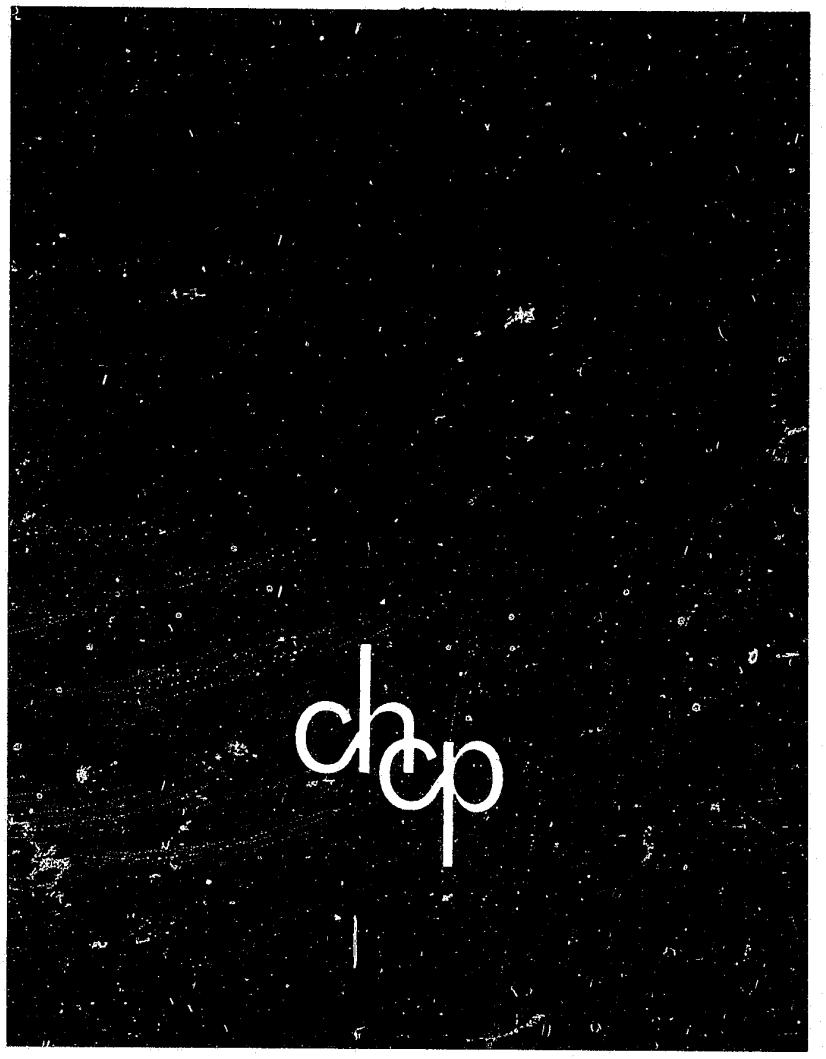

CORRECTIONAL HEALTH CARE PROGRAM

CORRECTIONAL HEALTH CARE PROGRAM

F I N A L R E P O R T

LEAA #77-ED-99-0026

APRIL 30, 1980

OMB APPROVAL NO. 43-R0525
EXPIRATION DATE 6-30-74

U. S. DEPARTMENT OF JUSTICE
LAW ENFORCEMENT ASSISTANCE ADMINISTRATION

DISCRETIONARY GRANT
PROGRESS REPORT

GRANTEE	LEAA GRANT NO.	DATE OF REPORT	REPORT NO.
Michigan Department of Corrections	77-ED-99-0026	4/28/80	6

IMPLEMENTING SUBGRANTEE

TYPE OF REPORT
☐ REGULAR QUARTERLY ☐ SPECIAL REQUEST
☒ FINAL REPORT

SHORT TITLE OF PROJECT: Medical Care and Health Services in Corr. Institutions

GRANT AMOUNT: $1,000,000.00

REPORT IS SUBMITTED FOR THE PERIOD THROUGH 4/30/80

SIGNATURE OF PROJECT DIRECTOR: Jay K. Harness, MD.

TYPED NAME & TITLE OF PROJECT DIRECTOR: Jay K. Harness, MD, FACS, Director Office of Health Care

COMMENCE REPORT HERE *(Add continuation pages as required.)*

In December of 1977, the Office of Health Care of the Michigan Department of Corrections undertook the implementation of the LEAA funded program "Medical Care and Health Services in Correctional Institutions." This program was designed to provide training and technical assistance to ten (10) state departments of correction. This report describes the activities of this program and results as can be presently determined. It has been compiled from progress and final reports from each of the subcontractors, technical assistance reports, training and resource materials, and other project documentation. Additional detail is provided in the Appendices.

RECEIVED BY GRANTEE STATE PLANNING AGENCY *(Official)* | DATE

PROGRESS REPORTS--INSTRUCTIONS FOR LEAA DISCRETIONARY GRANTS

Grantees are required to submit Quarterly Progress Reports on project activities and accomplishments. No fixed requirements as to length or detail have been established, although some general guidelines appear below. It is expected that reports will include data appropriate to the stage of project development and in sufficient detail to provide a clear idea and summary of work and accomplishments to date. The following should be observed in preparation and submission of progress reports.

a. Reporting Party. The party responsible for preparing the report will be the agency, whether grantee or subgrantee, actually implementing the project. Thus, where a State Planning Agency is the grantee but has subgranted funds to a particular unit or agency to carry on the project, the report should be prepared by the subgrantee.

b. Due Date. Reports are submitted by the subgrantee to its State Planning Agency on a quarterly basis (i.e., as of June 30, September 30, December 31, and March 31) and are due at the cognizant Regional Office on the 30th day following the close of the quarter (unless specified otherwise by LEAA). The first report will be due after the close of the first full quarter following approval of the grant (i.e., for a grant approval on May 1 the first report will be due for the quarter ending September 30. It will cover the five month period May through September). The award recipient's final progress report will be due 90 days following the close of the project or any extension thereof.

c. Form and Execution. Three (3) copies of each report should be submitted. However, five (5) copies must be submitted for all final reports. (If the grantee wishes to submit the same report to several agencies it may utilize LEAA Form 4587/1 (1-73) as a face sheet completing all items and attach the report to it.) If continuation pages are needed, plain bond paper is to be used. It should be noted that the report is to be signed by the person designated as project director on the grant application or any duly designated successor and reviewed by the cognizant State Planning Agency.

d. Content. Reporting should be non-cumulative and describe only activities and accomplishments occurring during the reporting period. These activities and accomplishments should be described with specific attention to project phases or stages completed (e.g., initial planning stage, completion of preliminary survey effort, purchase of required equipment, staging of pilot training program, etc.). Reports should be concrete and specific concerning accomplishments (e.g., number of people trained, volume of correctional services provided, extent of equipment usage, etc.). Special emphasis should be placed on comparison of actual accomplishments to goals established for the report period. If established goals were not met, reasons for slippage must be given. Special reports, evaluation studies, publications or articles issued during the period should be attached, and major administrative or design developments should be covered (e.g., changes in personnel, changes in project design, improvements or new methods introduced). Budget changes should be touched upon. Problem areas and critical observations should be mentioned and frankly discussed, as well as project successes.

e. Dissemination. All three (3) copies of regular quarterly progress reports and all five (5) copies of final reports should be submitted to the subgrantee's State Planning Agency. After review the State Planning Agency will forward two (2) copies of the quarterly report and four (4) copies of the final report to the cognizant LEAA Regional Office. The Regional Office will route the reports to all interested LEAA units. Copies should also be provided to other agencies cooperating in or providing services to the project.

f. Special Requirements. Special reporting requirements or instructions may be prescribed for discretionary projects in certain program or experimental areas to better assess impact and comparative effectiveness of the overall discretionary program. These will be communicated to affected grantees by LEAA.

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SEPARATE ATTACHMENTS

Correctional Health Care Program Resource Manuals Series

American Medical Association's Standards for Health Services in Prisons

Correctional Health Care Program Videotape Series

I. INTRODUCTION

The Correctional Health Care Program (CHCP) was established as a result of a grant award from the Law Enforcement Assistance Administration (LEAA). The award was made to the Office of Health Care of the Michigan Department of Correction for an eighteen (18) month period beginning December 1, 1977. Due to some delays in start up and judicious spending throughout the grant period, it was possible to extend the program an additional nine (9) months, through February 28, 1980. The program was established in response to a growing awareness of the general inadequacy of health services available to individuals incarcerated in this nation's jails and prisons.

LEAA had previously, through the National Institute of Law Enforcement and Criminal Justice, supported the development of a Prescriptive Package on Correctional Health Care. That publication was the basis for a regional training program on Health Care in Correctional Institutions developed and delivered by University Research Corporation's Executive Training Program, also supported by LEAA. In 1975, LEAA provided funding to the American Medical Association to implement a program to develop accreditation standards for health services in jails and provide technical assistance to jails to enable them to meet these standards. This program was initiated in six states and has since expanded to include 23 states, involving several jails in each state. Given the success of these programs, LEAA made funds available for a program to address the problems of health services delivery in prisons.

PROGRAM OBJECTIVES

The Correctional Health Care Program was a training and technical assistance program designed to assist correctional personnel in improving health services in state prison systems. CHCP's primary objectives have been:

1. To identify critical areas of need in individual states and provide expert assistance in planning and implementing programs to address those needs.
2. To provide correctional health care administrators with information and skills necessary for the design, implementation, administration and evaluation of health services programs in the correctional setting.
3. To increase knowledge of alternative methods of medical care delivery

to improve care in an effective yet cost efficient manner.

4. To increase staff skill in handling problems common to prison medical care.

In the course of the program, these objectives and a number of secondary objectives were achieved through a series of training workshops, on-site and off-site technical assistance to the states, and the dissemination of several resource materials for future use and reference by correctional health care personnel. One of the most important secondary benefits that was achieved was the establishment of formal and informal communication linkages between correctional health care administrators and providers in the ten (10) participating states and personnel from other states and organizations who participated in CHCP as speakers and resources. These linkages have proved to be significantly beneficial to workshop participants who have remained in regular communication with each other since meeting at the workshops.

SUBCONTRACTORS

The grant award was made to the Office of Health Care of the Michigan Department of Corrections. It was this office which was responsible for the organization, administration and full implementation of the program. The Office of Health Care was uniquely qualified to organize this program since it had been established to address the health care problems faced by the Michigan Department of Corrections (MDOC). In July of 1975, Director of Corrections, Perry Johnson, established the Office of Health Care as the equivalent of a Bureau within the Department. This was in response to recommendations made in Key to Health for a Padlocked Society, a study of health care in Michigan correctional institutions funded by LEAA. Jay K. Harness, M.D., was appointed Director of OHC and given line authority over all health care staff and budgetary control. Since the establishment of OHC, the annual appropriation for health care has risen from $2,765,300 (FY 1974-75) to $17,657,100 (FY 1979-80) while the number of approved staff positions has grown from 83.0 to 509.7 full time equivalent positions. This reflects substantial commitment to the improvement of both quantity and quality of health services provided within the MDOC. The phenomenal growth of OHC has begun to taper off having achieved reasonably adequate funding and staffing, and improved facilities. Particular attention is still being devoted to better management techniques, quality assurance measures, and cost containment efforts.

To assist in the implementation of CHCP, the OHC subcontracted with the following agencies for specific program activities: the American Medical Association, Division of Medical Practice, Program to Improve Health Services in Correctional Institutions (AMA); Michigan State University, Colleges of Human and Osteopathic Medicine, Department of Community Health Science (MSU); the University of Michigan, School of Public Health, Department of Medical Care Organization (UM); and University Research Corporation (URC). Each of these agencies was exceptionally well qualified for the role it undertook in this program. As the single most prominent professional organization of physicians, the AMA has been a leader in establishing acceptable levels of quality in health services. Their recent experience in developing accreditation standards for health services in jails set the stage for the development of standards for prison health care. MSU has been very active in developing continuing education programs for physicians and other health care professionals in both the academic and community setting. This experience proved invaluable in developing the training workshops and technical assistance for correctional health providers. The Department of Medical Care Organization of UM has a national reputation of excellence in training health services administrators through its masters and doctoral programs and the institutes it routinely conducts for the continuing education of administrators. UM was responsible for the training program for administrators and policy makers, and provided technical assistance in management techniques and system analysis.

In accord with the grant requirement, the evaluation component of the program was opened to competetive bidding. Evaluation proposals were solicited from a number of firms knowledgeable in both corrections and health care. A committee was appointed to review these proposals and make a selection. University Research Corporation, a Washington based firm, submitted a proposal which scored well when rated comparatively with the other proposals and proposed the lowest budget.

URC proposed a dual focus to the evaluation of this program, encompassing an assessment of both the program processes and its outcomes or results. This dual focus was related to the "pilot" nature of the program and the consequent importance of identifying and describing program features and activities which contributed to the achievement of the program's objectives. Thus the approach called for an evaluation of discrete program activities (such as training and technical assistance) as well as the cumulative and overall effect of these efforts in contributing to improvements in the organization, management and delivery of health services in the ten states.

STAFF RECRUITMENT AND TRAINING

Staff recruitment was the first major activity to be undertaken by the Office of Health Care and the subcontractors. While a number of key actors from both Universities and the AMA had been involved in the proposal development, these people alone could not conduct the many necessary activities, and active recruitment for additional staff began prior to the grant award, and continued for several months. The objective of recruitment was to assemble a team of people with both health care administration and corrections experience who would be able to further develop and implement CHCP.

Recruitement proved to be difficult in that there was not a very substantial resource pool from which to draw correctional health care professionals. In the end, only a few members of the recruited staff had any actual experience in corrections. Therefore, to familiarize CHCP staff from both universities with the unique aspects of providing health services in prisons, arrangements were made with the Michigan Department of Corrections for orientation tours to be conducted at several Michigan institutions. CHCP staff visited the State Prison of Southern Michigan, Huron Valley Women's Facility, Muskegon Correctional Facility and Marquette Branch Prison. During each tour, project staff examined physical facilities, interviewed inmates, met with and questioned prison administrative and medical personnel, and observed the provision of health services to patients.

In addition, CHCP staff held a number of interviews with selected personnel from the MDOC. These included persons from the central office with overall responsibility for health services in Michigan institutions, as well as physicians, nurses and administrators from several institutions not visited. To supplement these direct contacts, staff initiated a literature review and began attending national meetings and seminars pertinent to correctional health care. All of these things provided CHCP staff with in-depth exposure to the particular problems and constraints encountered in designing and operating health services in prisons. Brief biographical sketches of most CHCP staff can be found in Appendix A.

II. STATE SELECTION

CHCP was initially designed as a pilot project to develop an appropriate methodology for assisting correctional health care administrators and providers in improving health services in their prisons. The training and technical assistance program was therefore designed to be implemented in ten states.

Selection of the ten states for participation involved the identification of selection criteria, the collection of information from states through an application process, the evaluation of applications with respect to selection criteria, and the final selection of ten states from among qualified candidates.

Since it was anticipated that a large number of states would wish to participate in CHCP, it was important that criteria be developed by which candidate states could be evaluated as objectively as possible, and that the selection process result in a group of ten states that were sufficiently varied in characteristics to adequately test the efficacy of CHCP's approach to training and technical assistance. Representatives of all of the agencies involved in CHCP met and decided that the ten states selected for participation should represent a mix in terms of the following criteria:

Geographic location - All regions of the United States should be represented.

Size of state - The geographic area of the state (number of square miles) and the dispersion of facilities would affect the design of health care programs.

Stage of development of correctional health systems - The number and type of health professionals and the "sophistication" of the system would be related to the need for technical assistance.

Degree to which courts are requiring improvements in health services - This type of legal pressure would influence a state's need for immediate technical assistance.

Organizational structure of correctional health services - How health services are organized at the institution and central agency would influence the likelihood of being able to use technical assistance appropriately.

Each of these criteria have several dimensions, which were reflected in the application of questionnaire and application evaluation process.

