SUMMARY OF FINDINGS AND RECOMMENDATIONS

I. COMPREHENSIVE REVIEW OF CMS CONTRACTUAL PROCEDURES AND TERMS; REVIEW OF ALL SUBCONTRACTUAL PROCEDURES AND TERMS: STATE AUDITOR.

Formal request to the Office of the State Auditor to utilize all powers and authority of that Office to conduct a comprehensive review and investigations of the privatization of health care services to prisoners and detainees at MCI-Framingham, specifically the provision of services through contracts with Correctional Medical Systems, EMSA Correctional Care, and Mediq Mobile X-Rays, Inc.

The purpose of the audit is to determine fiscal accountability for public expenditures received and utilized by private providers in health care services for correctional facilities in Massachusetts; to determine the extent and quality of services provided through contractual obligations; to review all contract negotiations and procedures utilized to procure and award contracts to out of state companies, including subcontractors; to review compliance procedures in enforcing contract terms to populations designated to receive services stated in the contracts and subcontracts.

II. ESTABLISH AN INDEPENDENT OVERSIGHT AND MONITORING ADVISORY COUNCIL.

Since there are currently no independent audits or reviews of the provision of health care and other services to prison inmates, especially women at MCI-Framingham, an advisory council should be established to evaluate and provide ongoing oversight to monitor the quality of health care, the performance of staff, contract provisions as matched with population needs, and to determine appropriateness and adequacy of care. The composition of the Council would be medical and health professionals, who would establish and monitor standards of care to be consistently provided, and work with relevant agencies and offices to enforce compliance and establish appropriate protocols for care and treatment.
III. COMPREHENSIVE REVIEW OF LEVEL AND QUALITY OF SERVICES PROVIDED TO INMATES IN PRISON FACILITY AT MCI-FRAMINGHAM: DEPT. OF PUBLIC HEALTH.

Formal request to the Commissioner of the Department of Public Health to utilize all powers and authority of that Office to conduct a comprehensive review of all health care needs and services provided to the female inmate population at MCI-Framingham, and to report on findings and recommendations of the study. The review should include specific references on the unique and specific health care issues of female inmates, and a determination of medical model servicing needs of this population. The review should include morbidity and mortality evaluations, population needs assessments, and evaluations of levels and quality of care provided.

The role of the Dept. of Public Health should be expanded to enable the Dept. to participate in the determinations of inmates' health care needs, and contractual negotiations and terms stating servicing models to meet needs, and to review and formulate recommendations based on established standards of care for inmates that is equal to those received by other persons in society. The Dept. should participate in the Advisory Council.

IV. COMPREHENSIVE REVIEW OF ALL CONTRACTUAL AND SUBCONTRACTUAL POLICIES, PROCEDURES, AUDITING MECHANISMS, AND DETERMINATION OF NEEDS, SERVICING MODELS TO MEET NEEDS, AND COMPLIANCE ENFORCEMENT: EXEC. OFFICE OF PUBLIC SAFETY, DEPT. OF CORRECTIONS, DIVISION OF PURCHASE OF SERVICES AND PROCUREMENT.

This review should be a coordinated initiative to determine mechanisms for the improvement of privatization initiatives in the provision of health care and other services to inmates at correctional facilities, including compliance enforcement procedures, audits to obtain fiscal controls and accountability on public expenditures, assessments on quality of care and to determine that funds expended are purchasing services that are needed and provided on a consistent and ongoing basis, and that contractual terms and obligations are being fulfilled.

V. DEVELOP AND IMPLEMENT A STATEWIDE PLAN FOR INTERMEDIATE COMMUNITY CORRECTIONS PROGRAMS THAT ARE ALTERNATIVES TO INCARCERATION, INCLUDING CIVIL COMMITMENT PROCEDURES FOR SUBSTANCE ABUSE TREATMENT PROGRAMS FOR WOMEN.

