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Medical Is From Mars, Psych Is From Venus: Improving Communication and Getting What the Patient Needs

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Even the best of clinicians find correctional institutions difficult environments in which to work. Inmates frequently have multiple medical, mental health, and substance-abuse issues that are not easily managed by a single provider. Furthermore, the number of correctional patients with coexisting mental health and medical needs is increasing.

Studies suggest that inmates in both jails and prisons bear a heavier burden of chronic medical illnesses than do people in the general population. In a recent study, an estimated 44% of state inmates and 39% of federal inmates reported a current medical problem other than a cold or viral infection, while 16% of state inmates and 8% of federal inmates reported multiple impairments.[1] The prevalence of chronic conditions varied by age and gender. Among 34-to-49-year-old prison inmates, the leading condition was being overweight, with a prevalence of 47%. Other leading medical conditions were:

1. Hypertension (24.7%);
2. Obesity (24.7%);
3. Arthritis (23.1%);
4. Asthma (13.9%); and
5. Hepatitis (12.9%).[2]

Female inmates in both state and federal prisons were more likely to report a current medical problem than were male inmates, but both were equally likely to report a dental problem. Among both state and federal inmates, females were more than one and a half times more likely to report two or more current medical problems than were male inmates.[3]

Medical problems among jail inmates are not very different than those reported in prisons. Chronic medical conditions reported by jail inmates in another study include:

1. Arthritis (13%);
2. Hypertension (11%);
3. Asthma (10%); and
4. Heart problems (6%).

Less than 5% of jail inmates reported cancer, paralysis, stroke, diabetes, kidney problems, liver problems, hepatitis, sexually transmitted diseases, tuberculosis (TB), or human immunodeficiency virus (HIV). Twenty-two percent of jail inmates reported one medical problem; 14% reported two or more.[4]

Equally concerning statistics can be found for mental illness among inmates. In 2000 the American Psychiatric Association estimated that about 20% of prisoners were seriously mentally ill, with 5% being actively psychotic at any

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Cost-Effective Medical Management

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The corrections industry has an alternative to the privatization of medical services or the more risky self-management models followed in the majority of US jails and prisons. Currently, approximately 2.4 million inmates are housed in American correctional facilities, about 1 out of 110 citizens.

Although this is the only segment of the US population with a constitutional right to receive adequate physical and mental health care, the medical department is one of the most heavily scrutinized parts of a correctional facility. How much does this quality medical care cost the taxpayers? On average, correctional facilities spend 13%–18% of their budget on health care each year. Correctional facilities must provide adequate and timely care that meets community standards for acute, serious, and chronic medical and mental health conditions. However, a properly designed self-management model helps to manage that cost and provide a transparent, fee-for-service-rendered product.

Rising Costs

Several factors contribute to increasing medical costs. The inmate population has quadrupled since 1980. This burgeoning population, along with offsite visits and a national average of 21% inflation in health care costs over the past 5 years, has significantly increased

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activity. In fact, HIV is more common among female inmates than male ones.

Because most studies concentrate on the impact of positive relationships on such behaviors, Staton-Tindall et al. explored the extent to which negative relationships affect and moderate the beneficial effects of positive relationships on risk behaviors among female inmates. This study attempts to demonstrate that positive relationships are associated with reduced health-risk behaviors and that the effect of positive relationships on these behaviors is decreased when more negative relationships are present in subjects' lives.

Methods

The authors' study used secondary data collected from the Criminal Justice Drug Abuse Treatment Studies (CJDATS), which was funded by the National Institute on Drug Abuse (NIDA). A total of 366 female participants from the following three studies were used in this analysis: Restructuring Risky Relationships, Transitional Case Management, and HIV/Hep C Prevention. The participants were all screened to be heavy drug users at risk for substance dependence. Self-reported data were collected through face-to-face interviews. Independent variables were the perceived positive and negative relationships of parents, peers, and romantic partners six months before incarceration. Dependent variables were HIV risk behavior, such as needle or drug use and risky sexual activity six months before incarceration.