APPLICATION PROCESS

Before selecting the ten states, it was necessary to rate the characteristics of each state with respect to the selection criteria. It was decided that each state would be asked to complete a two part questionnaire describing the state Department of Corrections and health services in each institution. These questionnaires were intended to serve as applications to the program for any interested state, and were designed to:

- provide a basis for selecting states for participation in CHCP;
- provide content data for specific areas of the workshop curricula; and
- establish a baseline assessment of the status of correctional health services in the United States.

The questionnaires and program descriptions were mailed to forty-nine states (excluding Michigan) and the District of Columbia on March 24, 1978. Copies of these questionnaires are included in Appendix B.

The applications contained questions on the following topics:

For State Agencies

- Number of institutions
- Security levels, age ranges, number of inmates, capacity, number of employees, and year of construction for each institution
- Organizational structure of the corrections agency
- Decision-making authority
- Legal pressures
- Budget data - total current and predicted expenditures for corrections, health care

For Individual Prisons

- Prison location
- Correctional health personnel - number and type of FTE's
- Health services administration
- Health care budget - amount and how incorporated into institutional budget
- Health services provided, by whom

Each of these topics required several different types of questions. As applications were received the information was summarized and recorded on a state profile.

Completed applications were received within a month from the following 33 states and the District of Columbia:

Alaska	Kansas	Oklahoma
Alabama	Maryland	Rhode Island
Arizona	Massachusetts	South Carolina
Arkansas	Missouri	South Dakota
California	Nebraska	Tennessee
Colorado	Nevada	Utah
Connecticut	New Hampshire	Virginia
Florida	New Jersey	Washington
Georgia	New Mexico	Washington, D.C.
Hawaii	New York	Wisconsin
Illinois	North Dakota	
Indiana	Ohio	

It was necessary to design procedures to evaluate applications in such a way that each application could be objectively compared with all other applications. Using criteria agreed upon by all of the collaborating organizations, University of Michigan staff devised a scaling procedure, whereby each application was assessed on a scale of one (1) to five (5) for each of seven (7) different dimensions. A variety of characteristics were considered for each dimension.

SCALING AND CLUSTER ANALYSIS

The information received from applicant states varied considerably in completeness, accuracy, and consistency. For this reason, it was not possible to design a completely objective method by which states could be characterized. The scaling procedure relied on a process of subjective and relative consideration of many pieces of information. To minimize individual bias, at least two staff members assessed and scaled each application. The scaling procedure identified which questions on the application should be considered in arriving at a score for each dimension. Additional information, such as agency reports, court decisions, etc., were used when available. Following is an outline of

the seven dimensions and the information used for scoring each dimension.

Size Of Correctional System

- number of inmates
- number of facilities
- number of beds
- number of FTE's
- range of inmates per institution

Dispersion of Inmates and Facilities

- number of rural versus urban facilities
- number of inmates in each type of facility
- range of inmates between types of facility
- distance between facilities

Organizational Configuration of Correctional Health Services

- authority for decisions regarding organization and administration of health care
- authority for decisions regarding specific functional areas, standards
- recruitment decisions
- staff development policies
- to whom health administrator reports
- responsibility for health service functions
- budget control

State of Development of Correctional Health Services System

- malpractice protection for clinical staff
- changes currently occuring and specific problems
- correctional health manpower
- management of individual institutions' medical services
- responsibility for health service functions
- intake examinations
- functions of health care staff
- infirmary functions
- hospitalizations

Level of Allocation of Resources for Correctional Health

- current operating budget - corrections and health care
- expected expansion of expenditures for health care
- probability of increases in funding in next two years

Legal Pressures for Change in the Health Services System

- statewide injunctions
- institutional injunctions
- individual court decisions

Probability of Substantial CHCP Impact

- degree of legal pressure
- expected expansion of expenditures
- changes currently occuring and specific problems

The scaling procedure described above was augmented by input from all of the collaborating organizations and the Project Director.

Since the objective was to select ten states which represented a mix of characteristics, it was necessary to compare each state to every other state on all seven dimensions. A computer file containing the scaled profiles for each state was prepared, and a cluster analysis was performed. The purpose of the cluster analysis was to identify groups, or clusters, of states which were the most similar in all dimensions. Because a mix of non-similar states was desired, only one state was selected from each cluster. The selection of finalist states among the clusters was made based on two criteria: (1) the finalists should represent good geographic coverage of the United States; and (2) the probability of program impact should be high in all finalist states. By this process, thirteen states were chosen: Arkansas, Colorado, Florida, Illinois, Maryland, Missouri, Nebraska, Nevada, North Carolina, Rhode Island, Tennessee, Washington, and Wisconsin. Further detail on the scaling procedure and cluster analysis can be found in Appendix C.

SITE VISITS

For each of the finalist states, two to three-day site visits were arranged starting in May, 1978 and concluding in mid-July. Prior to the first site visit, a detailed interview guide (see Appendix D) was prepared by CHCP staff from OHC, UM, MSU and URC. Site visit teams consisted typically of representatives from

each of these organizations. Each visit usually consisted of a visit to the central office to interview corrections administrators, and visits to at least three prisons, depending on the size of the system. In the institutions, interviews were conducted with administrators and health care providers, and tours of the health care and housing facilities were undertaken. The site visit teams prepared extensive descriptive reports of the state systems, which were later reviewed by CHCP staff.

Following completion of the site visits, three of the states visited were excluded because, in the opinion of the site visit teams, either present condititions in the state would minimize the effectiveness of our assistance at the time or because the state's problems were relatively minor compared to other states visited. The ten states selected for participation were Colorado, Florida, Illinois, Nebraska, Nevada, North Carolina, Rhode Island, Tennessee, Washington, and Wisconsin.

III. STANDARDS FOR HEALTH SERVICES IN PRISONS

One important component of the Correctional Health Care Program was the development of standards for the accreditation of health services in prisons. At the time CHCP was established, there were a set of prison health care standards being cited. The American Corrections Association (ACA) had included a number of standards on health services in their complete set of Manual of Standards for Adult Correctional Institutions. The standards were somewhat limited in scope, and health care professionals were not satisfied with them. Another organization to develop standards was the American Public Health Association (APHA). While these standards were substantially more comprehensive than the ACA's, there were questions about the attainability of these standards. Additionally APHA standards encompassed areas (particularly environmental issues) over which, traditionally, health care professionals in corrections had very little, if any, control. LEAA was still looking for the development of a single set of standards which would address all of the pertinent issues and yet allow an attainable level of compliance. The American Medical Association's participating in CHCP was sought specifically to develop such a set of standards, since the AMA had developed expertise through its national project to set health care standards in jails. Implementation of the AMA Standards for Health Services in Jails had demonstrated that well-defined, operationally sound and uniformly accepted guidelines can result in:

- increased efficiency of health care delivery
- greater cost effectiveness, and
- better overall health protection for inmates, staff and the community.

With this in mind, it was hoped that national standards for health services in prisons could likewise result in improved correctional health care for the prison population.

The development and dissemination of the AMA Standards for Health Services in Prisons were two of the major activities undertaken during the AMA project period (April, 1978 through October, 1979). Additional supportive activities included the development of:

1. a plan for an accreditation program
2. evaluation instruments to record compliance with the AMA Standards for Health Services in Prisons, and

3. guidelines for basic health care facilities, space and equipment.

The processes involved in the AMA's subcontract included four major steps: setting standards, establishing an accreditation process, identifying resources, and disseminating information. Each of these is described in more detail in the following pages.

STANDARD SETTING

Since the AMA already had a "National Advisory Committee to Improve Medical Care and Health Services in Correctional Institutions" in place, a sub-committee of this group - consisting of four members of the committee and two consultants - was formed to provide assistance in the identification of prison health care standards. The already developed jail health care standards provided the basis on which to build needed prison health care standards. Because health services in prisons are generally more comprehensive and often provided under different circumstances than jails, the standards developed for jails had to be revised substantially to measure the situation found in prisons. Additional standards were developed by the sub-committee and then were presented to the full National Advisory Committee for review. Over a twelve month period, the prison standards were developed, revised and refined.

On several occasions, health care and corrections professionals reviewed the standards in draft form and provided feedback to the committee. Correctional health care administrators, providers, and trainers attending CHCP workshops in Michigan reviewed and discussed the standards as did attendees at the AMA's Second National Conference on Correctional Health Care. In addition, drafts of the standards were mailed out to interested correctional personnel and organizations such as the American Dental Association, the Joint Commission on the Accreditation of Hospitals, and the General Accounting Office. Approximately 432 individuals of diverse backgrounds as well as representatives of 23 state correctional institutions critiqued the prison standards and provided helpful comments. The full AMA National Advisory Committee provided continuous input and guidance to the prison sub-committee, and gave approval to the AMA Standards for Health Services in Prisons. These standards were accepted and endorsed by the AMA's House of Delegates in July of 1979. In October, the AMA printed copies of the standards for distribution to interested persons and organizations. (Copies of the AMA Standards for Health Services in Prisons accompany this report).

ACCREDITATION DESIGN

Standards in and of themselves do not necessarily provide a motivation for initiating needed improvements in a prison health care system. Thus, an accreditation plan and process were developed by the AMA to provide a system of measuring prisons against the standards. The prison accreditation plan and process were patterned after the highly successful jail accreditation program.

The plan developed for prisons outlines the procedures necessary for accreditation. The forms and evaluation instruments developed to assist in the accreditation process included:

1. an application for accreditation;
2. a self-survey questionnaire for the evaluation of health services;
3. guidelines for conducting an on-site survey of correctional health services; and
4. fifteen individual survey instruments (based upon the developed standards) for the on-site evaluation of health services in prison.

Copies of the accreditation plan and support documents are contained in Appendix E.

RESOURCE IDENTIFICATION

Standards cannot operate in a vacuum. Staff, facility, space and equipment provide the support to enhance the execution of standards. Thus, AMA project activities were also directed to provide guidelines for these resources as well.

To develop staffing guidelines, AMA staff attempted to ascertain prevailing staffing patterns in correctional institutions of varying sizes. A questionnaire was developed for the purpose of identifying existing prison health services staffing patterns and future needs and it was mailed to ten state Departments of Correction for pre-testing. Of the ten questionnaires mailed, six were returned; however, of the six only two were adequately completed. On the basis of this field test, the questionnaire was revised.

The revised questionnaire was then mailed to eight other state Departments of Correction with directions requesting personnel at institutions of varying sizes to complete the form and return it to the AMA. Five of the eight states

contacted responded, with a combined total of fifty correctional institutions reporting. Attempts to compare the responses from different institutions proved ineffective because in the variability in the comprehensiveness and method of delivery of health services. It became evident that realistic staff/inmate ratios could not be established without substantial further qualification, and the effort was abandoned.

Efforts to establish guidelines for space and equipment needs were somewhat more successful. Recommendations were sought from various correctional health planners and managers, and from related health care professionals representing dental, x-ray lab and pharmacy services as well as physician practice management programs. Suggestions were obtained from these individuals regarding their basic space and equipment needs for operating their support services in prison health facilities. It is hoped that the suggestions contained in the finalized Guidelines for Prison Health Facilities, Space and Basic Equipment, a copy of which is contained in Appendix F, may prove useful as general examples; however, it is recognized that they may be neither applicable nor feasible to implement in a given facility.

DISSEMINATION OF INFORMATION

Throughout the program period, the AMA kept national attention on the development of the prison health care standards through exposure at its National Conferences on Correctional Health Care and through AMA publications. Letters were written to the state medical societies and nursing associations in the ten CHCP states provided information about the standards, the Correctional Health Care Program, and offered assistance from the AMA project staff. Further assistance was provided by addressing prison health care administrators, providers and trainers at educational workshops regarding the implementation of selected standards in the following areas: legal aspects of prison health services, health education, effective utilization of medical societies, and in-service education.

IV. TRAINING WORKSHOPS

CHCP was developed as a training and technical assistance program designed to assist corrections administrators and health care providers in improving health services in the prisons in which they work. This section of the report will describe the series of training workshops which comprised a major component of the program. Planning for the workshop series began early in the first quarter of CHCP. The University of Michigan was assigned responsibility for three of the workshops: an introductory workshop for health service administrators (Administrators' Workshop I), a follow up workshop for the same audience (Administrators' Workshop II), and an issue-oriented seminar for state policy makers (National Seminar). Michigan State University was responsible for the design of a workshop for correctional health care providers (Provide Workshops I, II and III) which was to be conducted three separate times. Although there was no provision for a workshop for training officers in the grant proposal, it became obvious during the provider workshops that the involvement of training officers from the ten states could be instrumental in the introduction of new programs. For this reason, the Office of Health Care conducted a workshop (Trainers Workshop) for training specialists, correctional officers and health care providers from the states to discuss the training needs of health professionals. Following is a detailed description of each training session.

ADMINISTRATORS' WORKSHOP I

The initial Administrators' Workshop took place on August 12-18, 1978 in Ann Arbor, Michigan. It consisted of seven days of lecture and small group sessions, and several evening informal programs. Preparations for the workshops took place over several months prior to the workshop, and involved a variety of activities. UM staff established a library of reference materials relating to correctional health care, and used previous publications liberally in the development of the workshop curriculum. In the application forms, CHCP staff requested that applicants indicate areas that they considered to represent major problems in delivering health services. Responses to these questions suggested that there exists a common set of problems faced by Departments of Corrections in administering health care services. During the site visits to

the finalist states, CHCP staff discussed with administrators and health care providers the problems they face in working within a state bureaucracy and in delivering services to confined populations. The major problem areas identified in the applications to the Program and during the site visits provided a framework of topics for this first workshop.

The objectives of the Administrators' Workshop I were as follows:

1. Provide a framework for decision making regarding the organization of health service delivery programs.
2. Increase knowledge of the various alternative models available for each component of the delivery system and provide critical analysis of the advantages and limitations of these system models.
3. Increase understanding of critical structural and organizational features of correctional systems in state governments and their applications for prison health care systems.
4. Provide participants with information regarding the existing and proposed standards for the provision of health care services in correctional institutions.

The course was designed to provide participants with a framework for analyzing needs, identifying alternative delivery approaches and assessing resources necessary for implementing alternative modes of delivery. To accomplish this, the following sessions were defined for inclusion in the workshop:

- Definition of the role of the health services administrator.
- Definition of goals of correctional health services.
- Characteristics of correctional settings which impede effective management of health programs.
- Review of legal issues in correctional health care.
- Mental health services in correctional settings.
- Management of ambulatory care in correctional settings.
- Provision of dental services to inmates.
- Recruiting health care providers for correctional settings.
- Monitoring and assessment of health services in corrections.
- Health records in correctional settings.
- Inpatient acute care services.

- Pharmacies and drug distribution services.
- Issues in financial management of correctional health care programs.
- Implementing change in correctional health care programs.

In addition to staff from UM and OHC, a number of outside speakers were brought in for specific sessions. These included Myron Allukian, DDS, MPH, Assistant Commissioner and Director of Community Dental Programs, Department of Health and Hospitals, City of Boston; Robert L. Brutsche, MD, MPH, Medical Director, Federal Bureau of Prisons; Marcia R. Claussen, RN, MA, American Medical Association Program to Improve Health Care in Correctional Institutions; James H. Daugherty, MPH, Director of Prison Health Initiative, National Health Service Corps; Clare P. Evans, Research Associate, Medical and Chirurgical Faculty of the State of Maryland; William P. Isele, JD, Department of Health Law, Office of the General Counsel, American Medical Association; Richard A. Kiel, MBA, Chief, Health Services Section, North Carolina Division of Prisons; Lambert N. King, MD, PhD, Department of Medicine, Cook County Hospital; Fred C. Munson, PhD, Professor of Hospital Administration, University of Michigan; Eric Neisser, JD, Associate Professor, Rutgers Law School; Cecil Patmon, RN, MA, Medical Services Administrator, Illinois Department of Corrections; Sally H. Shanklin, MHA, Director of Health Services, Georgia Department of Offender Rehabilitation; Albert H. Taubman, PhD, Chairman, Department of Pharmacy, Northeastern University; Ellen Winner, JD, New York Legal Aid Society; and Martha Wheeler, JD, past president of the American Correctional Association.