Currently there are no civil commitment procedures for women who are experiencing substance abuse and in need of substance abuse treatment programs that are alternatives to incarceration. There is a 28 day civil commitment procedure for men and programs to accommodate the need for substance abuse treatment and rehabilitation. Legislation has been filed to remediate this problem. (House 792)

Program models as alternatives to incarceration for women should include substance abuse treatment and detoxification as civil commitment procedures and alternative sentencing, medical models, educational programs, programs for incarcerated women with children or who are pregnant, day reporting, pre-release and halfway houses, community service, and other models. Program models should focus on the specific and unique needs of women.

The statewide plan should include the establishment of a Central Office for Alternative Sentencing and Regional Centers to coordinate initiatives among corrections, probation, community corrections programs, the courts, service providers, and other relevant parties.
Establish Standards of Care for Inmates in Correctional Facilities; Establish a Medical Model for Women; Establish Protocols for Detoxification and Drug Treatment, Health Care Procedures and Diagnostic Testing.

EOPS, DOC, and all contracted service providers should work with the Advisory Council to evaluate and implement uniform standards of care, in a clearly articulated statement, that inmates and detainees will receive throughout their incarceration, in health care, mental health care, and other services. Statements on standards for female inmates should include a commitment to the specific needs of women, and should be distributed to all prison and corrections officials, personnel, service providers, and others. Training sessions should be conducted periodically on all standards of care, treatment models, detoxification treatment programs, protocols for medical procedures and emergency response systems, and equality of care procedures. Vigilance for adherence to maintaining standards of care should be applied during transitional periods when contracts are being negotiated or renewed, and lapses in care can occur. Standards of care should be consistent with medical practice and treatment procedures applied to all persons in society, and should include attitudinal perspectives in training and applicability to incarcerated persons.

Protocols should be implemented, with accompanying training, to ensure strict adherence to health care admissions policies and contractual terms, including:

- appropriate assessments of medical needs and treatment plans to be immediately implemented in a timely manner, upon admissions of inmates, or as needed for inmates experiencing medical and health care needs.

- the taking and recording of medical history, actions to be taken on specific health concerns, dates and timeframes of treatment or services, the obtaining and tracking of previous medical records and medications needed, and the utilization of records and history to facilitate treatment and care.

- improved request for treatment procedures for inmates who are, or who become, ill, and/or who need medical care, and who present symptoms or articulate complaints; requests should be honored in a timely manner, with an immediate medical assessment.

- improved procedures for providing and tracking records to hospitals, clinics, physicians, technicians, etc.

- improved procedures for the distribution of medications needed; if inmates enter prison with prescribed medications, these should be allowed for continuity of care.

- improved systems to monitor and follow up with lab. tests and results; tracking system for testing results and applicability to treatment programs; when contracted or sub-contracted, testing results should be immediately reviewed by medical professionals on staff at prisons and by primary provider medical personnel.

- improved assessments on inmates needing care by providing a medical history or synopsis, to accompany diagnostic tests, such as x-rays, that are being evaluated or interpreted by a secondary provider.
Upon questioning at the hearing, these facts were confirmed as true, by CMS, DOC, and EOPS.

9. The Committee had been informed that the x-ray equipment at MCI-Framingham was inoperative or broken, and that a portable x-ray machine had been used on July 20.

Upon questioning, this was confirmed to be true. The equipment was inoperative, according to DOC Health Services, because it had been disconnected while a mammogram machine was being installed. (The members had been informed that this type of equipment had been installed by EMSA in 1992.) The Committee was informed that portable x-rays (which do not always provide quality and clear x-rays) had been used for 3 years at the facility. While a subcontractor under CMS, Dr. Ronald Goldberg, interpreted the x-rays, no other physician reviewed the x-rays.

10. Dr. Goldberg stated at the hearing that he receives 15-20 x-rays delivered to his home for interpretation, dictates the results into a recorder, sends the x-rays back, and receives $100-$150 for a batch of them. He stated he does not receive any medical history of the person whose x-ray he reads, or any summary of their history with the x-ray.

