimal health care. They have a list of approved medications, chronic medications for serious illnesses. They have a list of timely lengthy processes where they have to write to a big company owner of health care to get permission to use treatments,

medications, or take them out. In the meantime, people and their conditions are getting worse and worse. A lot of times people don't get the medication before they die. Just seeing people that are in prison don't have family support, church support, something, they aren't real articulate, they are norm. Somebody that has got a lawyer, family that they need health care, those people might get a little better treatment.

It's a lot of disadvantaged people they are homeless or whatever, sick. There is something stupid. You have a lot of people in there from shoplifting because they are hungry or whatever. I'm not saying it's right. It is a serious threat to society and they are being killed in jail. Then you have more and more, House Bill 743, House Bill 930, House Bill 804, 303, where they want to make mandatory testing, mandatory sentences of HIV and a whole lot of other tests. I guess at one time they wanted to make summer camps for people with AIDS. I don't want to see something like that happen.

I don't think it's an enormous problem that's going to go away. It's just getting

worse. The number of HIV positive inmates as shown, statistics show, not the numbers, and these are likely underestimation of the tree. As of February 11th, 1992, there were reportedly 278 HIV positive inmates in Pennsylvania institutions, 38 with full-blown sumptoms, 14 out of 88 were to the AIDS. These numbers are high. Realities are a problem with far more injectable positive than being reported. No records are kept of the number of HIV positive inmates in the county prisons.

Estimating that the serum positivity rates in Pennsylvania prisons and jails range from 3 percent to 12 percent. Actual number of HIV infected people in Pennsylvania State Correctional Institutions is probably between 630,520 people, and this would mean between 1,170, 4,680 HIV infected inmates in the state and no end in sight. As of April this year, 7,826 people in Pennsylvania with AIDS. That's probably much higher than that, because that's just reported cases. This problem isn't going to go away. It's unfortunate. It's going to cost a lot of money to deal with. It's got to be dealt with or the problem is going to get

worse.

This is more or less why I'm here, to let people know this is a problem. I have six recommendations made up by prison society and coalition for prison and jails. First one being Secretary of Health and Commissioner of Corrections should convene and personally participate in deliberations that enter the part on HIV planning counsel, including representatives from the community to develop effective public health system into state prisons and jails.

Number two, Pennsylvania Secretary of Health should order this department to regulate and issue detailed up-to-date standards of care for HIV disease and ensure that they are disseminated to all prisons and jail health care providers. Extra emphasis should be placed on the frequency unrecognized patients of HIV disease. Minimum standards developed by the National Center of HIV Disease and publish in its March 1991 report on HIV disease in correctional facilities or a model.

Number three, Secretary of Health and Corrections in the Governor's office of

administration should cooperate to expand current HIV training for programs for state health care workers to reach health care workers providing care to people with HIV and county prisons and jails.

Four, Parkinson Health and Correctional should provide more funding, logistical support to our county health departments and local AIDS service organization, and to state and county prisons to supply specialized counseling, education, and other care.

Five, correctional administrators must understand and enforce the limitations of confidentiality of HIV-related information act. Under state law, HIV testing cannot be compelled, must be confidential by appropriate counts. Moreover, results of HIV tests and other HIV-related information cannot be distributed to non-medical personnel without subject written permission.

Number six, quality of health should assure that its public information materials explain how confidentiality is involved and all of its implications for prisons and should put its legal staff at the disposal of local gag

law.

I'm contacted by a lot of prisons, Graterford, director of treatment. I've had conversations with the superintendents of Rockview, Smithview, Camp Hill, and others. Some of them are looking for people to come in and provide support, educational seminars. It seems to be a problem with Department of Corrections, Diane Marks, I don't really know who the problem is, there is so much paperwork, things have to go through this person and that person and you get bounced around.

I work closely with a lot of health departments, Montgomery County Health Department, I've been trying to get into Graterford. They have a contract for bid proposal or something to get in there. Everything is just tied up in Harrisburg or wherever.

All I can do is ask you to use your influence to chart the problems, I've talked to people. I'm not saying cut people loose from jail or anything like. Provide a little better health care, centralize health care so there is one company providing health care whether it's

by state or private. It should be a little more controlled, more updated, people should have up-to-date training. It really needs to be looked at how it is to be addressed. If you have any questions, I would be glad to answer them.

MR. CHAIRMAN: Thank you very much. Mr. O'Connell.

MR. O'CONNELL: No questions.