The workshop was attended by 29 correctional and correctional health administrators, three from each of the participating states except Rhode Island (which sent two), and a number of administrative personnel of the Michigan Department of Corrections. At the beginning of the workshop and at the conclusion, the University Research Corporation asked each of the attendees to complete a course assessment questionnaire. Results of the workshop evaluation are presented in detail in Section VI of this report and Appendix H. Workshop materials are contained in Appendix G.

ADMINISTRATORS' WORKSHOP II

The second Administrators' Workshop was held in Ann Arbor on September 16-20, 1979. This workshop consisted of four days of large group sessions, small

group discussions and lectures, and two evenings of optional informal discussions on specific topics. The workshop was planned as a more intensive follow up conference, designed to complement the first workshop and take advantage of the intervening year of technical assistance activities. Its orientation was much more focused and specific than the first workshop.

The theme of the workshop was "Management Control." The presenters approached the topics from the perspective that the quality and efficiency of health services provided can be improved by increased management control over program operations. Specific workshop objectives were as follows:

1. Present information on and discuss a variety of management activities for maintaining programmatic control.
2. Provide several specific illustrations of the ways in which these management techniques may be used.

Preparatory to planning this workshop, a survey questionnaire was distributed to health care administrators in the ten participating states. This survey was designed to elicit the potential participants' needs and preferences in workshop content and scheduling. Issues that were encountered in the technical assistance phase were suggested as topics with specific problem areas identified. A majority of administrators returned the questionnaires indicating preferences and commenting on the curriculum design. Workshop topics and the organization of the programs were developed as a result of this input from participants.

The workshop was designed to allow maximum time for large group discussions and small group problem-solving. The following topics were covered in the nine sessions:

- Policies and procedures.
- Standards and accreditation.
- Professional staff management.
- Budget management.
- Management information systems.
- Facilities planning.
- Mid-level practitioners and protocols.
- Organization of pharmacy services.
- Dental health services.
- Intake health appraisals.

In addition to staff from UM and OHC, presenters included a number of

people from CHCP and non-CHCP states who had particular expertise and experience in specific areas of interest to the participants. These included: Carol J. Charney, BSN, Director of Nursing Activities, Health Education Foundation of Eastern North Carolina; Colin Clipson, MSC, Professor of Architecture, University of Michigan; Michael Easley, DDS, University of Michigan; Wilhelm Haag, RPh, Pharmacy Supervisor, Virginia Department of Corrections; Howard Johnson, MHA, Health Services Administrator, Minnesota Department of Corrections; Stephen Minnick, Accreditation Manager, Maryland Department of Public Safety and Corrections; John Mudri, BBA, Compliance Group Supervisor, Drug Enforcement Administration; John Murdock, MPA, Assistant Commissioner for Health Services, New York Department of Correctional Services; Robert M. Stevens, MSPh, Director, Pharmacy and Medical Supplies, Rikers Island Health Services, New York; and Joseph Wehrer, BA, Professor of Architecture, University of Michigan.

This follow up workshop was attended by twenty-four administrators from eight of the ten participating states (Nevada and Washington were unable to send participants due to urgent problems in the state). The criteria which were suggested to the states for selecting delegates to the second Administrators' Workshop were the same as those suggested for the initial workshop: delegates should be persons who have authority for the planning and day to day management of health services at either the central office or institutional levels. Due to the significant turnover in administrative staff during the fourteen months between the workshops, only about half of the participants to the second workshop had attended the first one. Workshop materials can be found in Appendix G; the evaluation report is in Appendix H.

PROVIDERS WORKSHOP

The Providers Workshop was held on three separate occasions during the Fall of 1978: September 30 - October 6, November 3 - 10, December 2 - 9. The primary goal of the workshops was to enable participants from each of the client states to gain a broader perspective of correctional health care delivery systems and to increase their ability to better deliver services to inmates.

The curriculum of the workshops was developed through the use of several different activities: site visit surveys, review of the literature, and discussion with consultants. At the completion of this process, the following instructional objectives were identified:

1. Provide participants with an overview of current trends and issues regarding the criminal justice system.
2. Provide participants with an overview of current trends and issues with respect to correctional health care.
3. Increase participant familiarity with currently drafted AMA Standards for Health Services in Prisons.
4. Introduce participants to the basic elements of the "knowledge utilization model," so as to assist them in developing new programs within their respective prisons.
5. Provide participants with an increased awareness of the potential effects of job-related and environmental stress on job performance.
6. Introduce techniques for the control and reduction of stressful conditions which occur within the correctional setting.
7. Acquaint participants with alternative approaches for the improvement of interpersonal communication skills.
8. Provide participants with a basic understanding of protocol-directed health care, the rationale for adapting and utilizing protocols in corrections, and strategies to employ in the implementation of a protocol-directed system.
9. Provide participants with a basic understanding of a health information system and the skills for implementing such a system within the correctional setting.
10. Provide participants with information regarding alternative approaches to medication distribution systems within corrections.
11. Provide participants with a basic understanding of health education programming in a correctional setting, the rationale for adapting and utilizing health education, and a systematic approach to planning, developing, implementing and evaluating such programs.

The instructional strategies employed for the workshops included a mix of large group presentations (lectures) and a series of small group problem-solving sessions. Small groups consisted of 10-12 participants with a CHCP staff member as facilitator. In addition to the formally scheduled sessions, participants were also able to participate in open agenda sessions in which they could determine the topics for discussion.

In addition to MSU and OHC staff, presenters included Ellis MacDougall, Director, Arizona Department of Corrections; Martha Wheeler, past president of the American Corrections Association; Marsha Claussen, RN, MA, AMA staff consultant; Esther Fergus, Department of Psychology, MSU; L. Wendell Rivers, PhD, Neuropsychologist, Adjunct Professor of Community Medicine, St. Louis University College of Medicine; Peter Vidor, MSW, Clinical Social Worker, Riverside Correctional Facility, MDOC; Willie Wilson, MA, Chief Psychologist, Riverside Correctional Facility, MDOC; Dennis Lassiter, Assistant Chief of Health Services, North Carolina Division of Prisons; Barry Wolcott, MD, Assistant Chief, Department of Medicine, Brooke Army Medical Center, Fort Sam Houston, Texas; Henning Engmark, RPh, Chief Pharmacist, State Prison of Southern Michigan; Dean Rieger, MD, Medical Director, Huron Valley Women's Facility, MDOC; Richard Huff, DO, Medical Director, Muskegon Correctional Facility, MDOC; Diane Haynor, RN, Nursing Director, Muskegon Correctional Facility; Robert Longman, PA, Muskegon Correctional Facility; William Carlyon, PhD, Director of the Department of Health Education, AMA; Judi Witter, Health Education Specialist; Janice Wine, RN, Nursing Director, Huron Valley Women's Facility, MDOC; Terri Schumacher, RN, Assistant Director of Nursing, Huron Valley Women's Facility.

A variety of instructional materials were utilized during the workshops. These included a series of "critical incident" videotapes concerning the need for medical record systems within the correctional setting developed by Susan Helbig, RRA, and Jack Ellis, MSW, small group simulation materials for determing appropriate program change strategies, slide tape presentations on selected subjects, and a number of different problem-solving materials for use by small groups. Participants also had the opportunity to view several films and videotapes on issues related to correctional health care and to examine a representative display of current literature in the field.

The three workshops were attended by 173 participants from the ten states and Michigan. A breakdown of the participants by type of health care profession can be found in Figure 1. Those participants eligible for continuing education credits received them.

FIGURE 1

PARTICIPANT PROFILE - PROVIDER WORKSHOPS

POSITION	%
Nurse - RN	43.9
Nurse - LPN	9.2
Physician	7.5
Physician Assistant	6.3
Administrators	5.2
Medical Technicians	3.4
Custody Staff	2.8
Nurse Practitioners	2.3
Psychologists	2.3
Hospital Supervisors	2.3
Dentist	1.7
Pharmacist	1.1
Health Records Specialist	1.1
Other	10.4

Evaluators from URC attended the first and second Providers Workshops but not the third. Throughout the workshop, participants were asked to complete evaluative questionnaires which would form the basis for the evaluation report. Because the same workshop was held on three separate occasions, MSU staff were able to incorporate changes suggested by participants and the evaluator into the schedule for the second and third workshop. Results and discussion of the evaluation can be found in Section VI of this report and Appendix H. Workshop materials are contained in Appendix G.

TRAINER'S WORKSHOP

The Workshop for Training Specialists, Health Care and Custody Personnel took place on February 26-28, 1979 in East Lansing, Michigan. The program was designed by the training consultant and other OHC staff to discuss strategies for meeting the training needs of health care professionals as identified in the previous workshops. The objectives for this workshop were as follows:

1. Inform trainers and other correctional personnel about the Correctional Health Care Program.
2. Discuss specific training strategies for staff development.
3. Identify training needs in correctional health care.
4. Provide information for the development of health care training programs.
5. Propose a strategy for resolving real and perceived professional conflict.

OHC, UM, and MSU staff described the CHCP workshops and technical assistance activities in the ten states and discussed the types of programs that could be established in individual institutions. In addition, Robert Richards, PhD, Assistant Dean of the College of Human Medicine at MSU, and Director of the Grant Rapids Area Medical Education Corporation, addressed the group on the continuing education requirements of health care personnel and the role of the training officer in meeting those needs.

This workshop was attended by 26 participants from nine of the ten states (Washington was unable to send representatives at that time). This group was roughly one third training officers, one third custody officers and one third health care providers. URC evaluated this workshop and the results will be discussed in Section VI of this report. A copy of the evaluation report is included in Appendix H, and copies of the training materials are in Appendix G.

NATIONAL SEMINAR

A National Seminar oriented toward correctional leaders and policy makers in all fifty states and the District of Columbia was held on October 21-23, 1979 in Ann Arbor, Michigan. The seminar was designed to alert state officials to the nature of the problems in correctional health care, and to suggest various strategies for the solution of the problems. In order to be sure that issues of concern to state corrections administrators throughout the country were represented in the seminar, the conference was co-sponsored by CHCP and the American Correctional Health Services Association (ACHSA) - a professional organization for correctional health care administrators and providers with membership representing correctional agencies throughout the country. ACHSA established an advisory committee to review the seminar agenda and speakers and offer suggestions.

The theme of the National Seminar was "Cost-Effective Strategies for Improving the Quality and Efficiency of Correctional Health Care Programs." The specific conference objectives were:

1. Acquaint participants with current issues in health care delivery in correctional institutions.
2. Describe short-and long-run strategies for improving prison health care.
3. Discuss the roles of correctional directors and state legislators in achieving these improvements.

In order to accomplish these objectives and to engender interaction among participants, the following topics were discussed:

- Correctional Health Care in Prespective - Keynote address.
- Problems in delivering health care in correctional institutions.
- The U.S. Health Care System: issues and lessons for corrections.
- Legal issues and trends in providing health care to inmates: what the courts are saying.
- Standards and accreditation of health services in correctional institutions.
- Cost-effective strategies for achieving improvements: experiences from CHCP.
    - System assessment and development of long range plans
    - Use of clinical protocols and mid-level practitioners
    - Centralization of pharmacy services

- Strategies for providing hospital care and specialty services
- Reducing costs resulting from medically inappropriate transfers
- Centralizing authority and responsibility for health care services.

Presentations at the seminar were made by CHCP staff based on their experiences in working in the ten CHCP states during the preceding year. A number of guest speakers were also invited to discuss specific issues in their area of expertise. These included Richard A. Kiel, MBA, President, American Correctional Health Services Association; Perry M. Johnson, MS, Director, Michigan Department of Corrections; William P. Isele, JD, Office of the General Counsel, American Medical Association; Robert L. Brutsche, MD, MPH, Medical Director, Federal Bureau of Prisons; Susan Ainslee, MS, Reserach Associate, Correctional Standards Program, American Corrections Association; and Kenneth L. Fiaver, MLIR, Associate Director, Office of Health Care, Michigan Department of Corrections.

Fifty-two persons from forty states, the District of Columbia and the Federal Bureau of Prisons attended the National Seminar. The group of participants was made up of directors and deputy directors of corrections, state legislators and their aides, and correctional health care administrators from central state agencies. The seminar provided a unique opportunity for senior corrections officials and representatives of state government from a wide variety of states to discuss with CHCP staff and each other the problems and issues confronting them as they make decisions on resource allocation and expenditures for correctional health care programs. It was apparent from floor discussions and from informal interaction during the conference that exposure to alternative strategies for program design provided participants with useful ideas to try in their states. Workshop materials can be found in Appendix G. URC did not evaluate this conference.

V. TECHNICAL ASSISTANCE

In addition to the provision of training workshops, the other major aspect of the Correctional Health Care Program was technical assistance to individual states. Planning for the technical assistance phase of the program began early in the project, although actual technical assistance in the states did not begin until after the first Administrators' Workshop. The technical assistance aspect of the program was intended to complement the administrators' and providers' workshops by focussing on specific problems in the participating states and working with health services professionals to design and develop alternative strategies to deal with problems.

TECHNICAL ASSISTANCE PLANNING

Technical assistance planning essentially began during the preliminary site visits to the states. During those visits, CHCP staff explained the nature of the program, and encouraged state administrators to begin thinking about their needs for technical assistance. It was emphasized that immediately subsequent to the first workshop administrators would be asked to specify their technical assistance needs, based on their knowledge of their systems, and the information they gained at the workshop.

In the meantime, CHCP staff made their own preparations for technical assistance. Based on site visit reports, original applications, and supplementary descriptive materials requested during the site visits, CHCP staff developed their own estimates of what the most pressing needs were in each state. It was determined that the most likely modes of technical assistance delivery would be either the consultant model, which would generally result in the investigation of a specific problem and a written report discussing the problem and strategies for dealing with it, and the mini-workshop model, which would be a one to two day work session on a specific topic conducted within the state for selected groups of health providers. These will be discussed in more detail on page 28. The overall coordination of technical assistance in each state was to be the responsibility of a single individual to avoid confusion; UM staff were given this responsibility. All technical assistance provided to a state was to be part of a unified plan with each collaborating organization performing in its particular area of expertise.

Prior to the first Administrators' Workshop when discussions on technical assistance would be initiated with administrators from each state, the TA coordinators met with Courtland Cammaan, PhD of the Institute of Social Research of the University of Michigan to discuss how the technical assistance phase of CHCP would be conducted. Dr. Cammaan has extensive experience in technical assistance, and discussed with CHCP staff such issues as the objectives of the technical assistance programs and relationships between program staff and correctional staffs in the participating states. He also explained some of the common problems and pitfalls that outside consultants encounter when working within complex organizations such as departments of corrections.

At the end of the first Administrators' Workshop and each of the Providers' Workshops, participants were asked to identify their technical assistance needs using their workshop experience as a frame of reference. In most cases, however, the needs identified during the workshops were preliminary, incomplete and often unrealistic in light of the program resources. Substantial follow-up work was required before a final TA plan, agreed to by both parties, was developed for each state.

The TA planning process as it evolved, was an iterative one, with several stages of refinement and contact necessary before actual assistance could be provided. The iterative process was affected by both program and state dynamics, which are discussed below:

- CHCP defined TA as reactive and responsive to the states' needs. For this reason, CHCP was initially reluctant to shape, structure or limit the state's freedom to identify their priority problems.
- In the absence of clearly defined or articulated topic or resource limits, a number of states identified needs that were considerably beyond the program's capability to address. Negotiations between CHCP and the states then occurred resulting in either a redefined priority list or requests scaled down in scope and comprehensiveness.
- A number of states floundered in identifying TA needs and this required a more proactive response from the program staff. In several instances, an evaluation site visit was conducted to aid the state in identifying TA needs which the program could address.
- Several states faced crises which diverted management's attention from the program. In these instances, the program lost the momentum created by the workshops, and when the crisis was over, it was difficult to create and sustain a high level of interest and attention.

- The state's involvement in the TA process was also affected by the state's commitment to implementing changes. Those states committed to change were more interested in using the assistance available through CHCP, than those which regarded the health care system as adequate or of minimal concern.
- The delivery of technical assistance frequently involved a collaborative effort with the states, and expectations that information would be collected, task forces and study groups formed, etc., as part of the state's role in TA. This collaborative working relationship was difficult for the states because they were understaffed, addressing crises, or had to work through a cumbersome multilayered review and decision making structure. In addition, the health care administrators in most states lacked authority for the line staff and thus faced difficulties in including them in planning and implementation efforts.