Participants rated positive and negative relationships based on conflict, mutual activities, and levels of involvement during the six months before incarceration. Their HIV/AIDS risk, needle use, and risky sexual behaviors were measured. Drug use was also examined in the six months before incarceration. Descriptions of these measures are detailed in the article.

Findings

Table 1 in this article illustrates the participant characteristics. The average age was 35.6; almost 40% were unemployed; over 60% were white. The average number of years of education was 11. Over 13% of participants were married or cohabiting.

Analysis in this study showed that higher scores for positive parental relationships are associated with lower HIV and drug use risk six months before incarceration. A higher score on positive peer relationships is negatively correlated with drug use six months before incarceration, and a higher score on negative peer influence is associated with drug use six months before incarceration. Additionally, negative peer relationships increases the likelihood of drug use. The moderating effects of negative peer or parent relationships on the association between positive peers and risk behaviors are not significant.

Conclusion

Staton-Tindall et al.'s study examined the association between positive and negative relationships of romantic partners, parents, friends, and risky behaviors among female inmates. It also examined the extent to which negative relationships moderate the effects of the positive relationships on this population's risky behaviors. The hypothesis that positive parent and peer relationships protect against risky behaviors was supported. The hypothesis that the impact of positive relationships on risky behaviors is decreased by the impact of more negative relationships was not supported.

Surprisingly, both positive and negative romantic relationships were not significant indicators of risky behaviors. The authors suggest that, although women may view their romantic relationships as positive, they may engage in risky behaviors with their partners. The article suggests that this should be an important area of focus for future research. The authors suggest that their study may provide relevant findings for assessing and treating for this population's transition into the community after release from prison. ■

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the cost of running an adequate medical department.

The changing demographics of inmates also play a role. A higher degree of poverty, lower education, undiagnosed or underdiagnosed medical conditions, higher rates of infections, and higher rates of substance abuse all contribute to a sicker inmate population.

Another major challenge for correctional institutions is adequately staffing their medical departments. Because the majority of correctional facilities are located in remote areas where there is often inadequate clinical supervision, many qualified nurses prefer to go to patient-care-focused centers.

The main cost drivers of medical in correctional facilities are as follows:

- Health care staff (45%), a fairly stable cost;
- Pharmaceuticals (23%), a fairly stable cost;
- Outside services (18%), a cost that can vary significantly; and
- Other costs (14%), which do not include the cost of losing or settling lawsuits.

While dealing with these challenges, correctional facilities must be proactive and strive to meet goals necessary to keep their medical departments running smoothly. For example, a medical department that follows a self-management model can provide quality medical and mental health care while, at the same time, being sensitive to the particular problems of a correctional population, such as higher rates of drug-seeking and manipulative behavior. Problems like these contribute to the prevalence of lawsuits, which are a common occurrence in correctional facilities. Medical departments must therefore be managed in a way that minimizes the frequency of these lawsuits. When a lawsuit does occur, the correctional facility will almost always win, if the medical department and staff are managed properly and if adequate, timely care is provided that meets the standard of community care.

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As previously noted, the health care staff is almost always the main cost driver in a corrections medical department. Nevertheless, it is extremely important to retain a quality nursing staff and not continually recruit new staff. A medical department can take the following steps to promote its recruitment and retention of nursing staff when there is a national shortage:

- Offer a competitive salary, plus the usual excellent government benefits, which are most likely better than those offered in private industry.
- Ensure that a physician or mid-level health care provider is available, at least by telephone, 24/7.
- Provide comprehensive, user-friendly nursing guidelines that won't force nurses to perform beyond their state licensure rules and regulations.
- Regularly train nurses on these guidelines to improve their confidence and sense of comfort. This training, which should be provided by either the medical director or a senior nursing staff member, will reduce the need for agency nurses.
- Redesign the clinical staffing and workflow, based on objectives or tasks that will not only improve staff satisfaction and quality of care but also can keep you within your budget.
- Provide a one-time tour of the facility, not just for each applicant but also for his or her significant other, if needed. This will help them to realize that correctional facilities are a lot different than what they have seen in the movies and will increase the chance of recruitment when the market is very competitive.
- Streamline the nursing sick-call process by nursing staff, to reduce the number of hours physicians must be in house.