11. There remains discrepancies on the interpretation of the x-rays. Dr. Goldberg stated that there was no sign of pneumonia or fluids on Ms. Andrade's x-rays. However, the mortality review report states that the "chest x-ray was interpreted incorrectly", that the "chest x-ray was not of good technical quality", and that "the chest x-ray was reviewed by an outside independent radiologist who confirmed pneumonia". The mortality review team stated that Ms. Andrade more than likely contracted pneumonia while at the HSU at Framingham prison.

12. There are serious concerns about the qualifications of persons making decisions about medical services, contractual negotiations and awards, levels and quality of health care, etc. The question remains one of should correctional persons be making decisions regarding health care services.

III. OVERSIGHT AND MONITORING.

13. There is no independent oversight or monitoring of quality or level of medical care provided at prison facilities. DOC conducts only internal audits. There are no quality assurance reviews conducted, or adequacy of care studies or audits.

In 1992, when 3 women died at MCI-Framingham under similar circumstances, the Committee requested that 3 independent physicians conduct an independent review. This report was submitted to the Committee on the death of Robin Peeler, and other health
conditions in the prison facility. One of the Committee's recommendations, resulting from the review, was the establishing of an Independent Oversight and Monitoring Council to oversee, review, and advise corrections officials on health care services for prison inmates. Funding for the 3 member panel of physicians was vetoed in the budget by the Weld Administration.

14. There is inadequate and insufficient monitoring and oversight of contract compliance issues, to ensure that the terms of the contract are adhered to, and that what health care and services are included in the contract, are complied with. There are no clearly stated and obviously articulated standards of care and medical procedures applicable to incarcerated persons.

15. Contracts for medical services in prisons are not reviewed by medical or health professionals, or the Dept. of Public Health, nor are these persons involved in any negotiations or contractual determinations of care to be provided, levels of services, quality assurance, and contract terms.

16. There are serious deficits in channels of communication and accountability mechanisms among EOPS officials, DOC officials and personnel, and the Superintendent of the Framingham facility, and the health services provider, CMS. Administrators and officials appeared to be completely unaware of the conditions of Ms. Andrade, the factors contributing to her conditions, the care she received or did not receive, and a range of other information.

17. There are no reporting systems within or among prison officials and administrators, on the types of illnesses within the prisons, or the nature and extent of the illnesses, or on the medical-health needs of inmates. There are no concomitant studies to articulate research needs and updated medical treatment protocols for specific illnesses or diseases.

IV. EMERGENCY RESPONSE SYSTEMS

18. Ms. Andrade was forced to attend a court hearing on July 21, two days prior to her death, while she was experiencing multiple illnesses, without an attending physician, or a medical release that she was well enough to attend court.

19. There are serious concerns about emergency response systems when persons in prison require medical care beyond that which is supposed to be provided at the HSU. In Ms. Andrade's case, as in past cases in which female inmates died, there was extensive time delays in the provision of medical care, in the timeframe of decisions when she needed emergency or intensive care, on whose responsibility it is to provide specific care needed outside the prison facility, on transporting patients from prison to the care provider, on determinations of when
additional care is needed, and on channels of communication and decision-making.

20. When Ms. Andrade experienced respiratory distress on July 22, and was sent to Framingham Union Hospital, there was confusion and delays as to who was responsible for care, and why there was no intensive care unit available. It is unclear whether or not this is true for any female inmate in need of emergency services, or intensive care treatment. Framingham Union did not have available beds, and she was sent to Leonard Morse in Natick, where there was a time delay before she received treatment. Reports are that the delay was from 2-1/2 hours to 6 hours. Some of the delay was reportedly due to confusions about whether or not Shattuck Hospital could accept her for care. They could not. Ms. Andrade expired on the morning of July 23.

V. ACCESS TO CARE; ALTERNATIVE TREATMENT PROGRAMS.

21. The Committee had long been concerned about health care procedures, such as availability of local community care, when needed, alternative sentencing such as drug treatment programs, request for medical treatment procedures by inmates, emergency response systems, the need for comprehensive screening and medical history upon entrance into prisons, continuity of care, and other areas. All areas are relevant to Ms. Andrade's case.