MODALITIES FOR THE PROVISION OF TECHNICAL ASSISTANCE

Several modalities for the provision of technical assistance evolved during the course of the program. MSU organized the TA they provided around three major topics addressed in their workshops and identified by workshop participants as priority areas. These topics were: staff development including stress and communication, health education and clinical protocols. The administrators in each state were sent descriptive information about these options and asked to rank them in terms of the importance to their state, and identify the level of concern, e.g., planning, developing, implementing or evaluating each of the programs.

These requests from the states were then acted upon by MSU staff. Usually each topic was addressed at group meetings of 10 to 20 participants selected by the state. The MSU staff person followed a generic process for each topic addressed, tailoring the approach to the specific requirements of the stae. Generally, the product of these TA engagements was a task force formed to either plan, develop or assist in the implementation of the selected health care delivery program. See Appendix I for more detail on the MSU TA process.

The approach of UM and OHC to TA was more open-ended in both the topics covered, and the approaches used. The range of approaches included the following:

- Site visit evaluations of either the overall health care delivery system or a specific component, followed by an assessment report with recommendations of actions needed.
- The development of specific products which could be used in implementing management control systems in such areas as health records or management information systems.
- Documentation of needed improvements, including strategies for accomplishing these improvements.
- Consultation, assistance, critique and review of processes and products being developed by the state.
- Assistance in identifying resources, consultants, and materials needed by the state.
- Assistance in problem solving, and in addressing short term information collection, analysis or documentation needs.

There was a considerable amount of overlap of topics addressed in both training and technical assistance, and technical assistance built on the information gained during the workshops wherever possible. Areas most frequently addressed by the TA included: Management Information Systems, Staff Development, Pharmacy Services and Health Records. Although a considerable amount of time and effort went into narrowing down the number and scope of the TA requests that CHCP would address most of the technical assistance provided resulted in some follow up state efforts, and in a number of instances actual plans to implement change. The specific activities in each state will be described in the following section of this report.

STATE TECHNICAL ASSISTANCE ACTIVITIES

Over several weeks following the conclusion of the Administrators' Workshop, the TA coordinators remained in frequent contact with correctional administrators in the states to develop the technical assistance plans. During the three month period during which the Provider Workshops were being conducted, the TA coordinators visited each state to finalize plans for technical assistance. Through these follow-up discussions with administrators, and through the input of providers attending the workshops, a Technical Assistance Plan was negotiated for each state and approved by CHCP staff and state administrators. These plans were submitted to the Office of Health Care, and served as the basis for all technical assistance in the

FIGURE 2

TECHNICAL ASSISTANCE PROVIDED BY AREA

Technical Assistance Area	Needs Initially Identified	Planned	Provided	Status of Implementation
COLORADO				
Management Information System	X	X	X	Forms completed implemented 9/1/79
Management Quality Care	X	-	-	-
Referral Hospital Service	X	-	-	-
Evaluate Mental Health	X	-	-	-
Triage/Protocols	X	X	X	Committee established
Develop Communication Resource	X	-	-	-
Guidance for establishing health care program		X	X	Report to committee. Site selection still pending
FLORIDA				
Protocols	X	X	X	Developmental
Staff Development	X	X	-	-
Management Information System	X	X	X	Ready for pilot
Review of Master Plan	X	-	-	-
ILLINOIS				
Management Skills/Staff Development	X	X	X	Committee formed to conduct needs assessment & training development.
Pharmacy	X	X	X	Report provided Credibility for changes previously proposed.
Recruitment	X	-	-	-
Standards and Obligations	X	-	-	-

Figure 2 (continued)

ILLINOIS (continued)

Technical Assistance Area	Needs Initially Identified	Planned	Provided	Status of Implementation
Health Records	X	X	Postponed unavailability of prof. staff.	-
Management Information System/ Budget	X	-	-	-
Monitoring/Evaluation Quality	X	-	-	-
Protocols	-	X	X	Previously developed protocols adopted by committee.
Intake Health Appropriations	-	X	X	Implemented: scheduling, procedures standardized; staffing patterns changed.
Health Education	-	Requested later	X	Did not address interest of participants.
NORTH CAROLINA				
Health Records	X	X	X	Task Force formed; developed design; policy written in draft form.
Pharmacy Services	X	X	X	Task Force formed; policies & procedures written; implemented changes in specific areas.
Diet Therapy	X	-	-	-
Quality Evaluation	X	-	-	Task Force on continuity of care.
Management Information System	X	X	X	Task Force formed; design for collecting & utilizing data.
Central Hospital--Space Utilization	X	-	-	-
Clinic System	X	-	-	-
Design of Program Evaluation Instrument	X	-	Request cancelled	-

FIGURE 2 (continued

NORTH CAROLINA (continued)

Technical Assistance Area	Needs Initially Identified	Planned	Provided	Status of Implementation
Protocols	-	X	X	Task Force formed; relying on in-system expertise.
Staff Development	-	X	X	Task Force formed; planning mtg. held; need for long-term system plan.
RHODE ISLAND				
Pharmacy	X	X	X	Medication storage New procedures
Medical Records	X	X	X	Still top priority for change
Protocols	X	-	-	-
Policies and Procedures Manual	X	-	-	-
Management Information Systems	X	-	-	-
Program Survey and Evaluation--MSU	-	X	X	Report was instituted.
Staff Development	-	X	X	Committee established.
Health Care Education Programs	-	X	X	Committee established.
TENNESSEE				
Medical Records	X	NA	Prof. staff unavailable	-
Management Information Systems	X	NA	Postponed	-
Establish Centralized Budget	X	NA	-	-
Grant Application	X	NA	-	-
Evaluation of Program	X	NA	-	-
Intake Screening	-	X	X	Report useful for planning.
Evaluation of Central Hospital	-	X	X	Alternatives for facility evaluation.
Dental Services	-	X	X	X
Cost Estimates of Four Proposals for Hospital Service Delivery	-	-	X	Cost estimates presented at appro. committee meeting - one accepted and funded.

FIGURE 2 (continued)

NEBRASKA

Technical Assistance Area	Needs Initially Identified	Planned	Provided	Status of Implementation
Mental Health Services	X	-	X	Referrals to other programs.
Program for Diagnosis and Evaluation	X	X	X	Through report of overall assessment.
Management Information Systems	-	X	X	Still in design stage.
Policies and Procedures Manual	-	X	X	Policies manual written and approved.
Protocols	-	X	-	State staff felt they could address this problem.
Staff Development	-	X	X	Planning committee formed.
Overall Assessment	-	-	X	-

NEVADA

Evaluation of Medical & Dental	X	-	X	Recommendations in report not implemented due to shortages in staff.
Management Information Systems	X	-	-	-
Monitoring System--Planning New Facilities	X	-	-	-
Staffing Request/Justifying New Positions	X	-	-	-
Organizing Mental Health Services	X	-	-	-
Policies & Procedures Manual	X	-	X	No progress due to shortage of staff.
Medical Record Format	X	-	-	-
Staff Development	-	X	-	State cancelled request.
Protocols		X	-	State cancelled request.

FIGURE 2 (continued)

WASHINGTON

Technical Assistance Area	Needs Initially Identified	Planned	Provided	Status of Implementation
Strategy for Implementing POMR and MIS	X	-	X	Record fully implemented in one instit.
Plan for Acute In-patient Services	X	-	-	-
Review Policies and Procedures	X	-	-	-
Management Information Systems	-	X	X	Eval. possibilities for design.
Pharmacy	-	X	X	Task Force appointed.
Staff Development	-	X	X	-
Protocols	-	-	X	Draft Form.

WISCONSIN

Communication Between Divisions	X	-	-	-
Management Information Systems	X	X	X	Implemented.
Medical Records	X	X	X	Committee working on.
New Facility Design	X	-	-	-
Community Resources	X	-	-	-
Mental Health Services	X	-	-	-
Medical Intake Process	X	-	-	-
Referral--Secondary & Tertiary Care Study	X	X	X	Used as background in planning.
Dental Services	-	-	X	Upgrading equipment; redesign staffing.
Staff Development	-	X	X	-
Health Education	-	-	X	Interested staff members involved in training.

succeeding year. Further detail was added to each item in the plan through communication between the state administrators and the staff member or consultant responsible for that item.

Beginning in October, 1978, and proceeding for approximately eleven months, CHCP staff provided technical assistance on an on-going basis to the ten participating states. CHCP staff from all collaborating organizations met frequently to discuss the activities in each state. The TA coordinators submitted monthly reports detailing the progress in each state and frankly and confidentially discussing the personal and political dynamics in each state which could affect the outcome of CHCP involvement. Additionally, reports were written following most TA site visits and included in the file of materials on each state. Figure 2 summarizes the technical assistance provided to the ten states. The following state-by-state narrative summaries outline TA objectives and accomplishments in condensed form. A comprehensive description of the processes and outcomes of both the training and the technical assistance phases is included in the evaluators report contained in Appendix H.

COLORADO

Technical assistance objectives:

1. Determine the most appropriate location for health services within the Canon City complex.
2. Develop a health information system for the Department of Corrections.
3. Assist in identification of goals and develop program plan for the implementation of clinical protocols.
4. Develop training plan for health care providers in the Department of Corrections.

CHCP staff made six visits to Colorado. During these visits CHCP staff met with the site selection committee and the architects regarding the location of the health services; key administrators and health care providers to review program possibilities for the use of clinical protocols; training staff and health care providers regarding training needs; and administrators to collect information on the health information needs of the department. As a result of these visits and additional investigation the following documents were submitted to the Colorado Department of Corrections:

- A report on service and locational alternatives for the delivery of health care services in the Canon City complex.
- Summaries of utilization data concerning inpatient and outpatient services delivered to inmates by the Colorado State Hospital, including transportation cost data.
- Data collection forms designed specifically for the Colorado Department of Corrections, with instructions for their use.

The committee investigating the potential use of clinical protocols in the Colorado Department of Corrections decided to develop protocols for the purpose of triaging inmate complaints in filed units and institutions without 24 hour nursing coverage.

FLORIDA

Technical assistance objectives:

1. Identify health information needs of administrators at both the central office and at several representative institutions.
2. Develop a health information system for use in collecting utilization and productivity data at all Florida institutions.
3. Train health service workers in the use of the data collection system.
4. Facilitate committee activity in regard to the development of a program for the use of clinical protocols.

CHCP staff made five visits to the Florida Department of Corrections central office and several large institutions. The purpose of these visits were to discuss with central office administrators and institutional providers their health information needs; the current computer capacity for data collection and tabulation, and the current organization of health services at a number of representative institutions; and the development and implementation of clinical protocols for use by the medical technicians throught the department. The following documents were submitted to the Florida Department of Corrections as a result of the technical assistance effort:

- A detailed questionnaire designed to elicit information on the health care delivery system and the health information needs of Florida's institutions.
- A manual health information system designed specifically for the Florida Department of Corrections, including a summary of the

purposes of a management information system, data collection forms for use in Florida institutions, and a detailed procedure manual for implementing the system.

The committee established to develop the use of clinical protocols for use in Florida institutions determined that they would adapt protocols developed by the army for use by medical technicians, the largest body of care providers in the system. A planned four week trial of the protocols in seven institutions was to occur following a visit by two committee members to Fort Sam Houston to observe the army protocols in use.

ILLINOIS

Technical assistance objectives:

1. Evaluation of the intake health appraisal system at Stateville.
2. Provide consultation on appropriate health record management.
3. Provide consultation on pharmacy management in correctional institutions.
4. Assist in the planning of a staff development program.
5. Assist in the planning of a health education program for inmates.
6. Assist in the development of clinical protocols to be used by mid-level care providers.
7. Design a portion of the orientation program for all new corrections employees which would sensitize them to the special problems of delivering health services in a correctional institution.

CHCP staff made four visits to the Stateville facility for the purpose of observing and evaluating the intake health appraisal system and the drug distribution system in this institution. These visits involved extensive interviewing of administrators and providers concerned with these areas. CHCP staff made three additional trips to meet with committees established to consider the development and implementation of health education, staff development and clinical protocol programs.

The following documents were submitted to the Illinois Department of Corrections as follow up to the evaluation efforts:

- A report outlining the results of the evaluation of the intake health appraisal process at the Joilet Reception and Classification Center, which contains a description of current practices, an assessment based on AMA standards and recommendations for change.
- A report containing an evaluation of the Stateville pharmacy and drug distribution system, which outlines current practices which are inappropriate based on professional pharmacy standards and AMA standards.

It was not possible to provide assistance in health record management because the Illinois Department of Corrections was unable to recruit health records professionals with whom CHCP could work. As a result of other technical assistance activity, a planning committee was established to develop a management training program for health care supervisors and administrators and operationalize it within a year. A task force was to be appointed to investigate the use of clinical protocols for specific ailments and chronic conditions.

NEBRASKA

Technical assistance objectives:

1. Conduct a general assessment of the health care delivery system.
2. Redesign the health information system in order to produce more useful and accurate information.
3. Work with the health services administrator to develop policies and procedures for health services in all Nebraska institutions.
4. Assist representatives of the Nebraska Department of Correctional Services in the information of plans for a staff development program.

CHCP staff visited the Nebraska Department of Correctional Services on five occasions. The purpose of these visits were: (1) to meet with health services administrators to identify the inadequacies of the current information system and identify additional information needs; (2) to discuss the process for developing policies and procedures for all Nebraska institutions; and (3) to discuss the staff development needs of health care staff.

The following documents were submitted to the Nebraska Department of Correctional Services as a result of the technical assistance effort, both on-site and off-site:

- a report containing a general evaluation of the Nebraska health delivery system, including specific recommendations for staffing the new facilities, and identification of problem areas in which immediate technical assistance is recommended.
- a data collection system, including forms designed specifically for collecting health care utilization data in Nebraska institutions, with detailed instructions for their use.
- an outline of policies and procedures needed by the Nebraska Department of Correctional Services, including references to ACA and AMA standards.

As a result of the technical assistance, a planning committee was established to complete planning and implement a staff development program focussing on communication skills, individual decision-making, support systems and the legal ramifications of providing health services in corrections.

NEVADA

Technical assistance objectives:

1. Perform a general evaluation of the health care delivery system in all Nevada institutions.
2. Assist in the development of a policies and procedures manual.

Note: Identification of other technical assistance priorities were attempted, but due to organizational and administrative problems in Nevada, they were unable to commit staff and resources to follow up on the TA process.

CHCP staff made three visits to meet with administrative staff to discuss the value and uses of a comprehensive evaluation, and the staff development needs of health care providers, and to observe the process of health services as delivered in Nevada institutions.

The following documents were submitted to the Nevada Division of Prisons as a result of technical assistance efforts:

- an evaluation report documenting current practices in the health care delivery system and recommending areas for change and program development.
- an outline of policies and procedures required by the Nevada Divsion of Prisons and recommending a process for development.

NORTH CAROLINA

Technical assistance objectives:

1. Assist in the development of a management information system, specifically identifying information needs, outlining technical specifications for various components, and recommending linkages between financial data and utilization data.
2. Assist in the definition of a new medical record taking into account clinical management needs, quality assurance needs, and management information requirements.
3. Perform a general evaluation of the centralized drug distribution system, and identification of information needs.

CHCP staff visited the North Carolina Division of Prisons on five occasions, during which time CHCP staff consulted with health services administrators, trainers and providers who were actively involved in pursuing solutions to problems identified during CHCP workshops. Early in the technical assistance phase of the program, several task forces were appointed to deal with specific areas. The TA coordinator and other CHCP staff members served as resource persons to these task forces.

The following documents were submitted to the North Carolina Division of Prisons as part of the TA efforts:

- an outline of proposed data sets needed by the Division to generate adequate health services utilization and productivity information.
- a report evaluating the current organization and management of the central pharmacy in relation to specified goals, and recommending programmatic and procedural changes to improve program functioning.