MR. CHAIRMAN: Mr. Parrish.

MR. PARRISH: No questions. Thank you for your testimony.

MR. CHAIRMAN: I just have one question. In cell blocks across the Commonwealth of Pennsylvania, do you believe as an individual person who has worked with those who have HIV and those who have full-blown AIDS that there should be a separate wing for communicable diseases in the institution?

MR. RUGGIERI: The only way that I can see isolating people would be to the fact where the immune system is weakened to the point where breath of germs or poor hygiene of other inmates would be a threat to them. As long as they are still healthy and not real sick, I think they

should be allowed to participate in everything everybody else is participating in, jobs, recreation, and everything else.

I've had AIDS for nine years, I ride a motorcycle, I play sports. In jail, I didn't have a lot of problems. I'm not gay, so I didn't have a lot of that kind of harrassment. A lot of people with HIV that are gay suffer discrimination and violent behavior. I was never a weak one or coward. People always had to think about what they said to me. I found a lot of different responses. I had people talk to me that wanted to prove they were still friends, shake hands, help me, whatever. People that didn't know what to say or say something that would offend me were real careful about the words. I had a lot of people just act natural around me. And after people got over the initial shock, they came back to just acting normal.

I do everything a normal person does. I have to be careful if I have sex with a woman, I use condoms and all that. But with people saying you can't date and all that when you're HIV, I've had a couple girlfriends since I was

HIV. I haven't given it to them. I try not to spread it. You don't have that with every person out there. There is some cases that they want to spread it.

The big danger is the people who don't know they are HIV and they have HIV and spread it. There is a lot of people you know shooting and people smoking crack and shooting heroin, prostitutes out on the streets, spreading it like crazy. People living in abandoned houses, people at fire hydrants, go into restaurants and use the bathrooms. It's terrible.

All the companies are left, all these disadvantaged people, there is help for them. Help runs for everybody, no matter what color they are. I'm friends with every colored person. Our board of directors is gay, straight, black, white, Hispanic. We have everything down there. We have street people, homeless, bankers, nurses. We can't solve every person's problem. We sure try. We give them a lot of support trying. I just would like to see governments get a little more interested in helping people.

We get a little bitter sometimes when

we see money going to all these other countries and this peoples hate us, but we're right over there dropping all kinds of medicine, lending them money, building buildings. We had people that are sleeping on steam beds, they won't keep them. We have people with AIDS that are homeless, they are dying because they are in the cold. We have a lot of problems.

Correctional facilities, they don't really partake people. The gay education, profession, something they do when they came out, when maybe they wouldn't be going back to jail all the time. They come in with court costs, fines, supervision fee for probation and parole, they can't afford a car. If they can get one, they can't afford the insurance. They can't afford rent, bus fare, clothes for the job. Think about what these people are up against.

It's bad enough just being out on the street. Coming out of a jail where you had bills and trying to make it, plus having to make reports and therapy. It's impossible for the large people to ever get back into the street, get back into the community. They need more

help before they get out the door. We need more places like group homes, halfway houses where they phase back into the community, help them get in a job. Not all these people have families, friends, wives or anything to come out to. They are better off in jail, some of them.

They know when they come out, they are never going to be able to comply with the law of probation, they just come out and go on a spree, drinking, drugging, whatever it is they were in there, go back in jail, that's where all their friends are. They don't have anyone outside. A lot of that has got to be changed. It's never going to change. We're just going to have to build more and more prisons, more and more violent disgusted people that are angry about everything.

Big problem is now with overpopulation. People are living and living longer, more treatment, more medications. These problems are never going to end. We're going to have to start doing like Australia, economize instead of other continents, economize other plants. I guess that's why we're working on the space program. There isn't any answer in sight. We

all know that.

MR. CHAIRMAN: Any other questions? We thank you very much for your testimony. And we appreciate the input. I don't think economizing plants, I don't think we're going to economize plants. I appreciate the rest of the testimony related to the health care and your sincerity and concern. Thank you very much.

Mrs. Frances Zemel here?

(No audible response)

MR. CHAIRMAN: Dr. Walter Tsou.

DR. TSOU: The last speaker.

MR. CHAIRMAN: Good afternoon. Do you have a prepared testimony?

DR. TSOU: I do.

MR. CHAIRMAN: State your name for the record, and you are in order. You may proceed.

DR. TSOU: Representative Richardson, members of the Health and Welfare Committee, ladies and gentlemen.