22. There is a serious lack of alternative sentencing models, including a medical model and substance abuse treatment model, for incarcerated female inmates, or as alternative intermediate sanctions for women. A wide range of models is needed.

At the public hearings, this issue was addressed, and extensive questioning in this area ensued. EOPS and DOC responded by stating that there would be provisions in the forthcoming capital planning and operations legislation, to include alternative programs in county corrections facilities. Members of the Committee stated that these were not true alternatives, as intermediate sanctions as alternatives to incarceration should be community-based and coordinated among all agencies, and relevant criminal justice systems. County corrections facilities were not appropriate placements for alternative sentencing programs.

23. It was reported to the Committee that there are problems with other services at MCI-Framingham, such as mental health services, "suicide watch" procedures, etc. It was reported that women on suicide watch are often unclothed and being observed by male guards. A complete review of all prison health care is strongly needed, in all areas of health, mental health, educational, and social servicing. The review should include an identification and remedial plan specific to extensive problems with routine health and mental health care, and critical care.
Findings and Recommendations.

RECOMMENDATIONS: MEDICAL CARE AND HEALTH SERVICES.

1. Review all decision-making procedures and medical determination protocols, upon admission into a prison facility for women. Determine exact modes of communication, procedures to follow, emergency response systems, and other such medical/administrative procedures and decisions.

Develop and implement strict compliance procedures between state agencies and contracted providers and subcontractors, to maintain adherence to contractual terms.

Conduct ongoing staff training on all procedures developed and implemented as a result of reviews and reforms. Conduct ongoing and periodic training on protocols, procedures, and treatment models.

2. Develop protocols for detoxification treatment, complementary to a range of health needs experienced by female inmates and detainees; develop protocols for medical treatment models that are specific to the needs of female prisoners.

3. EOPS and DOC should review staffing ratio terms on all contracts and subcontracts, and revise and upgrade ratios to achieve and maintain adequate levels needed to access and deliver quality health care to female prisoners. All physician and nursing staffing levels should be included in the review. Physicians who are contracted, or hired, to be present on a full time basis, should be available at all times during the timeframes in which they are paid to be available.

All staff ratios should be evaluated and adjusted to ensure that adequate medical personnel, matched to appropriate population needs, are available and in attendance.

4. Protocols should be implemented, with accompanying training, to ensure strict adherence to admissions policies and contractual terms, including the taking and recording of medical history, notations of actions to be taken on specific health concerns, dates and timeframes of treatment or services, and who will be providing the care, the obtaining of previous medical records, and the utilization of these records and history to facilitate treatment and care. If prisoners or detainees enter the prison with prescribed medications, these should be maintained for continuity of care for inmates.

5. Protocols should be developed, with accompanying training, on requests for medical treatment procedures in response to inmates symptoms or complaints. Requests should be honored in a timely manner, with no prolonged delays. Improvements are needed in the provision and tracking of records to hospitals, clinics, physicians, community care. (House 790)
6. Training sessions are needed on the treatment of inmates, especially with regards to health care, as that which should be equal to the quality of care and treatment provided to all persons, irrespective of the status of their incarceration. The training should focus on the need to dispel the "culture of contempt" aura that has consistently been used to describe attitudes towards inmates and detainees.

7. Develop a clearly articulated statement on standards of care that inmates and detainees will receive throughout their incarceration in health care, mental health care, etc. Statements regarding standards for female inmates should include a philosophical and practical commitment to addressing the specific needs of women. Statements should be distributed to all prison and corrections officials and personnel.

8. Establish a system to monitor and follow-up with adequate, sufficient, and appropriate prescription and medication distribution, as needed, on a timely basis. (House 790)

9. Develop a reporting system within and among DOC and EOPS corrections officials and administrators, on the types of illnesses within the prisons, the nature and extent of the illnesses, the medical/health needs of inmates. Information derived from the system should be applied to all prison facilities and relevant correctional decisions.