RHODE ISLAND

Technical assistance objectives:

1. Perform a general evaluation of the health care delivery system in all facilities.
2. Assess the health record in current use.
3. Review pharmacy operations and recommendations for relocation and redesign of pharmacy services.
4. Assist in planning a staff development program.
5. Assist in planning a health education program.

CHCP staff visited Rhode Island six times. The purpose of these visits were to conduct a general evaluation of the health care delivery system, to consult with the health services administrator on Rhode Island's needs for improvement in the management of the health services program, and to meet with administrators and providers to discuss staff development needs and the options for implementing an inmate health education program.

The following documents were submitted to the Rhode Island Department of Corrections:

- a general evaluation report addressing the following aspects of the program: physician services and the use of mid-level providers, pharmacy services, dental care, screening and intake, personnel problems, and utilization and cost information systems.
- an analysis of the health record and recommendations for improvement.

Planning committees were established to continue to develop and plan for the implementation of health education and staff development programs.

TENNESSEE

Technical assistance objectives:

1. Perform a general evaluation of program operations at the Central Hospital in the Tennessee State Prisons.
2. Evaluate the intake health appraisal system at the Juvenile Reception and Guidance Center.
3. Evaluate the dental services provided at correctional facilities within the Nashville area.

During the course of the program, CHCP staff visited Tennessee on five occasions. During these visits, CHCP staff assessed the medical intake procedures, and the health care programs at the Central Hospital through tours of the facility and in-depth interviews with administrators and providers. On one visit, a CHCP staff member provided emergency consultation to the Medical Director, who had been asked by the legislature to justify requests for capital expenditures with very little notice. During this visit, CHCP assisted Tennessee in developing several alternatives for providing acute inpatient care, with cost estimates for each.

The following documents were submitted to the Tennessee Department of Corrections as part of the technical assistance effort:

- an evaluation of the medical intake procedure in juvenile institutions, outlining inappropriate procedures and including recommendations for program improvements.
- a report suggesting long term goals and priorities for health services in Tennessee institutions, including a number of specific recommendations for improving the health service program at the Tennessee State Prison and the Central Prison Hospital.
- a report evaluating dental services as currently organized and delivered with recommendations for improved organization.

WASHINGTON

Technical assistance objectives:

1. Consult on the design of a health information system to coincide with the introduction of a new health record.
2. Evaluate the organization and management of pharmacy services in all Washington institutions.
3. Identify specific uses for clinical protocols in Washington institutions and the administrative factors affecting protocol utilization.
4. Review the structure and content of clinical protocols for use in prisons and differentiate between triage and treatment protocols.
5. Identify alternatives for the management of health services delivery in a large correctional institution.
6. Identify training needs of health care professionals in corrections and possible areas of role conflict between health care providers and other institutional staff.

CHCP staff visited Washington on four occasions and three staff members from the Washington Adult Corrections Division made a visit to Michigan to consult with CHCP staff and observe programs at Michigan institutions. Visits to Washington were made for the purposes of evaluating the pharmacy programs in the three major adult facilities, consult with the Medical Director on the health information system and the development of policies and procedures for the health services program, and conduct a workshop for administrators, trainers and institutional health care and custody staff to identify communication problems. Three staff members from the Washington Adult Corrections Division travelled to Michigan in order to visit selected Michigan prisons to observe health services procedures and interview staff. They were particularly

interested in sick call procedures at a large multi-security institution and a protocol directed health care program at another institution.

The following documents were submitted to the Washington Adult Corrections Division as part of the technical assistance efforts:

- a report outlining guidelines for the organization and management of pharmacy services, which summarized the current status of pharmacy service in Washington institutions and recommend strategies for re-designing the pharmacy services.
- sample forms for collecting health service utilization data, and procedures for their use.
- a report discussing communication problems within the Division and training needs of staff.

WISCONSIN

Technical assistance objectives:

1. Develop a data system for the collection of health services utilization information.
2. Develop a cost-effective referral system for patients requiring secondary and tertiary health care.
3. Identify role conflict issues between health care and custody staff.
4. Assist in planning a staff development program.
5. Assist in planning an inmate health education program.
6. Evaluate the dental service program.

CHCP staff made six visits to Wisconsin during the TA phase of the program. CHCP staff met with providers within Wisconsin institutions responsible for implementing the data collection system to discuss the process of implementation. Additionally CHCP met with the hospital study committee regarding the survey conducted on health care procedures and referral patterns for major Wisconsin institutions. CHCP staff used the results of this survey to provide Wisconsin with summary profiles of the health services systems at each institution, and to analyze the cost effectiveness of secondary and tertiary health services. Consecutive workshops were conducted on role conflict and training needs, staff development and health education programs. Dental services in Wisconsin institutions were evaluated by visiting several institutions, conducting in-depth interviews and meeting with central office staff.

The following documents were submitted to the Wisconsin Bureau of institutional health services as part of the technical assistance effort:

- a manual health information system consisting of data collection forms designed for the collection of health services utilization data and a procedural manual for implementing the system.
- a detailed description of the health service delivery systems in each of Wisconsin's nine major institutions.
- a report describing dental services in various Wisconsin institutions and recommendations for improved organization and delivery.

As a result of the TA in staff development, a planning committee was established to develop a pilot program on staff awareness. Following the workshop on inmate health education programs, participants decided to implement a health education program at seven institutions. Because of differences in populations and other factors, each institution will design its program independently but all will be based on the community resource model.

In summary, the technical assistance phase of the Correctional Health Care Program resulted in the initiation of numerous significant program improvements in the ten participating states. In addition to the specific projects described above, CHCP staff provided informal consultation to state administrators on a regular basis. There were, at times difficulties in matching the needs of the states with the expertise and capabilities of CHCP staff. The structure of the Program also presented some difficulties in coordination of TA activities between the several organizations involved in CHCP.

Based on the year's experience, a number of observations may be made regarding the technical assistance approach used by CHCP, and the situations which influenced the success of the technical assistance process:

* A number of the state correctional systems, despite fairly detailed explanations of the purposes, capabilities and limitations of the technical assistance activities, for several months did not fully understand the nature and potential benefits of the technical assistance program. Several of the states had difficulty in articulating specific projects for which technical assistance resources could be utilized, and often technical assistance requests that were made oriented more toward "fighting fires" than dealing with substantive problems in the delivery of health services.

* In some of the state systems, internal corrections department organizational and political problems make effective assistance from outside organizations, such as those involved in the Correctional Health Care Program, very difficult.

* It appears, from the sample of states with which we have been working, that the stronger the central office control over the health services system, the more likely the state is to try to make effective use of the technical assistance resources.

* Even for those states in which correctional health services would be characterized as being well organized and managed, there continues to exist problems in the delivery of health services in correctional institutions that could potentially be improved through an effective technical assistance effort.

As noted, the above represent only preliminary observations regarding the factors that influence the success of a technical assistance effort such as that offered through the Correctional Health Care Program.

VI. EVALUATION

Following LEAA's award of a grant for the Correctional Health Care Program to the Office of Health Care and in accord with its grant requirements the Office of Health Care solicited proposals from qualified organizations for the conduct of the program's evaluation. University Reserach Corporation (URC) submitted a proposal To Conduct an Evaluation of the Correctional Health Care Program, to the Office of Health Care on January 25, 1978, and was awarded the contract effective February 10, 1978.

URC proposed a dual focus to the evaluation of this program, encompassing an assessment of both the program processes and its outcomes or results. This dual focus was related to the "pilot" nature of the program and the consequent importance of identifying and describing program features and activities which contributed to the achievement of the program's objectives. Thus the approach called for an evaluation of discrete program activities (such as training and technical assistance) as well as the cumulative and overall effect of these efforts in contributing to improvements in the organization, management and delivery of health services in the 10 states.

OVERVIEW OF THE CORRECTIONAL HEALTH CARE PROGRAM AND ROLE OF THE EVALUATOR

The Office of Health Care grant application contained an approach and plan of action for stimulating and facilitating improvements in the correctional health care systems of the participating states. This plan of action consisted of a logical series of steps to be carried out during several program phases. The Correctional Health Care Program evaluation was also designed and implemented in several stages, and involved a colloborative working relationship with the CHCP staff.

The major activities of the first phase of the program included staff recruitment, the refinement of the program plan and the selection of the states to participate in the program. Following the award of the evaluation contract to URC, URC staff met with the CHCP staff to clarify the program design and the evaluation approach and begin the development of a colloborative working relationship. During this preliminary planning period, URC shared with the CHCP staff their knowledge of correctional health care systems, and provided input to the specification of the state selection procedures and the design and conduct of the site visits to the states.

By the late Spring, the state applications had been reviewed by the CHCP staff and a preliminary selection of 13 states had been made. The site visits which were conducted from May through July, 1978 were jointly planned by the CHCP staff and URC with each group contributing questions to be explored during the visit and critiquing the data collection formats which had been developed for use during the visits. Staff from the University of Michigan, Michigan State and URC also participated in the conduct of the visits.

The site visits addressed several purposes. One was to narrow down and make a final selection of ten states from among the 13 potential participants. Another was to collect baseline information on the states, so that changes stimulated by the CHCP effort could be identified, and a third purpose was to identify problems and system needs which could be addressed by the program.

The site visits also served to orient the CHPC staff to the state of correctional health care in these states and enabled them to become acquainted with state staff and familar with the major concerns and priorities of the administrators and key providers in the systems. In addition, the CHCP staff saw the site visits as an opportunity to further clarify and refine the content of the training workshops that were being planned for the Fall of 1978 and collect case examples and illustrative experiences to make the workshops relevant to the field. The visits followed a topical issue protocol and typically included interviews with health care and correctional staff in the central offices as well as visits to a few representative institutional health facilities.

Following the completion of the site visits, the final selection of participating states was made. Criteria were chosen to assure the selection of a diverse group of states. The criteria were:

- geographic area or region
- size of the system in terms of geographic area and the number of inmates
- the state of development of the correctional health care system
- the extent of legal pressures, suits and court orders
- the organizational structure in terms of centralized and decentralized decision-making.

The states selected represented considerable diversity on all of these criteria. They included small and large systems, small and large states; they varied in their stage of development, and the sophistication of their delivery systems, as well as in their organizational structures.

Site visit reports were prepared on each state. From this information URC developed a baseline profile on each of the ten states participating in the CHCP. In developing the profiles, URC staff abstracted information from the site visit reports and other related documents collected during the visits. A standard format was used to highlight features of each state's health care delivery system.

In September, 1978 the University of Michigan conducted the first of two workshops for correctional health care administrators and in October, November and December; Michigan State University conducted three workshops for health care providers from the ten states. Time was allotted during each workshop for CHCP staff to work with the states on the identification of technical assistance needs and priorities.

University Research Corporation evaluated each of the workshop deliveries, and a staff person attended the workshop for administrators and the first two offerings of the MSU workshop for providers. Since the providers workshop was to be conducted three times, the URC participant observer met with the MSU staff, and provided feedback on the sessions with recommendations for workshop changes or refinements. Evaluation reports on all four workshops were prepared and shared with the CHCP staff. (Copies of these reports are included in Appendix H.)

In February, 1979, the Office of Health Care in collaboration with MSU conducted a two day workshop for corrections department trainers and correctional officers. This workshop was designed to broaden the base of awareness and knowledge of CHCP in the participating states through the participation and involvement of custody personnel. URC's evaluation report on this workshop is also included in Appendix H.

Following the completion of the University of Michigan workshop, the U of M staff became involved in further refinement of the TA needs, which included planning visits to the states. When the MSU workshops for providers was completed, the technical assistance phase was formally started and TA was provided by the CHCP staff from the late winter through early summer of 1979. As TA activities began to wind down during the summer of 1979, the staff began work on program manuals. A total of 18 such manuals were developed; some on topics addressed during the TA, and others addressing areas identified as priority needs during the training and technical assistance efforts. In addition, the University of Michigan staff worked on the development and delivery of the second workshop for health care administrators which was conducted in September,

1979, and evaluated by a URC staff observer (see Appendix H). The program manuals mentioned earlier were distributed to participants at the workshop.

In addition to the training and technical assistance efforts directed to the ten participating states, the program included other efforts more national in scope. The American Medical Association, under sub-contract to the Office of Health Care, was involved in the development of standards for prison health care as part of the health care improvement effort. In addition, a national workshop on correctional health involving corrections personnel from across the nation, was conducted by the CHCP staff in October 1979. Although these two efforts were important aspects of the program, they had little direct bearing on the ten participating states, and thus were not singled out for special attention in the program evaluation.

In the summer of 1979, URC conducted follow-up program evaluation visits to the ten states. The purpose of these visits was to identify correctional health care system changes since the inception of the program, and assess the overall effect of the program on the organization, management and delivery of health care in these states.

One to one and a half days was spent on site in each of the ten states, and interviews were conducted with health care administrators and representative groups of providers who had attended the MSU workshops and/or were involved in the follow-up technical assistance activities. A topical outline was used to structure the interview process and to provide uniformity to the items discussed. The topics covered included the following:

Factors motivating the state to apply to the Correctional Health Care Program,

Factors which impeded or supported state's ability to derive maximum benefit from the program,

Efficacy of the Correctional Health Care Program Design,

Benefits derived from training at both the administrators and providers level,

Efficacy of the Technical Assistance Planning Process,

Areas in which TA was received, benefits of TA, status of changes stimulated by TA.

In addition, the baseline profiles developed on each state were shared with key state staff and used as a basis for identifying changes in the

organization, management or delivery of health care services -- including changes resulting from the efforts of CHCP as well as those which were independent of the program.

Six to eight weeks after the workshop for administrators, administrators in each state were contacted by mail and telephone to ascertain the extent to which the program manuals distributed during the administrator's workshop had been reviewed, were found to be useful and were being used in health care improvement efforts.

OVERVIEW OF THE EVALUATION APPROACH

The approach to evaluating this program developed by URC was based on a consideration of the following factors.

1. The Correctional Health Care Program was implemented during a period in which correctional systems, and particularly health care systems were undergoing substantial changes;
2. The ten states included in the program varied considerably on a number of major system dimensions (size, organizational structure, locus of responsibility for health care, staffing, etc.). They also varied in their health care improvement needs and in their organizational and resource capacity to make improvements;
3. Professional standards for correctional health care were, at the time of the program's inception, still in an early stage of development; and in fact a set of AMA recommended standards was one of the products to be developed during the program;
4. The CHCP program model was based on a colloborative relationship with the states; and one which gave the state substantial latitude in defining their own priorities for health care improvements.

These factors suggested that although the CHCP program objectives were expressed in terms of stimulating improvements in correctional health care systems, the evaluation should address the question of whether changes occurred, and how the program stimulated, facilitated, and supported these changes. The study questions were formulated as follows:

- Did changes occur in the organization, management and delivery of health care in corrections in the ten participating states?
- What changes occurred?
- What role did the program play in contributing to these changes?
- Which changes, in particular, can be attributed to CHCP?
- What aspects of the program design and delivery were most

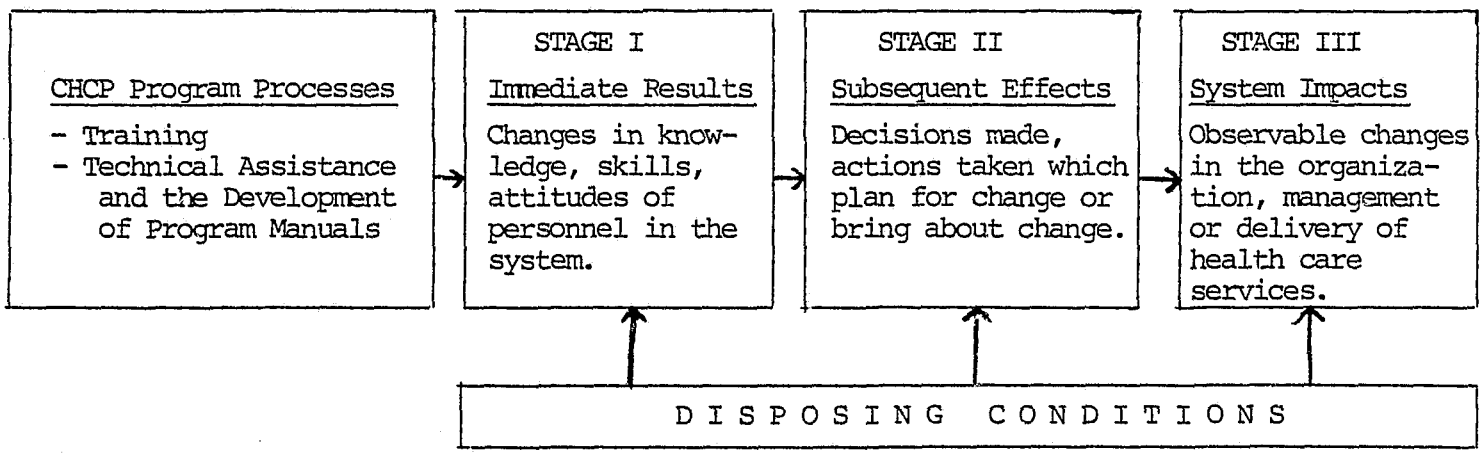
significant in effecting the changes.