I am Dr. Walter Tsou, and I serve as medical director and deputy director for Personal Health Services at the Montgomery County Health Department. I wish to express my appreciation to you and the members of the

committee for the opportunity to speak about prison health services. In the limited time that I have available, I would like to concentrate on the issue of turberculosis in the prisons. I understand you've heard extensive testimony on this topic, also. So I apologize if some of this is redundant.

MR. CHAIRMAN: That's all right.

DR. TSOU: I choose TB because it is a serious disease and its management is illustrative of the problems within prisons. My familiarity with this subject stems from our health department's work in the state correctional institution at Graterford, which is in Montgomery County. As you know, Graterford is the largest correctional facility in Pennsylvania and has an inmate population of over 4,000.

We first learned about a tuberculosis problem in Graterford in July of 1991 when approximately nine active cases of turberculosis were reported to the Pennsylvania Health Department. Investigation by the Pennsylvania Health Department at that time concluded that Graterford was ill prepared for handling

tuberculosis cases. When our health department began operations in October of 1991, we began to work with officials at Graterford in an effort to improve their TB program. While there has been a substantial improvement in the awareness and efforts by Graterford on the management of tuberculosis, there are still areas that require improvement. While many of these problems are related to staffing shortages, several problems can be resolved with stronger administrative oversight. I enumerate some of the problems below.

One, transfer of medical information from hospitals and other correctional facilities to and from Graterford is inadequate. Procedures and methods for procuring previous medical records and the transfer of these records to other correctional facilities is necessary for the proper continuity of medical care for inmates. It is costly for Pennsylvania to repeat medical work-ups on individuals who have been previously evaluated. The delay in information, especially in patients with active tuberculosis, could seriously jeopardize the health of other inmates and staff.

Two, because the volume and tracking of medical information is so extensive at a large institution, such as Graterford, a uniform TB registry used by all state correctional facilities and/or computerization of this information is necessary.

Three, internal mechanisms for gathering medical lab and X-ray results and placing these results on the chart or brought to the physician's attention needs to be standardized and expedited. As a health department, we have occasionally learned about lab results on inmates even before the medical staff at Graterford. This is not acceptable.

Respiratory isolation rooms must be made available for all inmates suspected of having tuberculosis. Currently Graterford only has three such rooms and our own county prison has none. These rooms should reverse flow ventilated to prevent the spread of tuberculosis throughout the infirmary.

Five, information on the arrivals, discharges, or transfers must be shared with the medical staff by the administration responsible for security. Occasionally, the medical staff

was left unaware that the inmate had already left Graterford. In at least two cases, inmates with active tuberculosis were released and lost to follow-up in the community.

Six, standard follow-up must be developed to assure that all inmates with suspected tuberculosis take and finish their medications. A review mechanism must be developed to review the medication administration records daily. Non-compliant inmates need to be identified and reviewed with the attending physician.

Seven, a person dedicated by each prison must accept responsibility to report all communicable diseases to the local health department. This is necessary to assure that appropriate treatment and follow-up has been provided. Furthermore, our department has assisted Graterford in some of their TB screenings but reporting is less than ideal.

Right, finally, privatization of prison health services has resulted in duplicative administrative structures and led to miscommunications and/or delays. The medical record department at Graterford is administered

separately from the medical care providers, which simply makes no sense.

The bottom line is that while much progress has been made, we still need to improve the management of tuberculosis within our correctional facilities in Pennsylvania. Multi-drug resistant tuberculosis, a disease which currently is extremely deadly and has become a very real problem in several states. Prisons in New York City have been radically changed because of the threat of drug resistant tuberculosis. Our prisons in Pennsylvania have been described as overcrowded, with high risk inmates, with HIV disease, drug use, and poor medical compliance. All of these factors serve as a perfect milieu for developing drug resistant TB.

In the 1920s, tuberculosis was among the five leading causes of death in America. Most of the American public would like prisoners to be locked up and forgotten. But unless we provide the necessary resources and exercise appropriate public health principals now in our correctional facilities, we will regret our current pecuniary indecisiveness and

bureaucratic complacency. Like a ticking time bomb, we can no longer afford to wait. It's time to act, and the time is now. Thank you.

MR. CHAIRMAN: Thank you very much. Doctor, you've testified before this committee before. It's good to see you again. You had enumerated a number of some of the problems. I would like to know whether or not you've had any opportunity at all to ever meet with the Department of Corrections.