10. Evaluate uniform standards of care that will accommodate emerging treatment models, evaluations of services, and utilization of services patterns.

11. Obtain detailed and updated comprehensive data on morbidity issues for women, especially incarcerated women, and apply findings to improve quality of care for incarcerated women. Since many women who enter prison, have previous health and medical needs, and often become more seriously ill while in prison, this data should be applied to updated admissions practices and health care policies, procedures, and treatment model programs, for all prisoners, and unique to the needs of female inmates.

12. Establish a system to monitor and follow-up with lab tests and results; tracking system for lab and testing results and applicability to treatment program. If certain aspects of health services are contracted or subcontracted, lab results should be immediately reviewed by medical professionals on staff at prisons, and by primary provider personnel.

13. When x-rays or other diagnostic testing is performed on inmates or detainees, medical history, or a synopsis, should accompany the tests to those who are performing them, or interpreting the results.
14. Develop an inventory of medical equipment and lab. machinery that is presently available in the HSU at Framingham, and what should be available to adequately treat the medical and health needs of inmates, especially female inmates. Ensure that the HSU equipment is up to quality standard health care and install equipment as needed.

II. OVERSIGHT AND MONITORING.

15. Establish an independent monitoring and oversight group to evaluate the quality, standards, and levels of health care needed and provided, to -

- review staff performance
- develop standards of care that are strictly enforced and monitored for compliance
- to identify the wide range of needs of inmates, specifically for female inmates, in all areas of care
- to review and formulate recommendations for service delivery through contract provisions
- to identify discrepancies and problem areas in all aspects of inmate care
- to institute mechanisms to ensure contract compliance in all areas, and to conduct quality assurance reviews (House 3660, To Establish an Independent Oversight and Monitoring Advisory Council.)

16. Contracts negotiated and awarded by corrections officials should include participation from the Dept. of Public Health and other relevant medical professionals. These parties should review all RFP's, contract terms and negotiations, prior to their being awarded, and should participate in all phases of the process, including servicing needs of specific populations, and treatment models needed to meet the identified needs, that are stated in the contract and subcontract documents.

17. Statements should be issued that clearly articulate the standards of care for female inmates, that include a philosophical and practical commitment to addressing specific needs of women. Statements should be distributed to all prison and corrections officials and personnel.

18. There should be strict procedural communications channels clearly stated, that provide for equal flow of specific information concerning prison population needs, availability of care and services, current data on illnesses and diseases, identification of ongoing training sessions and policies, contractual terms, emergency response systems, etc. These channels should be clearly outlined to all prison administrators, staff, corrections officials, health care and other providers, and all relevant persons.
III. EMERGENCY RESPONSE SYSTEMS

19. Establish periodic training and re-training of prison and medical personnel in procedures, policies, and critical situations and conditions, including an emergency response system, critical care procedures, staff back-up in serious or critical illnesses of inmates.

20. Development treatment plans and protocols for procedures for emergency response systems and servicing models, for inmates in need of medical treatment for serious illnesses, or when efficient, effective response systems are needed for emergency situations. These should include in-facility response patterns, with staffing actions articulated, and out-of-facility response patterns, and channels of communication.

21. Prisoners required to make court appearances during their incarceration, or as detainees, should receive a medical examination, and be cleared for the appearance by a physician.

IV. ACCESS TO CARE; ALTERNATIVE TREATMENT PROGRAMS

22. Reduce/eliminate time delays and confusions of care responsibility in areas such as the provision of specific care needed outside the prison facility, on transporting patients from prison to the care provider, on determinations of when additional care is needed, and on channels of communication and decision-making.

23. Develop treatment plans, including emergency response systems and servicing models, to ensure continuity of care, adequately treatment in community resources when needed, availability of intensive care space or emergency services, on a timely and pre-planned basis, or through a pre-contracted arrangement; improve interfacing with community providers and the utilization of adequate consultation services.