This formulation of the program evaluation questions thus allowed us to focus on changes without assessing the value, appropriateness or significance of the changes; which would be an almost impossible task with the resources available for the program's evaluation, and with the diversity of systems represented by the ten states, and in the absence of established and accepted professional standards for correctional health care.

The study methodology focused on examining the program processes of CHCP training and technical assistance as well as the results of these processes. The assessment of the CHCP program processes had two purposes: to evaluate the achievement of the training and TA objectives, and to identify the resulting effects of these activities. For recurring events, URC also conducted formative evaluations and made recommendations on modifications and refinements needed. In assessing program results URC used a schema of change processes which more clearly identifies the sequence and states of change. (See Figure 3).

FIGURE 3

OVERVIEW OF THE STATES OF CHANGE



This schema describes change as a series of logical and sequential steps or "begets" in which each stage provides the necessary conditions for the realization of the next stage. The CHCP effort consisted of two major program strategies, training and technical assistance. The aim of the training activites was to contribute to increases in knowledge and know how or skills, and indirectly influence attitudes about the feasibility, desirability, or possibility of change. Knowledge and attitude change are necessary prerequisites for changes in behavior. Behavior change, or subsequent effects, may be ovserved in decisions made or actions taken which lead to observable changes in the organization, management or delivery of health care services. Although these stages represent the logic of change, each stage does not inexorably lead to the next one. Disposing conditions, or factors external to the program and which the program has no control over may interfere with the logical flow of events. Disposing conditions may also facilitate or retard the change process.

A hypothetical example, based on actual program experience, may best illustrate this process.

> As a result of attending the CHCP workshop, an administrator in state X decides that it is now feasible to implement a problem oriented medical record in his system. With the help of the CHCP technical assistance coordinator, a task force is formed to examine the procedures necessary to change to a POMR system. The study is complete, and the recommendations are on the administrator's desk, when the Director of the Department of Corrections is fired, and replaced by a Director whose announced mission is to stabilize and consolidate the system, bringing to a halt all contemplated changes in the department.

In this instance, the change is stopped in stage II for reasons beyond the control of both the program and the health care administrator. At the same time, however, the training and technical assistance contributed to both immediate results (attitude change) and subsequent effects (the formation of a group to study the implementation of change), but failed in accomplishing the observable change in system improvement--the statewide implementation of a POMR system.

The use of this change model for evaluating the program's processes and effects aids in the identification of changes on-route to the accomplishment of the overall program objectives, whether or not the ultimate impacts are realized. This model thus represents an ideal one for the evaluation of the CHCP effort,

for it separates events and activities within the control of the program, from those external to the program. It also provides a means for dealing with the diversity that existed among the states in organizational structure, resources, objectives, and commitment to change.

PROFILE OF THE PARTICIPATING STATES

CHCP represented a pilot effort for assisting states to improve their correctional health care system and as a consequence, a heterogeneous group of states was purposively selected to participate in the program. This section provides a brief overview of the salient administrative and historical features of the participating states. Detailed profiles on the health care delivery system in each state can be found in Appendix H.

The states selected to participate in the CHCP were geographically dispersed with all major regions represented by the following states: the South - Florida, North Carolina and Tennessee; the Midwest - Illinois, Nebraska and Wisconsin; the West - Colorado, Nevada, and Washington; and the Northeast - Rhode Island.

Correctional system size was a criterion used during the selection process, and the selected states varied significantly in the size of their inmate population and the number of institutions in the system. Florida had the largest correctional system, with approximately 20,000 inmates housed in 25 institutions, and was organized regionally. Rhode Island, with 650 inmates in seven institutions, was the smallest. The number of institutions, however, was not directly related to the size of the inmate population for North Carolina had approximately two-thirds of Florida's inmate population with 80 institutions excluding five halfway houses. In addition, several other states had fewer institutions than Rhode Island, with more than double Rhode Island's inmate population.

In most of the participating states corrections was administratively an independent department in state government. Washington and Wisconsin were two exceptions, for in these states corrections was a division within a large, umbrella Department of Human Resources. The chief administrator for the department or division of corrections was usually a political appointee reporting directly to the governor. In the majority of states the Department of Corrections had a two tiered organizational structure consisting of the central office and the institutions. The two largest corrections systems, however, (Florida and North Carolina), were organized regionally, with Florida divided into five geographical regions, and North Carolina divided into East and West geographic commands.

Although there are some differences in administrative responsibility for health care and medical services, in most states the central office health care administrator does not have line authority over the institutional medical staffs, and does not have direct budget or fiscal controls over expenditures. In nine states, health care is a division or unit within corrections, while in Wisconsin, responsibility for health care was transferred from Corrections to the Division of Health. Both Corrections and Health, however, are divisions within the state's Department of Human Resources.

When the program began, five of the 10 states (Florida, Nebraska, Nevada, Tennessee and Washington) had medical directors and two -- Illinois and North Carolina had health care administrators in the central office, with overall administrative responsibility for health care. In Colorado and Rhode Island, health care was one of several areas assigned to a central office administrator. In Wisconsin, health care was officially centralized, including the budget and line authority. The reorganization, however, was a recent occurrence and the organizational structure was not yet fully developed.

Historically, responsibility for health care services in corrections has been decentralized, and most of the operational authority rested with the institutional administrator. This pattern has resulted in institutional differences in the care provided, fragmentation, and institutional variations in the quality of health care services.

As part of the CHCP state selection process, the states were visited by the program staff, and health care service problems were identified. A number of the problems were fairly widely shared, e.g., overcrowding and difficulties in the recruitment and retention of qualified medical staff. Other problems mentioned frequently were: inadequate mental health programs, inadequate medical facilities and equipment, inconsistent policies and procedures, lack of standards for health care management, inaccurate and inconsistent medical records, poor orientation and in-service training for the medical staff, and no professional staff development program.

Since all the states were facing problems in health care delivery, the CHCP was seen as a means for gaining assistance in solving these problems. The states differed, however, in the level, extent and type of assistance expected. A few states looked to the program for credibility and support which would help mobilize and involve institutional staffs in the change process, assist them in refining aspects of their systems, and demonstrate to the courts that they were serious about

improvements. This group of states also looked to the program to provide additional resources for changes in process. The CHCP was also seen as a national effort in correctional health care and state administrators wanted to have input in an effort that would have national implications.

Other states saw the program primarily as an opportunity to improve staff skills and inform them of the state-of-the-art of correctional health care. In addition, some states sought guidance in setting priorities and assistance in developing specific plans for addressing system priorities.

Factors operating in the states at the initiation of CHCP influenced these varied expections. They were:

- stability of the correctional system
- state of the system's development
- outside pressures--court orders and legal activity
- central office staff knowledge about correctional health care systems.
- resources available in the states for health care improvements.

During the initial CHCP phase two states, Florida and North Carolina, were involved in developing system-wide health care delivery plans. Both states had experienced relative stability in the Department, and evolved a structured correctional health system. The health care administrators in these states saw the CHCP as assisting them in refining and providing credibility to these plans. The CHCP as a national effort to upgrade health care delivery in corrections, would provide the states with national visibility, and they viewed it important to participate and contribute to a national effort that would impact on policy.

The state of Washington had similar expectations from the program. Although the Department of Corrections has not had the same stability as the other two states, and lacked internal support for the development of a health care system, the current medical director has successfully utilized community resources in developing a more effective system. However, he needed internal and external credibility to support his actions and saw the program as an opportunity to increase staff skills and improve staff receptiveness to change.

Three states, Colorado, Nebraska and Nevada, had more specific expectations from the CHCP which included health care delivery areas needing improvement, as well as skill training for their provider staffs. The Departments of Corrections in these states are relatively small--inmate populations ranging from approximately 2,500 to 1,500; the majority of institutions are located in close proximity, and

all were to be involved in capital improvement projects. All three Departments had experienced recent changes at the top. Central office involvement in the health care services was relatively new, and the role of the health care administrator was also evolving. The legislatures in the three states had also demonstrated support for upgrading the correctional environment, and had appropriated substantial sums for capital improvements. In addition, legal actions had identified health care as inadequate and the Departments were attempting to address these problems by centralizing aspects of health care and redesigning system components to upgrade the quality of the care.

Court orders or the expectations of judicial involvement had significant implications in three other states: Illinois, Rhode Island and Tennessee. In these states, therefore, the administrators saw CHCP as an opportunity to demonstrate to the court that actions were being taken to comply with judicial requirements. Also, they were seeking from the CHCP staff system assessment and the identification of options for short- and long-term solutions. All three states had experienced frequent changes in the top level administration and had a history of decentralized management. In response to the pending legal actions, Tennessee and Rhode Island established the positions with limited responsibility for health care, at the central office. In Illinois this position existed for sometime. Due to the size and complexity of the system, however, frequent changes among the top level administrators, changes directed to upgrading health care services were difficult to accomplish.

In Wisconsin, transfer of health care responsibility to the Division of Health was percipitated by a legislative investigation. Since the Division of Health was inexperienced in the delivery of correctional health services, the administrators saw CHCP as providing them with some basic assistance, as well as helping them develop a plan for the health care delivery system.

The diversity of state size, organizational structure and stage of health care system development, was reflected in differing needs and CHCP expectations. To address these needs and expectations, CHCP offered generic training events and TA tailored to specific state requirements. The following section describes the design, development and delivery of the Correctional Health Care Program processes.

CORRECTIONAL HEALTH CARE PROGRAM PROCESSES

The Correctional Health Care Program plan proposed training and technical assistance as the two major strategies for stimulating improvements in correctional health care systems, and identified state audiences for the training and technical assistance efforts. The plan further specified that responsibility for addressing the needs of these two groups would be shared by the University of Michigan (UM) and Michigan State University (MSU), with the University of Michigan focusing its efforts on correctional health care administrators, and MSU on health care providers at the institutional level.

TRAINING

Major responsibility for the design and delivery of training was shared by the University of Michigan and Michigan State University. The University of Michigan was responsible for training correctional health care administrators, while MSU's responsibility was for health care providers at the institutional level. The Office of Health Care was also later involved in conducting a workshop for correctional personnel and trainers. This workshop followed the third MSU providers workshop.

In selecting the topic areas to be included in the workshops, both universities drew heavily from the needs and problem areas identified during the site visits to the states. These visits, however, were more useful in identifying general areas of state staff interest than in identifying the levels of knowledge or skill which staff required to implement changes in the delivery of health care services. Although interviews were conducted with state personnel, many of whom eventually attended the workshops, the visits did not focus on identifying their specific training needs.

The development of the training designs was also complicated by the diversity of state systems represented in the program, for staff from states in different stages of development had different programmatic needs, priorities and emphasis. In addition, state staff varied in the extent of their professional experience, and their length of time in the correctional system, and there were differences in credentials held by staff performing similar functions in different states.

Although the state site visits preceded the delivery of the courses by at least two months, it must also be pointed out that workshops of five to six days in length usually take more than two months to develop. Thus, by the time

the site visits occured, both the University of Michigan and MSU had started preliminary course planning decisions.

Following the state site visits, which were jointly conducted by UM and MSU staff, course development occurred along parallel lines, and coordination between the two groups on course content, training methodology, etc., was quite limited. Since the UM workshop for administrators was the first program offering, however, the MSU staff was able to benefit from the UM course delivery experience and participant reactions to both content and presentation in preparing their workshop. The MSU workshop was also partially piloted on provider staff in the State of Michigan. This decision was made during the debriefing following the UM administrator's workshop, as a way of ensuring that the course would be appropriate in both content and approach to the needs of institutional health care providers.

The Office of Health Care workshop held in collaboration with MSU and UM followed the third and final presentation of the providers workshop. This workshop which was not included in the original CHCP plan, was offered in an attempt to broaden the base of state knowledge about CHCP, and involve state training personnel in understanding and possibly replicating the CHCP training effort.

CHCP funds were available to pay travel and per diem for training program participants. This was included in the program budget as a way of ensuring state participation, and minimizing the burden on state travel funds. The availability of these funds was an important factor in facilitating good state participation in the program. Nevertheless, states still had to ensure coverage for provider staff away from their jobs and for some states this represented a drain on personnel overtime. In some instances, coverage could not be obtained and this resulted in last minute substitutions.

The states had the primary responsibility for selecting workshop participants in accord with guidelines prepared by the CHCP. The administrators workshop was designed for central office health care administrative and medical staff, as well as institutional administrators of large medical facilities. The providers course was designed for institutional health care providers and supervisory personnel. A limited number of correctional personnel also attended the workshops, and their presence was seen as beneficial in facilitating communication and a sharing of perspectives on health care in the correctional setting.

Participant selection for the Office of Health Care workshop departed somewhat from these procedures, for in a few instances participants were invited directly by the Office of Health Care, rather than in concern with the State Health Care Administrator.

The states used fairly similar criteria in deciding how the 15 allocated places for providers were to be filled. Most states sought representation from regions, major health care facilities, and major provider groups.

Three 5-1/2 day workshops for correctional health care providers were presented by Michigan State University in October, November and December, 1978. The primary purpose of the workshops was to provide participants with a broader perspective of specific facets of the delivery system so as to increase their ability to deliver improved services to inmates. The workshops covered the same material for three different provider audiences making it possible for the states to send a total of 15 staff persons from their systems. Although the courses were revised slightly after each offering, the revisions were geared to tighten the schedule, improve the sequencing and flow of the materials, and the effectiveness of the presentations. The course content did not substantially change from one offering to the next.

The methods of course delivery represented a good mix between formal presentations and small group discussion and problem solving sessions, and participants were actively engaged in the workshop process.

As part of the course materials, participants received a Program Development Manual which included content outlines of each of the sessions, as well as supplementary material to aid participants in planning, designing and implementing new or revised programs in many of the areas covered in the workshop (e.g., Health Education, Protocols, Stress Management).

Although the states could send five people to each workshop, all the states were not able to avail themselves of the opportunity, and at the last moment the openings were allotted to some of the larger states like Florida and North Carolina who were eager to increase their state's representation in the program.

Some states also selected providers on the basis of their leadership abilities and their potential for implementing improvements in health care delivery. In addition, a few states consciously chose to send the higher ranking and more experienced providers to the first provider workshop. This was done to help the central office administration determine the utility of the provider workshop, and the value of sending additional staff to subsequent offerings. Several states also sent a central office administrator to one of the provider workshops to assure coordination of efforts between the central office and institutional level staff.

Two workshops for administrators were conducted by the University of Michigan CHCP staff. The first workshop was offered in August, 1978 and the second in September, 1979. The first offering was primarily designed to increase administrators' knowledge of alternative models for health care delivery and provide them with an analytical framework for analyzing needs, identifying alternative approaches, and assessing the resources necessary for implementing these alternatives. It was an intensive 6-1/2 day course with formal presentations and lectures representing the primary method of course content delivery. The course was generally well received, though participants were critical of the academic nature of the material and the formal methods of presentation which limited participation, sharing among the participants, and opportunities for applying the principles to back home problems and situations. See Appendix H for a copy of the evaluation report.