Medications also drive up costs. The following steps can help to alleviate this problem:

- Promote competition among different pharmacy vendors and learn the meaning of the common language that vendors use in their proposals, such as average wholesale price (AWP) and wholesale acquisition cost (WAC). Negotiate your rate upward from WAC, not downward from AWP.
- Adopt a formulary with very few designer drugs. The formulary should be reviewed yearly by the medical director because some brand name and designer medications will become available in the generic form. The information should be discussed with your pharmacy vendor.
- Monitor the cost and percentage of prescriptions, using the formulary and nonformulary medications at least quarterly. This is particularly true for psychotropic drugs. The medical director should be aware of the findings and take a proactive approach before these numbers get out of control.
- Be careful with electronic prescription software marketed as an "added value." There have been indications that this added value will shift the labor cost and liability for errors from the vendor pharmacy to your medical staff members who are now functioning as pharmacy technicians.
- A reasonable benchmark for the monthly cost of medications is between $25 to $35 per inmate. For example, in a jail that has an average daily population of 500, you would expect to spend approximately $17,500 per month, assuming that approximately 35% of inmates have medical indications to be on prescription medications, depending on geographic and demographic variances.

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Another cost driver is offsite visits, either to emergency rooms or as elective consults. The following actions can reduce and control the cost of this category:

- Correctional officers should conduct a comprehensive, practical initial screening when all arrivals are booked. Health care providers should conduct a medical and mental health screening, ideally within the first 12 to 24 hours to ensure early identification and intervention, when indicated.
- The early recognition and appropriate response to inmates' withdrawal syndromes from alcohol and opiates can tremendously reduce your cost and liabilities.
- Obtaining relevant outside records before incarceration can minimize duplicate or unnecessary offsite visits.
- Organizing medical records enables health care providers to make more timely and appropriate clinical decisions either in house or for outside visits.
- Implementing chronic care clinics for common medical conditions reduces offsite visits.
- Eliminating the use of paper files and implementing electronic medical records (EMRs) not only improves communication among staff members but also decreases redundancy of care. EMRs can help with gathering statistics and can reduce the chances of an institution's losing a lawsuit due to illegitimate hand writing.
- Consistently training nursing staff members prepares them to communicate crucial information with the physician or mid-level health care providers, which in turn allows them to make appropriate clinical decisions regarding transferring inmates to emergency departments.

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Mental Health in Jails and Prisons

Jails and prisons have become dumping grounds for the mentally ill. This problem began in 1955 with the invention of the psychotropic drug Thorazine. It was so effective at treating symptoms of psychosis that thousands of patients were released from mental health hospitals. Then, community mental health clinics filled up so quickly that they could not handle the caseload. Some patients became unstable, came into contact with law enforcement, and ended up behind bars.

To deal with this problem, jails have typically used one of the following ineffective strategies:

- The primary care physician diagnoses and prescribes psychotropic medications that he or she may not be comfortable with.
- A psychiatrist from the local mental health clinic finds time to come to the jail, in addition to handling his or her normal caseload outside of the correctional facility.
- The jail is forced to transport inmates offsite for mental health needs, causing an increased cost and security risk.

Each of these strategies results in long waiting lists for mentally ill inmates and opens the jail to significantly increased liability.