24. Ongoing monitoring is specifically needed in the area of petitioning for outside care, especially in emergency situations that demand critical care or care not provided within the prison facility. Determinations of the point at which outside care is needed should be based on medical decisions and not on contractual terms to reduce costs. Outside care should be available as needed, and should be pre-arranged, with specified channels of communication.

25. Develop and implement a statewide plan for intermediate community corrections programs that are alternatives to incarceration, including the establishment of a central office and regional centers to coordinate initiatives among corrections, probation, community corrections programs, service pro-
Program models as alternatives to incarceration for women should include substance abuse treatment and detoxification as civil commitment procedures and alternative sentencing, medical models, educational programs, programs for incarcerated women with children or who are pregnant, day reporting, pre-release and halfway houses, community service, and other models. Program models should focus on the unique and specific needs of women. While there is a 28-day civil commitment for drug treatment for men, there are no such programs available for women. (House 792)

The Committee is requesting a formal review of the provision of health care services at MCI-Framingham, medical issues concerning female inmates, population needs, and other aspects of health needs and services for female inmates, by the Department of Public Health.

The Committee will cooperate in all aspects with the Board of Registration in Medicine and the Mass. Medical Society in efforts to ascertain the need for investigation and possible disciplinary actions concerning professionals involved in the care of Joan Andrade.

Within 60 days of their investigations, EOPS, DOC, CMS, and other relevant officials shall submit findings and recommendations for reform and a remedial action plan to the Legislative Committee on Prison Health Care, including incorporations of the recommendations of the Committee. The plan shall include corrective measures and compliance enforcement mechanisms, to address identified problem areas, with strict timeframes for implementation.
1. There is no independent oversight or monitoring of quality or level of medical care provided at prison facilities. DOC conducts only internal audits. There are no quality assurance reviews conducted, compliance enforcement mechanisms, or adequacy of care studies or external audits.

There are no oversight or independent monitoring mechanisms available, nor are there any contractual procedures and oversight for the awarding of subcontracts, which can continue along several lines, nor are there articulated channels of communication between public agencies and private providers contracted by the state.

The previous contractor for health services, EMSA of Florida, received approximately $74 million for two year contracts, CMS of St. Louis and its subcontractors are receiving $38 million a year currently, yet the quality of health care provision remains a serious problem. There are little or no accountability mechanisms - for the measurements of quality and accessibility of care, or for fiscal accountability.

2. There are several areas of persistent problems throughout the history of the privatization of health services at prisons by both EMSA and CMS. Many recommendations produced by the House Committee in June of 1992, are the same as those being presented in these findings and recommendations. In 1992, the House Committee requested assistance for an independent review by three area physicians. Funding for their assistance and report was passed by the Legislature, and vetoed by Governor Weld.

The CMS contract states that, upon admission, all women are to be provided with a full screening, a health plan, a full physical examination, diagnostic and laboratory testing, and emergency services, if needed, and a complete medical history, along with previous records. Yet, these components were seriously lacking in Joan Andrade's admissions records, as they have been in other cases presented to the Legislative Committee.

There are no mechanisms for enforcing lack of contract compliance, or of ensuring that terms of contracts and subcontracts are met, and that strict adherence to terms that are paid for by state funds is enforced.

3. There are serious deficits in channels of communication and accountability mechanisms among EOPS officials, DOC officials and personnel, and prison administrative officials, and the service provider, CMS and its subcontractors, and on human, provider, and fiscal accountability.
4. Contracts for medical services in prisons are not reviewed by medical or health professionals, or the Dept. of Public Health, nor are these persons involved in any negotiations or contractual determinations of care to be provided, levels of services, quality assurance, and contract terms adherence.

5. During past hearings, the House Committee found that there are often incentives written in contracts to reduce outside care or community care for prison inmates, especially hospitalizations and emergency treatment. This practice seriously compromises the health care of inmates, and even endangers their lives, when appropriate, adequate, and timely care is not provided outside the prison facility, when such needed care does not exist in the prison.

