SUBCOMMITTEE ON CRIME AND CORRECTIONS
STATEMENT of MARTIN F. HORN, SECRETARY
PA DEPARTMENT OF CORRECTIONS

February 22, 1999

Good morning Chairman Birmelin and members of the Subcommittee on Crime and Corrections.

I have been asked to talk to you today about the medical care the Department of Corrections provides to its inmates and our policy on medical experimentation. With me today are Dr. Fred Maue, Medical Director for the Department, and Catherine McVey, Director of Health Care Services.

The Department of Corrections provides health care services to inmates in accordance with community standards for health care and the standards of the American Correctional Association (ACA). It is our constitutional responsibility to ensure that three basic health care rights of inmates are achieved. Inmates have the right to access to care. Inmates have a right to the care that is offered, and inmates have the right to professional judgement. These rights were enunciated by the US Supreme Court decision in Estelle v. Gamble in which local, state, and federal governments were held liable if they deliberately or recklessly fail to provide medical care.

These basic rights are regionally managed by three health care vendors. The Bureau of Health Care Services provides administrative and clinical

oversight to the vendors and to the Department's nursing staff. In addition, the Bureau coordinates the Management Review and Quality Improvement processes with the institutions. Both of these activities facilitate the attainment of high standards of health care delivery. Management Review is an audit process which provides the institutions with specific, quantifiable feedback regarding correct and incorrect practices. Quality Improvement is an ongoing process of planning and executing a continuous stream of medical care self-improvement. Procedurally, the Quality Improvement process occurs through Central Bureau of Health Care staff working as a team with the institutional medical care providers, analyzing the day to day delivery of health care, discussing specific cases, and developing new and enhanced mechanisms and processes for institutional services.

We see approximately 30,000 medical care treatment contacts per month. These contacts include blood pressure checks, immunizations, dressing changes, testing, physicals, and doctor-ordered follow through. The most common chronic care clinic is for hypertension, followed by asthma and diabetes. A significant number of inmates are also provided dental care, with a monthly average of 5500 inmates seen by dentists and approximately 1500 inmates receiving dental hygiene care monthly.

The number of inmates with AIDS has grown from 39 known cases in 1991 to 273 in 1998. However, the number of deaths due to AIDS has declined from 35 in 1995 to 23 in 1998. We believe that this is the result of new medication which we now provide to inmates. Consequently, because beneficial treatment is available, the number of inmates coming forward with HIV has increased from 404 in 1995 to 704 in 1998.

The Department is increasingly concerned with the growing number of cases of inmates identified with Hepatitis C. Although Hepatitis C affects individuals from all walks of life, some patient populations present special problems, these include patients with HIV, hemodialysis, and alcoholic liver disease. These are precisely the kinds of patients we are seeing.

Hepatitis C has a long latency period, and untreated, may result in liver cancer or cirrhosis of the liver. Until recently, the effectiveness of treatment was very low. Recent treatment advances offer the promise of improved response, but at great cost. The matter is complicated because most treatments have significant side effects, including psychosis, depression, and suicide. Treatment contraindications include persons with previous psychosis or depression and histories of drug abuse.

We are moving as quickly as we can to determine the best course of action, and will insure that our inmates receive the standard of care consistent with community practice.

The Department has had great success with managing the containment of TB through our aggressive testing and treatment protocol. In the years 1995 through 1997, we had three active cases; last year we had none. We adhere to strict annual testing procedures for all inmates and staff for early detection and intervention.

Last year the Department implemented the statutorily mandated medical services co-pay requirement for inmates. Inmates are charged $2 per sickcall visit. Co-pay is not charged for follow-up visits, chronic disease care, infirmary or long-term care, or emergency services. The overall impact of co-pay on sickcall has been a 48% monthly reduction on inmates signing up for sickcall during the first six months of operation. This reduction has allowed an increase in the number of scheduled medical appointments. It has also allowed staff to devote more time to health education and prevention activities. We believe that co-pay has achieved its intent. It has separated inmates with medical conditions needing care from those with minor complaints. To date, the program has generated savings of $400,000.

Our cost of health care per inmate per day is $3,464 per year. This includes medical, mental health, and dental care as well as pharmaceuticals. It is important to note that many inmates who come to us are medically compromised due to their prior life style. Therefore, it is necessary for the Department to offer a broad spectrum of health care services. We provide inmates with all medically necessary care that is essential to life and health, including chronic care clinics, speciality consultations, infectious disease management and immunizations, hospice care, and renal dialysis. There are also limits to the health care that is provided. We don't allow cosmetic surgery, sterilization, biofeedback, dental cosmetic care, and chiropractic services.

In 1996, we established a long-term care facility, SCI Laurel Highlands. This institution is designed to handle inmates who are elderly and disabled. Approximately 125 inmates are receiving long-term skilled, intermediate, and geriatric care.

Currently, we have 44 inmates who are receiving renal dialysis. That care is provided at SCI Laurel Highlands and SCI Graterford.

Last year, the Department initiated the use of telemedicine. The provision of medical care through video conferencing media allows for audio, video and data collection and transmission of information between an inmate and a

physician who is located at a base site. To date, this technology has allowed us to conduct 1,028 consultations primarily in the areas of psychiatry, dermatology, and infectious diseases.

Sixteen of our institutions are now equipped to handle telemedicine; two are on the way. We have seen numerous advantages with this tool, including a decrease in the cost of consultation services, increased access to appropriate specialized care, and elimination of security risks and manpower costs associated with transporting those inmates who otherwise would need to be taken to outside appointments. When all telemedicine programs are operational, we expect annual savings of $500,000 for these off-site trips.

With respect to medical experiments involving inmates, the Department of Corrections expressly prohibits the use or employment of inmates as subjects in any medical, pharmaceutical, or cosmetic experiments or testing. This has been our long-standing policy. However, I should note that this policy does not constitute an automatic ban on the use of pharmaceuticals and other medical protocols that, although technically classified as experimental or under testing, are generally accepted by the medical community for the treatment of diseases such as HIV and AIDS. Our position is consistent with the ACA standard on

Inmate Participation in Research. Quite simply, to allow experimentation would jeopardize our ACA accreditation.

In addition, any requests from legitimate research, treatment, or medical personnel designed to evaluate the effectiveness of generally accepted medical practices or procedures are assessed by our Medical Practice Review Committee. In practice, this Committee has not been activated in recent years for this purpose.

The Department's policy on medical experimentation respects the belief that inmates are not truly free to give consent due to the inherently coercive environment of prisons.

This concludes my presentation. If you have any questions, I would be happy to answer them.