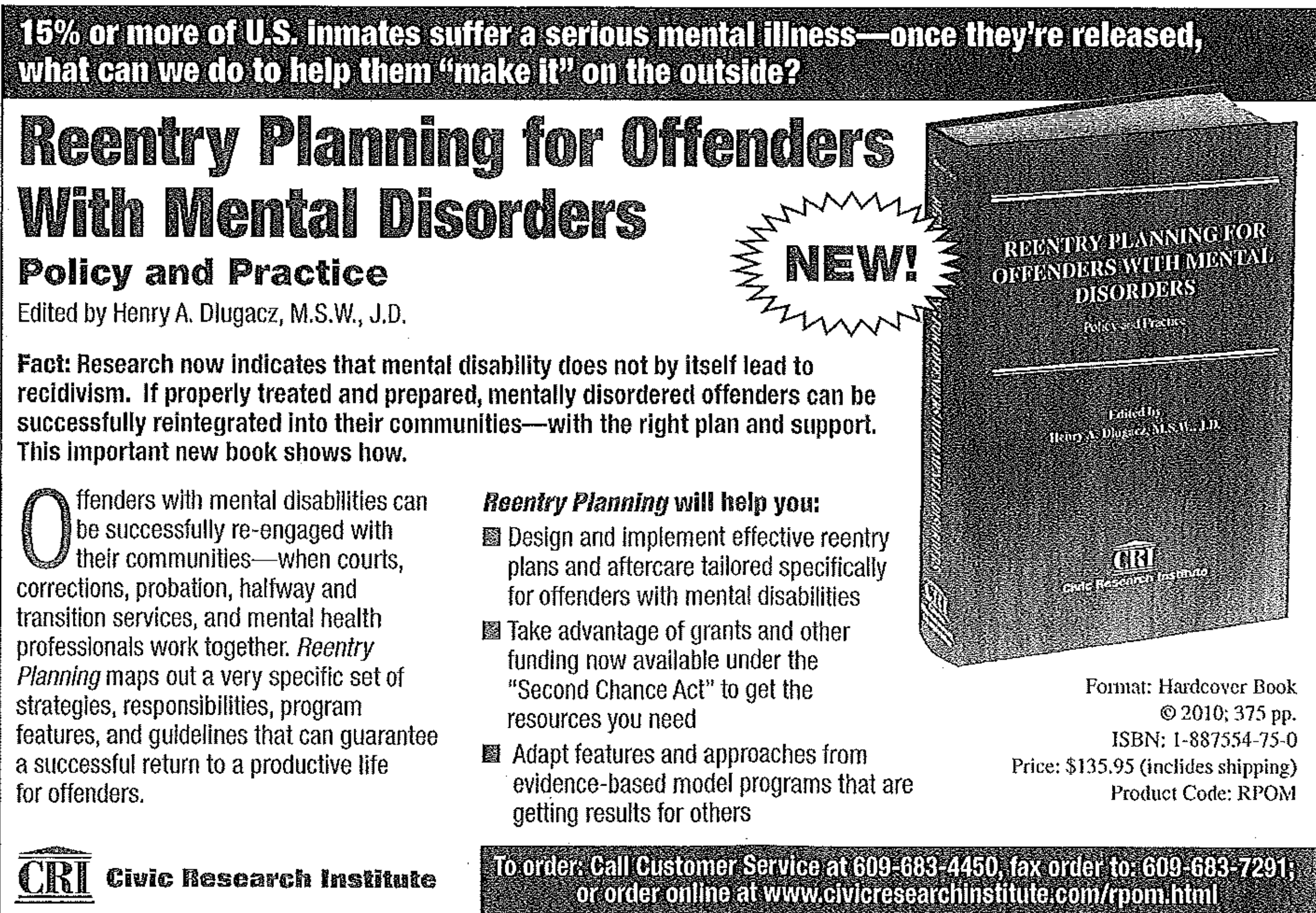
Telepsychiatry uses videoconferencing to connect inmates with a qualified psychiatrist anywhere in the world. By implementing it, a jail can reduce the labor hours and security staff needed to transport inmates offsite. The timely access to mental health care also reduces the number of grievances filed by inmates and their families, lessens dangerous or aggressive behavior, and avoids the abuse of psychotropic medications.

Psychiatrists participating in a telemedicine program should be sensitive to the special needs of the correctional population and comfortable with prescribing generic, time-proven psychotropic medications that can reduce pharmaceutical costs.

Conclusion

Correctional medical departments need to control costs while providing care that meets the standards of their communities. Jails and prisons have an alternative to privatization of medical departments. This alternative can be effective in providing both high-quality care and cost savings.

Kaveh Ofogh, MD, is the founder and president of MEDIKO PC, a self-management model without privatizing the medical department. It provides cost-effective medical services in correctional facilities. For the past 12 years, medical costs for the correctional facilities under his clinical management have all been lower than their states' average, and neither he or any of their medical departments has lost or settled a lawsuit. He can be reached at (804) 433-1040 or kofogh@medikopc.com



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