II. SUBCONTRACTS AND TRANSITIONAL CARE.

6. During the transitional period between contracts of EMSA and CMS, little or no apparent steps were taken by CMS, prior to the initiation of the term of their contractual obligations, to prepare for taking over the provision of health care services. Visits to MCI-Framingham, along with documents received by the Committee indicate that forms used by EMSA are still being used by CMS, staff that worked during EMSA's contract period are still working under CMS, with no apparent review of their professional status, training levels, etc. In addition, Mediq, Inc., the provider subcontracted to provide x-ray services, also worked for EMSA prior to working for CMS.

7. On previous occasions, both CMS and DOC stated that the medical equipment machinery was "state of the art". At the hearing, officials admitted that this was not true. Observations by independent persons were that there was no "high-tech" or emergency equipment available at MCI-Framingham. It is unclear whether CMS, DOC, or subcontractors are responsible for the level of care provided through laboratory or diagnostic testing that utilizes medical equipment.

8. There are many confusions about the procedures and bidding processes required by primary providers when they are subcontracting for services or components of the contract terms. The director of Mediq Mobile X-Rays, Lawrence Smith, is headquartered in Pennsylvania, with offices in Massachusetts. When asked how Dr. Ronald Goldberg obtained the subcontract to read x-rays, the response was that "he was the lowest bidder". However, at a public hearing of the Committee, Dr. Goldberg, when questioned about a former associate now working for Mediq, responded that he had received a call from the former associate, and was asked if he was interested in interpreting x-rays on prison inmates. It would appear that there was no bidding process used in Dr. Goldberg's obtaining the subcontract to CMS.
receives 15-20 x-rays delivered to his home for interpretation, dictates the results into a recorder, sends the x-rays back, and receives $100-$150 for a "batch" of them. He does have any other information provided to him about the person whose x-ray he is interpreting.

According to Mr. Smith, Mediq worked for EMSA, but "quit because we didn't like some of their practices".

It is unclear to whom and by what methods Dr. Goldberg reports or communicates his work, his billing for tests done, or any other aspects of his subcontracted work. CMS stated at a hearing that they were unaware of Dr. Goldberg's subcontract by Mediq, or his past history.

9. Since CMS is contracted by the state through an HMO standing, it is unclear what methods are used to issue public information about the availability of the contract, the RFP to be issued, negotiation procedures, who defines and determines the terms of the contracts and subcontracts, and the awarding procedure. These problem areas are applicable also to the subcontracting process.

10. The director of Mediq appeared to be unaware that Ms. Andrade should have received a full diagnostic screening and medical examination, including x-rays, if needed, upon admission into the prison facility on July 13. The company has no records of Ms. Andrade's admission medical history, and only had records of her x-ray taken on July 20. Part of the CMS contract is that full examinations, including x-rays, are to be provided upon admission.
RECOMMENDATIONS: CONTRACTS AND SUBCONTRACTS WITH PRIVATE SERVICE PROVIDERS.

1. PRIMARY CONTRACTED PRIVATE SERVICE PROVIDERS.

1. Establish an independent monitoring and oversight group to evaluate the quality, standards, levels of health care, contract compliance, and to conduct quality assurance. The Oversight and Monitoring Advisory Council (House 3660) would monitor contract provisions and the application of terms to be matched with population needs. The composition of the Council would include medical professionals, the Dept. of Public health, health professionals and other relevant persons.

2. The Legislative Committee has requested a formal audit from the Office of the State Auditor to conduct a comprehensive review and investigation of the provision of health care services to prisoners at MCI-Framingham, through contracts with CMS, EMSA, Mediq Mobile X-Rays, and other subcontractors.

   The purpose of the audit is to determine fiscal accountability for public expenditures received and utilized by private providers in health care services for correctional facilities in Massachusetts.

3. The Legislative Committee has requested a formal review of all contractual and subcontractual policies, procedures, auditing mechanisms and compliance enforcement from the Executive Office of Public Safety, the Dept. of Corrections, and the Division of Purchase of Services and Procurement.