DR. TSOU: We have not had an opportunity to meet with Commissioner Lehman. We've had had phone conversations with his medical director, Dr. Julie Anderson, and we have been working on a regular basis with deputy superintendent of treatment at Graterford, Mr. Thomas Stachlek, S-t-a-c-h-l-e-k.

MR. CHAIRMAN: He's the deputy commissioner of health. Have you met this Diane Marks, director of health services for Pennsylvania Department of Corrections?

DR. TSOU: I have not.

MR. CHAIRMAN: She's supposed to be the director. She was here, but they couldn't talk. They were gagged by the Attorney General's

Office. And the Department of Corrections told them that they couldn't answer any questions. I just wanted to know if you had a chance to talk to them, maybe she'll talk to you and maybe you can find out what is going on.

DR. TSOU: I can tell you that the Department of Corrections has released a document describing their policies and procedures concerning tuberculosis.

MR. CHAIRMAN: Does it work? See, people can always release documents. Those documents look so good on paper. But what does it mean to the inmates who are walking around feeling like they are amongst people who have tuberculosis when it's like a closed mouth thing.

One of the things I can say today was that I was appreciative of someone who told us, it was Dr. Ross, who said it's the way you frame your question that gets us sometimes the answers. We were at Graterford yesterday and I asked whether or not there were any cases of AIDS up there, they told me no. They said it was the way I asked the question is why I got that answer, in terms of the tuberculosis

problem. Maybe you can help shed some light.

DR. TSOU: Did they say that there are no cases of AIDS?

MR. CHAIRMAN: No AIDS.

DR. TSOU: Tuberculosis.

MR. CHAIRMAN: Tuberculosis. They said they tested everybody in the institution, and that all those persons that were tested, if they needed, if they needed medicine, they were given corrected medicine.

DR. TSOU: They've made the same statements to us. There are situations where people are considered TB suspects where the actual diagnosis, culture diagnosis has not returned yet. And they do have patients in there who are TB suspects, who are pending a diagnosis, formal diagnosis. It takes usually six weeks for these culture results to come back.

MR. CHAIRMAN: Isn't that a cute way of subterfuge?

DR. TSOU: Yes. I think that's probably not giving you the full answer.

MR. CHAIRMAN: In other words, it's not borderline lying, but it's close to it?

DR. TSOU: I don't want to indict them.

MR. CHAIRMAN: I don't want you to indict anybody. It's like stretching the truth?

DR. TSOU: The truth, yes.

MR. CHAIRMAN: Or the lack thereof. In other words, they don't give all the information, so they can't accuse you of doing anything that looks malicious. But at the same time, you have all these inmates that are being subjected to this health care.

What do you believe is the thrust or the movement behind this regionalization concept that they've come up with now that they want to put seven or eight institutions under three different regions dividing up the health care for the Commonwealth of Pennsylvania eastern, central, and western part of the Commonwealth, so that a health care provider in each one of these areas would then become the primary care vendor for those seven or eight institutions by region?

DR. TSOU: I have, I guess, more questions than answers to that. In the large part it's related to the quality of who the vendor might be that would serve those eight

institutions in a given range. A highly competent and qualified vendor with individuals working at a variety of regional correctional facilities with common administrative roles and methods for providing medical care could be actually advantageous to the Commonwealth. But again, the caveat has to be what qualifications, what qualifies such a vendor. Does that make sense?

MR. CHAIRMAN: Yes, that makes sense. Because as they are moving, they have already lifted RFPs. My concern is whether or not the bureaucracy that presently exists now by institution by institution to farm this out now regionally, I just want to know whether or not not only the quality of insurance but the assurance that there is going to be some medical delivery service to these inmates who in some cases are indicating, particularly the severe cases of medical illness and other psychological illnesses in the institution, which is mental illness, I'm just wondering how they are going to get a fix on it.

They say it's going to be more cost containment, but I'm not sure. We're just

trying to get for the record so our committee can vote and say we support this or don't support conceptually how that is going to work. I agree with you it's going to depend on who is the person who gives the care.

Contract, I don't want to get the contracts. It's going to be built in prior to before they be allowed to be given this contract where certain things are not taken into consideration of the prisoners inside, the kind of coalitions, because many inmates we talked to yesterday feel the people there don't even care. They seem like next number, come on in, next number. Then after one doctor can say this guy has got a serious illness, the next doctor come in and discharges him. I don't understand.

Isn't there something about code of ethics amongst doctors that if you diagnose this individual patient as having the sickness, the next day the very, without consulting the doctor, the very next day you discharge him?