The second administrators workshop benefitted substantially from a year of CHCP activity and the staff's extensive involvement in providing TA to the states. It also benefitted from a pre-course survey in which participants were asked to identify and prioritize their preferences for course subject matter. This course, which was designed to present information and discuss a variety of management activities for maintaining programmatic control, was significantly more practical and problem oriented, involved the participants as panelists and presenters, and stimulated informative exchanges among the participants and between staff and participants. The collegial relationship which had developed between CHCP staff and state administrators in the intervening year was clearly evident in the tone of the workshop.

Nine of the ten states were represented in the workshop, with only the Nevada Department of Corrections declining to send staff. Although this workshop was intended to serve the same group of administrators as had attended the first workshop, slightly over half of the attendees were new to the program and their state systems.

As can be noted in Figure 4, there was some concurrence in topics addressed in the first and second workshop with several new topics added to the second offering. Even where the topics were the same, the content addressed and the practical focus of the presentation made the material new and useful.

FIGURE 4

CORRECTIONAL HEALTH CARE TOPICS ADDRESSED IN TRAINING (BY WORKSHOP OFFERING)

Topics	WORKSHOPS					
	Administrators		Providers			Correction
	1st	2nd	1st	2nd	3rd	Training
Standards for correctional health care systems	x		x	x	x	
Mental health services in correctional settings	x					
Management of ambulatory care in correctional settings	x					
Dental health services to inmates	x	x				
Monitoring & evaluation of health service systems	x	x				
Health records/health management information systems	x	x	x	x	x	
In-patient acute care services	x					
Pharmacies & drug distribution systems	x	x	x	x	x	
Financial mgmt. of correctional health care programs	x	x				
Implementing change in correctional health care systems	x		x	x	x	
Policies & procedures		x				
Professional staff management & recruitment		x				
Planning for new health facilities		x				
Staff training & communication skills			x	x	x	
Stress in the correctional setting			x	x	x	x
Health education programs in correctional settings			x	x	x	x
Issues & trends in Criminal Justice & correctional Health Care			x	x	x	x
Utilization of protocols in primary care delivery		x	x	x	x	x
Adopting knowledge utilization model			x	x	x	x
Priorities/planning for TA	x		x	x	x	
Overview of administrator's programs						x
Overview of provider's programs						x
Resolving professional conflicts						x
Training needs, priorities, & strategies						x
Professional licensure & continuing education						x

FIGURE 4 (continued)

Topics	WORKSHOPS					
	Administrators		Providers			Correction
	1st	2nd	1st	2nd	3rd	Training
Role of health service administrators	x					
Goals in correctional health services	x					
Characteristics of correctional settings which impede effective management of health programs	x					
Legal and mental health issues in correctional health care	x					
Intake health appraisals		x				

In February, 1979 a two day workshop was conducted under the direction of the Office of Health Care for state correctional health care and training personnel. The purpose of the workshop was to broaden the base of knowledge in the states of the CHCP effort, particularly among training and custody personnel. Nine of the ten program states were represented at this workshop, and each was represented by at least one training or staff development officer.

The workshop included overviews of the administrators and providers workshops as well as mini-sessions in several of the topics included in these two workshops, drawing more heavily from the workshop for providers.

The workshop was well received and judged useful by the participants.

As a composite experience, the training phase of the program provided an opportunity to analyze the design and delivery of workshops for correctional health care personnel and identify issues which may prove useful for similar programs in the future. Following is a summary of the more salient issues:

- The design of the first series of training events was based on limited information on participant skill and knowledge needs, and the courses were designed before the program had established priority areas for the health care improvement effort. It was thus difficult to narrow the scope of the workshops, and as a result the courses provided a broad overview of health care issues, rather than an in-depth treatment of a few topics. The scope of the workshops also communicated an open agenda for TA, a message which later had to be clarified when the states had difficulty defining TA priorities within the program's resource level and capability.
- The administrators and providers courses were developed and delivered by two separate groups in the CHCP consortium, and covered substantially different topics. At the same time, the program did not outline a set of procedures for the two state audiences to use in developing a unified state strategy and action plan for health care improvements, and thus similarly affected the TA planning process.
- Course design occurred early in the program and at that point the CHCP staff had limited knowledge of state staff expertise and innovative state efforts, thus they were constrained in their ability to incorporate field experience in the design and

presentation of course material. The positive reception accorded the inclusion of field experience and the participation of state staff as presenters and panelists in the second administrator's workshop indicated the importance of this approach for course relevance and acceptability.

- Both the administrators and providers courses were designed to run a full week, and the time was heavily scheduled. The participants reacted negatively to such a demanding schedule, and subsequent efforts which were less intensive and demanding, were more positively received.
- The courses employed both large group lectures and small group discussions and problem solving sessions. Participants preferred the small group participatory style which allowed greater opportunities to share and exchange information and learn from each other.
- Participants also preferred presentations which were well focused, and included practical approaches and procedures which they could implement. Such sessions were found more useful than those which presented conceptual and the theoretical material.

COORDINATION BETWEEN TRAINING AND TECHNICAL ASSISTANCE

In many programs training activities are ends in themselves, and are viewed as valuable if they contribute to increased knowledge or skills and more effective job performance. The Correctional Health Care Program, as a change oriented effort conceptualized training as a necessary but not sufficient means for improving correctional health care systems. Training was thus viewed as a strategy for preparing and facilitating state staff to implement changes to be accomplished with the support and direction available through the technical assistance effort.

Because of the significance of training in the CHCP design, its role in facilitating the Technical Assistance planning process needs to also be examined. Training can support TA planning by providing staff with information and knowledge to identify problems and deficiencies in their systems, by enabling them to identify well defined and focused problems appropriately addressed by TA, and by identifying procedures for gaining organizational commitment to address these problems.

Both the administrators and providers workshops scheduled time for TA planning. In the first administrator's workshop, the morning of the last day was set aside for state participants to meet with the CHCP staff person designated as the TA coordinator for their state, and identify problem areas and priorities for TA. The expectation was that the course would facilitate this process by introducing participants to management and programmatic options in the delivery of health care. The workshop did not, however, specifically link the material presented to the TA process.

In the workshop evaluation report following this workshop, the URC evaluator noted that the "workshop fell short in failing to more directly and specifically relate the workshop to the assistance activities that follow." It was also noted that "the workshop could have been more specifically directed to help state administrators assess their needs, establish priorities, chart a course of action to implement change, and specific workshop sessions could have been designed to facilitate that assessment, planning and implementation process."

Although all of the state teams did identify possible areas for TA, the subsequent experience indicated that these represented at best tentative possibilities, and it was necessary to devote considerable time following the workshop to clarifying state needs and CHCP resources and capabilities to address these needs.

The MSU workshop for providers, partly as a result of this experience, was more focused on linking the materials presented to the identification of TA needs. Following major course presentations, participants were asked to assess the utility of the health care delivery methods discussed to problems and needs within their states, and on the final day of the workshop to review and use these assessments in the identification of TA priorities. Nevertheless, this process involved only providers, and three different groups of providers from each state. Thus it was still necessary to coordinate this process with the providers who had attended the other workshops, as well as coordinate the provider identified needs with those identified by the administrators.

The Office of Health Care workshop for trainers, health care and custody personnel, which was offered partly to assist the TA planning process, failed to link the content of the workshop to the TA phase of the program. Participants thus left the workshop without a clear sense of the next steps.

DESIGN AND DELIVERY OF TECHNICAL ASSISTANCE

Technical Asssistance was planned and delivered along separate but parallel tracks with the University of Michigan responsible for the overall coordination of TA to each state. As was noted in the previous section, planning for TA began during the workshop with both administrators and providers using their workshop as a frame of reference for identifying TA needs. In most cases, however, the needs identified during the workshops were preliminary, incomplete and often unrealistic in light of the program resources. Thus, substantial follow-up work was required before a final TA plan, agreed to by both parties, was developed.

The TA planning process as it evolved, was an iterative one, with several stages of refinement and contact necessary before actual assistance could be provided. The iterative process was affected by both program and state dynamics which are illustrated below.

- CHCP defined TA as reactive and responsive to the state's needs. Thus, the CHCP staff was initially reluctant to shape, structure or limit the state's freedom to identify their priority problems.
- In the absence of clearly defined or articulated topic or resource limits, a number of states identified needs that were considerably beyond the program's capability to address. Negotiations between CHCP and the states then occurred resulting in either a redefined priority list or requests scaled down in scope and comprehensiveness.
- A number of states floundered in TA needs and this required a more proactive response from the program staff. In several instances, an evaluative site visit was conducted to aid the state in identifying TA needs which the program could address.
- Several states faced crises which diverted management's attention from the program. In these instances, the program lost the momentum created by the workshops, and when the crisis were over, it was difficult to create and sustain a high level of interest and attention.
- The state's involvement in the TA process was also affected by the state's commitment to implementing changes. Those states committed to change were more interested in using the assistance available through CHCP, than those which regarded the health care system as adequate or of minimal concern.
- The delivery of technical assistance frequently involved a collobora-tive effort with the states, and expectations that information would

be collected, task forces and study groups formed, etc. as part of the state's role in TA. This collaborative working relationship was difficult for the states because they were understaffed, addressing crisis, or had to work through a cumbersome multi-layered review and decision-making structure. In addition, the health care administrators in a number of states lacked authority for the line staff and thus faced difficulties in including them in planning and implementation efforts.

Several modalities for the provision of technical assistance evolved during the course of the program. MSU organized their technical assistance around three major topics addressed in their workshop and identified by workshop participants as priority areas. These topics were: staff development including stress and communications, health education and clinical protocols. The states were informed about these options and asked to rank them in terms of importance, and identify the level of concern, e.g., planning, developing or implementing each of the programs.

These topics were then addressed by a MSU staff person on site. The format used involved group meetings of up to about 20 participants selected by the state. The MSU staff person followed a generic process for each topic addressed, tailoring the approach to the specific requirements of the state. Generally, the product of these TA engagements was a task force formed to either plan, develop or assist in the implementation of the selected health care delivery program.

The University of Michigan's approach to TA was more open-ended in both the topics covered, and the approaches used. The range of approaches included the following:

- Site visit evaluations of either the overall health care delivery system or a specific component, followed by an assessment report with recommendations of actions needed.
- The development of specific products which could be used in implementing management control systems in such areas as health records or management information systems.
- Documentation of needed improvements, including strategies for accomplishing these improvements.
- Consultation, assistance, critique and review of processes and products being developed by the state.
- Assistance in identifying resources, consultants, and materials needed by the state.

- Assistance in problem solving, and in addressing short term information collection, analysis or documentation needs.

There was a considerable amount of overlap of topics addressed in both training and technical assistance (Figure 5) and areas most frequently addressed by the TA included Management Information Systems, and Staff Development (6), followed by Pharmacy Services and Health Records (4).

Although a considerable amount of time and effort went into narrowing down the number and scope of the TA requests that CHCP would address, most of the technical assistance provided resulted in some follow up state efforts, and in a number of instances actual plans to implement change. The effects of the training and technical assistance efforts are documented in detail in the next section.

FIGURE 5

CHCP TOPICS ADDRESSED IN TRAINING AND TECHNICAL ASSISTANCE

PROJECT AREAS	WORKSHOP OFFERING TRAINING	STATES RECEIVING TECHNICAL ASSISTANCE
Management Information System	Administrator	Colorado, Florida, N. Carolina, Nebraska, Washington, Wisconsin (6 States)
Protocols	Admin/Prov/Correct.	Florida, Illinois, Washington (3 States)
Staff Development/Training Needs	Corrections	Illinois, N. Carolina, Nebraska, Rhode Island, Washington, Wisconsin (6 States)
Pharmacies/Drug. Dist. Systems	Admin/Providers	Illinois, N. Carolina, Washington, Rhode Island (4 States)
Health Education Program	Prov/Correct.	Illinois, Rhode Island, Washington, Wisconsin (4 States)
Health Records	Admin/Providers	N. Carolina, Rhode Island, Washington, Wisconsin (4 States)
Dental Health Services	Administrator	Nebraska (1 State)
Policy & Procedure Manual	Administrator	Nebraska, Nevada (2 States)
Evaluation of Secondary and Tertiary Delivery Health Care	Administrator	Wisconsin, Tennessee, Illinois (3 States)
Dental Services	Administrator	Tennessee, Wisconsin (2 States)
Cost Estimate on Four Proposals of Hospital Services Delivered	Special Case, non-training consideration	Tennessee (1 State)
Overall Program Assessment/ Standards Employed in Assessment	Admin/Provider/ Corrections	Nebraska, Nevada, Rhode Island (3 States)
Facility Planning	Administrator	Colorado (1 State)

EFFECTS OF THE CORRECTIONAL HEALTH CARE PROGRAM ON THE HEALTH CARE SYSTEMS IN THE PARTICIPATING STATES

This section presents the findings of URC's summative evaluation which examined the immediate results, subsequent effects and system impacts stimulated by CHCP. The findings discussed in this section are based on the information collected during follow-up evaluation visits to the ten participating states. The information collected relied heavily on respondent reports of change; however, during the site visits URC staff spent a considerable amount of time facilitating the identification and reporting process. Before conducting the visits URC staff reviewed all of the program's file materials including monthly CHCP progress reports, TA visit reports, and documents prepared by CHCP as part of the technical assistance. This allowed staff to play an active role in helping state staff identify and discuss the areas of CHCP impact. In addition, the state profiles were used to collect updated information on changes which have occurred in the state, and to identify those changes facilitated by CHCP efforts.

As was noted earlier in this chapter, the Correctional Health Care Program was implemented during a period of growing momentum for correctional health care improvements, and many of the participating states were already actively engaged in improving areas of the delivery system. Where that was so, the program helped sustain the momentum. For the purposes of the evaluation, however, it was important to attempt to separate efforts already planned or underway, from those initiated or stimulated by CHCP. The profiles developed on each participating state identify all of the major system changes, irrespective of the source of the changes and this helped to separate program changes from those which were idenpendent of the program (See Appendix H - State Profiles).

This section addresses only those changes which are clearly the result of CHCP efforts. The changes are presented in terms of the following three stage schema discussed earlier.

- Immediate results--changes in knowledge, skills, or attitudes of personnel in the system
- Subsequent effects--decisions made, actions taken which plan for or initiate the change process
- System impacts--observable changes in the organization, management, or delivery of health care services.

State by state changes are presented on the following pages, followed by a discussion of the findings.

COLORADO

Immediate Results	Subsequent Effects	System Impacts
Increased ability to evaluate own system with reference to other states, identify system needs. Increased awareness of alternative staff utilization patterns; e.g., use of part-time physicians/expanded role for mid-level providers. Insights on cost-effectiveness of providing speciality clinics on site. Increased knowledge of medical records formats. Increased awareness of the effects of stress. Increased staff appreciation of own system; quality of personnel in their system. Enhanced ability to conduct cost analysis on various options for health care delivery. Expanded knowledge of MIS and its utility for effective management. Increased familiarity with protocols and applicability for their system. Expanded professional contacts and reduced feelings of isolation among provider staff; facilitated team building among state staff. Sensitized to legal issues for health care providers working in corrections. Sensitized providers to the need for better communication to deal more effectively with security personnel. Increased sense of importance within the system and enhanced feasibility of recruiting qualified staff.	Developed long-term objectives and goals for health care delivery. Planning to develop more extensive orientation program for new staff. Working on improved medical records. Developed new encounter forms which are ready for implementation. Appointed Committee for evaluation of alternatives for the location of health care facilities. Developed several alternatives for location of health care facilities in the new complex--final decision still pending. Appointed planning committee for development of clinical protocols. New set of forms developed and implemented for intake process. Redefined and expanded role of mid-level providers. More effective recruitment and employment of qualified professionals Completed several sections of policies and procedures manual.	None.