   This review would determine mechanisms for the improvement of privatization initiatives through contracting of private providers for health care services at prison facilities, including contract enforcement procedures, audits to obtain fiscal controls and accountability, and to determine that funds expended are purchasing services that are needed and provided on a consistent and ongoing basis, and that contractual terms and obligations are being fulfilled.

4. Contracts negotiated and awarded by corrections officials should include participation from the Dept. of Public Health, which should be included as members of the Advisory Council, and other relevant medical professionals. Contracts and subcontracts should be reviewed by DPH to aid in determinations of medical needs and treatment models to meet identified needs of inmates, and to ensure that contract terms are in compliance in all areas, especially admissions procedures and emergency treatment and response systems.

5. There should be strict procedural communication channels clearly stated and distributed, that provide for equal flow of
specific information concerning the provision of quality and adequate care as stated in contract terms. These channels should be clearly outlined to all prison administrators, staff, corrections officials, health care and other providers, and all relevant persons.

6. Contracts and subcontracts should be immediately reviewed to reduce or eliminate contract provisions that are incentives to reduce outside care or community care when needed for prison inmates. Quality care should be provided on a medically-needed basis, and not be driven by contractual reductions based on fiscal constraints. Protocols should be developed that determine appropriateness of care needed, on a timely basis, in community care networks or on an emergency basis, and that determine care that is limited and provided in prison facilities. Transitional care provisions are critically needed as part of the protocol.

II. SUBCONTRACTS AND TRANSITIONAL CARE.

7. There is an urgent need for specific measures to be immediately taken to ensure that standards of care and contract compliance is strictly adhered to in the provision of health care and other services to prison inmates during transitional periods. The Advisory Council should be included in these measures, along with corrections officials, health care providers, prison officials, and other relevant persons and agencies. Preventive measures should be enacted to ensure that lapses in care do not occur. Contractors and subcontractors should prepare well in advance of the inception of the contract terms and work closely with providers and others to ensure that standards of care are adequately and continuously maintained.

8. The audit by the State Auditor, and the review by DOC, EOPS, and Purchase of Services, should include reviews and audits of all subcontracting procedures and policies, to determine bidding processes, channels of communication, integrity of awarding of subcontracts, and implement accountability mechanisms. A remedial action plan should be incorporated into the report to the House Committee on Prison Health Care.

9. If CMS contract continues, immediate measures should be implemented to review all forms, procedures, staff performance, and other components, to update and institute new procedures, forms, etc., needed to provide quality and adequate care according to contractual terms for FY95.

10. All medical equipment should be examined by experts in the field, to ensure that updated, modern equipment is installed and maintained at quality levels of utilization and need by the prison populations. EMSA received funding for full x-ray tests and equipment usage, yet CMS was still using portable x-rays.
equipment used by EMSA for two years. According to DOC, portable x-rays have been used at MCI-Framingham for three years. In addition, the x-ray equipment was inoperative at the time of Joan Andrade’s admission, due to the installation of a mammogram machine. According to past statements by EMSA and DOC, they were responsible for, and were paid to install, mammogram equipment. Fiscal accountability and standards of care should apply to the availability of and use of, quality equipment to ensure accurate and thorough examinations as needed.

11. All proposed subcontracts, including who the providers are and their respective credentials, what the terms of their contracts are, how they will fulfill their obligations, what treatment models and protocols are used, and other relevant information, will be reviewed by corrections officials, the Advisory Council, DPH, and other relevant persons, prior to the awarding of the contract.

12. All standards of care implemented, all protocols developed, all treatment models and procedures, along with other relevant documents, will be provided to all contractors and subcontractors, with training provided when necessary.

13. Within 60 days of their investigations, EOPS, DOC, CMS, and other relevant officials shall submit findings and recommendations for reform and a remedial action plan to the Legislative Committee on Prison Health Care, including incorporations of the recommendations of the Committee. The plan shall include corrective measures and compliance enforcement mechanisms, to address identified problem areas, with strict timeframes for implementation.