DR. TSOU: I mentioned to you, there is lack of communication internally, at least in our experience with Graterford.

MR. CHAIRMAN: Is it done on purpose?

DR. TSOU: I think it's not good medical care that you're describing. I have previously testified in front of this committee that the delivery of health care and financing of health care should be considered separately. One of the complaints that you've raised here is illustrative of that point, because we may develop a wonderful cost containment program for prison health services. But if a delivery is fear of quality care, then we have not done ourselves a service to either inmates or the Commonwealth.

So I think that to help us perhaps define better that a high level quality of care is administered in the prisons, some efforts should be instituted by the Department of Corrections to describe minimum quality standards for providing health care in the correctional facilities.

MR. CHAIRMAN: Thank you. Chair recognizes Mr. Parrish.

MR. PARRISH: No questions, Mr. Chairman. Thank you again, Doctor, for your testimony.

MR. CHAIRMAN: Chair recognizes

Mr. O'Connell.

MR. O'CONNELL: No questions.

MR. CHAIRMAN: We thank you very much. We appreciate your comments. Look forward to working with you.

Let me for the record thank again Mr. David Yurky, Y-u-r-k-y, who is a volunteer and worker of my office, and has been the coordinator of these past two days of tour at Graterford and hearing and hearing here today at City Council and to also the rest of the staff that office also helped. David has been working on this for quite some time. We want to thank you for helping with the matters of some of those persons that did testify here today.

The Chair would also like to recognize the presence of Mrs. Lois Williamson, who is here, who is a prison advocate who is nationally and locally and carries a lot of respect with the kind of work that she does in and out of prison throughout the Commonwealth of Pennsylvania.

It is of particular interest that while we will adjourn these hearings today, it is the intention of this Chair, along with

collaboration with the House Judiciary Committee, that we may need another two days of hearings on this prison health care issue, because we certainly did not get much information from the Department of Corrections on this whole health care delivery system. And we must get that on the record.

The other thing is that there will be subsequent meetings that the staff will encounter with the Department of Corrections while this lawsuit is pending. I would like to ask that to make sure that we get a copy of the lawsuit from the ACLU so that that can be affixed to the notes of testimony of these two days of hearing, because there was one impediment from hearing from the Department of Corrections. So we need those to be directly tied to this testimony. So that when people read this testimony, they'll understand why we cannot get certain answers.

The other thing is that I just believe that there is much to be desired in correctional institutions when it comes to health. We only went to Graterford, and that probably houses more African-Americans and Latino and Hispanic

persons than any other prison throughout the Commonwealth, particularly geographically located near the City of Philadelphia. And the western part of the state, we have Western Penn out in Pittsburgh. I still don't believe that the population is as great as it is with respect to Philadelphia and Graterford. The rest of the institutions are spread out all over the Commonwealth and very difficult to get to in traveling. A lot of us have problems getting to see those other ones inside the institution.

As relates to the health care, my concern that if, in fact, we're going to move reasonably, that's got to be taken into consideration of who is administering the health care to these individuals, particularly without compassion or concern of the individual's health. It may be a preconceived notion, sort of like low expectancy of individuals that live or reside in institutions, such as in prison systems in Pennsylvania. And therefore, if the clinical persons have a low esteem and a low expectation of the people that they are supposed to be helping, then they probably are not going to be getting health care that they need. That

needs to be factored into any RFPs that are going to be presented to the Commonwealth before these vendors are allowed to get the contracts. That's got to be a prerequisite for getting it and also should be tied to insurance of quality of care for those individual inmates.

So on that note, we're going to adjourn this hearing with the proviso that the chairperson, both Health and Welfare Committee and the Judiciary Committee will be calling for additional hearings on this subject matter of prison health care for the Commonwealth of Pennsylvania. This meeting is adjourned at 4:50 p.m.

(Hearing concluded at 4:50 P.M.)

C E R T I F I C A T E

I, Tammy J. Rinehart, Reporter, Notary Public, duly commissioned and qualified in and for the County of York, Commonwealth of Pennsylvania, certify that the foregoing is a true and accurate transcript of my stenotype notes taken by me and subsequently reduced to computer printout under my supervision, and that this copy is a correct record of the same.

This certificate does not apply to any reproduction of the same by any means unless under my direct control and/or supervision.

Dated this 21st day of May, 1993.

BY: Tammy J. Rinehart

Tammy J. Rinehart, Reporter
Notary Public