State: COLORADO

FLORIDA

Immediate Results	Subsequent Effects	System Impacts
Increased communication among state correctional health care staff. Development of a network for information exchange with other states. Validation that state efforts were "on target", enhanced belief that they were effectively solving their problems. Encourage greater reliance on in-state resources and capabilities. Increased understanding of health care system within corrections; oriented new staff to the system; assist in upgrading staff skills. Introduced them to procedures/options for cost control. Increased awareness of effects of stress on staff and inmates.	Efforts underway to develop and implement a protocol system of care. Decided to establish a secure hospital unit for females within their acute care facility. Increasing their capability for specialty care. Expanding the functions performed by PAs and LPNs. Beginning to include stress management in orientation program for correctional personnel. Developing a standardized health information system; will be implemented on a pilot basis in a few institutions before going system-side. Will provide central office with comparable information on utilization of health services.	None.

State: FLORIDA

ILLINOIS

Immediate Results	Subsequent Effects	System Impacts
Increased knowledge of resources within state which can be used to support change directed efforts. Increased understanding of management process for pharmacy services. Increased understanding of strengths and weaknesses of own correctional health system; increases awareness of need for change, motivation for change. Greater appreciation of correctional health care as a profession; reduced isolation of health care providers. Increased understanding of effects of stress on staff and inmates. Increased credibility of state's priorities for health care improvement. Changed view--feasibility/acceptability of protocols.	Adoption of triage protocols. Protocols will be developed for chronic illnesses. Planning committee formed to develop staff development program. Increase in number of positions authorized for pharmacy system.	Changes implemented in the intake health appraisal for the four reception intake centers in the state.

NEBRASKA

Immediate Results	Subsequent Effects	System Impacts
Increased understanding of the administrative staff in health care delivery system and approaches to managing health care services. Expanded professional contacts within state and with other states. Increased knowledge of budget preparation and presentation. Increased understanding of effective staff recruitment approaches. Increased awareness of legal implications of health care providers working in the system. Reinforced notion that limited information available on organization and delivery of effective mental health services and supported need to proceed with current knowledge. Increased professionalism among provider staff; validated correctional health care as a profession. Increased ability to evaluate own system with reference to others, and increased ability to identify and prioritize needs. Sensitized participants to the effects of stress on staff and inmates. Helped to redefine responsibility for change from top administrators to all levels of staff. Change in provider attitudes towards change process. Stimulated momentum for changes. Increased understanding of need for open communications in system.	Introduced expanded role for nurse for conduct of sick call. Involvement of providers in the change process. Introduced monthly staff meetings to facilitate open communications--eventually to evolve as inservice staff development program. More open communications established between medical and security personnel; working relationship improved. Plan to incorporate material on stress in orientation program for new employees. Appointed four subcommittees to develop training in --time management --legal aspects --self concept --communications. Developed data collection system for service and provider utilization. Completed manual on policies--ready for system-wide implementation; procedures to be developed by institutional staff. Evaluated all institutions with reference to ACA standards. Planning to develop protocols for use by nursing staff.	None.

State: NEBRASKA

Immediate Results	Subsequent Effects	System Impacts
Increased understanding of options for health care improvements. Improved staff morale and sense of professionalism. Increased communications with other states' correctional health care staffs. Reduced sense of staff isolation, feeling that they are alone. Increased staff motivation to make improvements in health care.	In-service training program expanded to include stress management and resolution of professional conflict.	None.

State: NEVADA

NORTH CAROLINA

Immediate Results	Subsequent Effects	System Impacts
Facilitated the increased involvement of provider staff in planning and implementing health care changes. Increased sense of staff obligation to become change agents, advocates for improved health care. Increased sense of their importance as leaders in the field; increased their appreciation of the quality of staff in the system. Provider staff with a common framework for assessing system and identifying priorities for change. Enhanced health care programs ability to access and utilize resources available in the system. Surfaced system problems that were not previously recognized as problems.	Formed task forces in the following areas: Policy and procedures Health records Health management information system Central pharmacy Protocols Continuity of care Continuing education Policy and procedures manual developed/in internal review. Health records redesigned and standardized; modified POMR adopted. Standing order for nurses in field units developed, also recommended development of protocols for PAs. Will seek funding to develop health education self-instructional material for inmates. Plans for phasing in central pharmacy developed. Improved policies and procedures for pharmacy services developed. Budget amount specified for health care training; health care staff development needs incorporated in Department of Corrections manpower development and training plan. Developing an improved statistical information system.	None.

State: NORTH CAROLINA

RHODE ISLAND

Immediate Results	Subsequent Effects	System Impacts
Increased sense of self-confidence about reality of problems in system and ability to address them. Increased awareness of roles of administrators and providers in the system. Increased evaluative skills to assess health care delivery system and prioritize needs. Identified needs for more effective staff development efforts. Reduced sense of isolation and uniqueness; recognition that problems are widely shared. Increased knowledge of options on health care delivery, and state-of-the-art, e.g., gained knowledge of pharmacy and dental services, protocols and their use, etc. Increased understanding of legal implication for providers in corrections.	Established committee to develop health education program for inmates. Established committee for staff development program. Introduced dental screening in intake procedures; ordered additional dental equipment. Utilizing specialty clinics more extensively. Discontinued bulk medication storage in clinic areas, and developed improved procedures for controlled substances. Have developed a drug profile on each inmate. Developed a basic form for use during intake for major problem identification. In process of finalizing policies and procedures manual. Planning redesign of medical records. Changes procedures for medical record transfers among institutions.	Implemented annual physical exams for all inmates over 40.

State: RHODE ISLAND

TENNESSEE

Immediate Results	Subsequent Effects	System Impacts
Increased staff morale and sense of professionalism; reduced feelings of professional isolation. Increased information about other health care systems, improved perspective on their own. Increased knowledge of options for health care organization and delivery. Clearer sense of priorities for making improvements; view of health care as a system. Increased appreciation of the need to develop a health care system plan.	Approval of plans to renovate central prison hospital and build surgical center outside of the prison walls. More aggressive and effective procedures for staff recruitment and employment of a number of new professionals. Monthly meetings of clinic supervisors instituted to improve communications among health care personnel.	None.

State: TENNESSEE

Immediate Results	Subsequent Effects	System Impacts
Increased contact with health care professionals in other states; led to exchange of information. Lent credibility to efforts already underway. Strengthened conviction that they were moving in the right direction; making the appropriate changes, e.g., health records, use of mid-level providers, better use of community resources. Increased knowledge of options for health care delivery; e.g., decentralized sick call, self-care for inmates. Increased staff morale; validated correctional health as a real profession. Improved communications among state correctional health care staff; reduced sense of isolation. Provided reference points for assessing their own system. Identified need to improve communications between correctional and health personnel.	Redesigning medication distribution system and pharmacy services. Developing a protocol system of care. Plan to develop self care training program for inmates.	None.

State: WASHINGTON

WISCONSIN

Immediate Results	Subsequent Effects	System Impacts
Increased knowledge on planning and developing health care facilities, e.g., centralized infirmary care, standards for ambulatory care. Enhanced ability to evaluate options for providing secondary and tertiary care. Sensitized staff to need for open communications. Increased ability to develop and monitor budgets. Sensitized staff to inherent dichotomy between system security/health. Increased awareness of stress and its effects. Increased knowledge about pharmacy services. Increased knowledge about medical records. Increased expertise in recruitment of capable staff. Increased professionalism and perspective of health care in corrections as profession, reduced isolation. Provider staff sensitized to global nature of system problems. Changed attitudes of staff toward innovations, actually involved them in planning for change.	Established task force to evaluate pharmacy services. Initiated recruitment of additional professional staff. Obtained authorization for several professional positions. Phasing out inmate providers. Evaluated and redesigned staff utilization in some institutions. Formed Task Force to redesign the medical records. Initiated monthly meetings with staff, e.g., nurses, dentists. Standardized medical records format. Designed and implemented utilization data collection systems. In process of writing policies and procedures manual.	Implemented uniform exi screening t assure continuity of care. Implemented follow-up system for specialists care.

State: WISCONSIN

DISCUSSION OF FINDINGS

As can be observed from the preceding charts the program contributed to attitudinal and motivational changes as well as knowledge and skill acquisition. Changes in attitudes and motivation enabled staff to apply both existing and newly acquired knowledge in a series of actions--which, if carried through to completion, can result in significant changes in the management, organization, and delivery of health care services.

Attitudinal and motivational changes represented the most widely observed program outcomes. State staff participating in the program uniformly reported experiencing an increased sense of pride about working in the correctional system, and a reduced sense of professional isolation. To some extent, this may be the program's "Hawthorne" effect and the results of an effort specifically focused on health care staff. At the same time, however, prison health work represents unique environment, that is, outside the medical care mainstream. as the first national effort of this kind did give prison health workers and their situation visibility and recognition. Furthermore, it provided an opportunity for them to meet and interact with their professional colleagues. That exposure and the resulting opportunities to share perspectives and experiences, highlighted the problems that most systems face and established a feeling of mutuality among state staff. These perceptions helped to reduce the sense of isolation which was widely felt, and fostered the development of informal information and exchange networks, to sustain the supportive environment created by the knowledge that problems and the search for solutions are generally shared.

Meeting other state providers, frequently for the first time, contributed to a heightened awareness of existing state resources which can be marshalled in change directed efforts. Participating with colleagues in a workshop facilitated the development of working relationships, which were further strengthened by the professional respect their colleagues received. This made collaborative efforts seems desirable and possible, and helped to overcome constraints which may have previously impeded cooperative state staff efforts.

The CHCP workshops further provided health care staff with the opportunity, although somewhat limited, to interact with custody and correctional personnel and learn about custody and security perspectives on health care. Participants gained a greater understanding of correctional officers' concerns, as well as a greater appreciation of the importance of effective communications between

health-custody staffs. Acknowledging the importance of the health-custody relationship represented an important attitudinal change; one which will contribute to a more supportive environment for health care.

The program also introduced state staff to a growing body of knowledge and technology about correctional health care, which had not previously been systematically compiled or presented. This body of knowledge included professional health care standards for prisons, options in the organization and delivery of care, management techniques and procedures as well as information about other correctional health care systems. This exposure had several benefits. It provided state staff with benchmarks or standards for assessing their state's system. In some cases, it allowed staff to conclude that their system was better than expected, and thus made the improvement process more feasible. It also contributed to a strengthened resolve to more extensively utilize in-state resources. These standards also helped surface system inadequacies and stimulated states to reassess system needs and priorities. Once needs were clearly identified, the knowledge of options which had been gained could be applied in the selection of strategies to be implemented.

The CHCP workshops covered a substantial body of knowledge which represented state-of-the-art information, nevertheless, it did not uniformly represent new information for the program participants. Knowledge gain was a function of staff background and experience. Several topics, however, were singled out as important areas of information gain. They included clinical protocols, medical records, approaches for conducting cost analysis and maintaining cost controls, the effects of stress, and the legal implications for providers in corrections.

More positive perceptions of state staff and a clearer view of what needed to be accomplished, contributed to staff efforts to more effectively access and use existing resources. The numerous program effects identified indicate that attitude change and knowledge gain resulted in actions which can ultimately impact on the health care system.

Although many of the activities undertaken were specific in scope and focus to the needs and problems of the state, some generalized processes also resulted. In most states, task forces and working committees were formed to review specific features of the delivery system, recommend changes, and facilitate implementation of the changes once they were agreed upon. These processes were a direct outcome of the program's efforts, and frequently such work groups were formed as a result of CHCP recommendations. These working groups are significant

in two ways. In addition to the changes that these groups are likely to support, they represent a mechanism with considerable potential of institutionalizing a new process for change. Most change, in the correctional system, until now followed a top-down decision-making process. The involvement of line staff and administrators in a system review and planning process introduces a potential for surfacing and acting on needs identified by the line staff at the institutions, and also increases the potential acceptance of proposed changes, by staff who ultimately will be involved or affected by the changes.

Another, fairly widespread result of the program is the increased recognition given to staff development needs, and the planning and implementation of such efforts. Correctional health personnel in most systems have not until now been the recipients of formal training efforts directed towards health care. If they participated in staff development efforts, it was usually conducted under the auspice of the correctional system, and usually focused on the needs of custody personnel. The increased recognition given to the training needs of health personnel represents an important program result, with significant potential for on-going training and skill development. Such a process can support the implementation of procedure and service delivery changes, and contribute to organizational renewal on an on-going basis.

Increased attention to staff needs has been accompanied by efforts undertaken in some states to examine staff roles and functions, particularly those of the mid-level providers, and to link the use of protocols to expanded roles for PAs and nurse clinicians.

Other general and important program effects include increased emphasis on the development of health care policies and procedures and the development of management systems to enable central office administrators to collect better information and institute more effective controls.

Most of these program outcomes represent interim or on-route changes and very few impacts or actual changes in the organization, management, or delivery of services were observed. A major reason for this may be the program time-frame. The technical assistance component of the CHCP represented the primary means for facilitating system change. The technical assistance was provided over an 11 month period from October, 1978 to late summer, 1979. Shortly after the completion of the effort, URC conducted the follow-up evaluation visits to the states. Although this time frame was sufficient for establishing the processes which can lead to change, it is not adequate for changes to be implemented and observable. Change in most larger complex systems is slow and is rarely

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accomplished in such a short period of time. Change in the correctional health care system is even more difficult to accomplish quickly because it involves two subsystems, health-corrections, a public agency and an environment not particularly receptive to change.

The few impacts that were noted were the kind that could easily be instituted by an administrative decision, and in these instances the program provided the professional support which made these decisions easier to make and carry out.

Since the expectations of the program were not expressed in quantifiable terms (e.g., how many improvements, of what kind, in how many states) it is extremely difficult at this juncture to determine the extent to which the program met its objectives. Although very few actual improvements in health care were found to result from the program, the effort did contribute to an improved environment for change, and a recognition that change is both needed and possible. It also helped institute, in a number of states, a process which can support the momentum for change stimulated by this effort.

The benefits state staff derived from the program are numerous and far reaching. These benefits are reflected in increased professional confidence, more positive feelings about working in the correctional system, and an improved capacity to operate effectively within the system. Improved staff capability coupled with the means for instituting change, suggests that the foundations for making improvements in correctional health care have been laid. The work, however, is by no means over.

FACTORS AFFECTING CORRECTIONAL HEALTH CARE PROGRAM OUTCOMES

The outcomes presented and discussed previously were influenced by program design and implementation features, state characteristics and conditions and the interaction between program activities and state conditions. This section describes the variables constraining the implementation of program processes, the disposing conditions affecting the state's ability to utilize program resources for making changes, and the interaction between these two sets of variables.

The CHCP effort to improve health care in correctional systems like most efforts to produce change, represented a "best guess" about how its intended objectives could be accomplished. Although the program's plan was based on practical experiences in implementing correctional health care improvements,

particularly in the State of Michigan, it was also based on a number of program design and implementation assumptions. Some of these assumptions were explicit and their programmatic implications were recognized. Other assumptions did not become apparent until the program was well underway.

The working of any change directed effort can be conceptualized as a series of steps that logically proceed from one to the next. A plan of action is based on: 1) an identification of needs existing in a target group or population; 2) the articulation of objectives or statements of intended accomplishments relating to the identified needs; 3) the selection of strategies and activities--which represent the means for accomplishing the objectives; 4) specified resources which provide the wherewithal to conduct the activities; and 5) an organizational structure for managing and deploying the resources in the performance of the activities.

The development and implementation of an effective plan of action depends on achieving as good a match as possible among all of these program elements. Program objectives, for example, should be based on identified target audience needs; the program activities should represent appropriate means for achieving the objectives, and resources should be adequate in both quantity and type to perform the specified activities in the required manner.

But program plans are almost never perfect. Rather they represent "best guesses" about needs, processes and resources, from the information available when the plan is developed. As programs are implemented, additional information is acquired. This information, for example, may include refinements of target audience needs, better understanding of the limitations of the selected program processes vis a vis these needs, and a recognition that the resources may not be adequate to achieve the specified objectives. Sometimes the program plan can be modified to reflect this new knowledge. Frequently, however, the program plan incorporates decisions that were made that cannot easily be rescinded.

IMPLICATIONS OF PROGRAM DESIGN FEATURES

There were a number of program design and implementation features which affected both program operation and results. These features were based on two sets of assumptions: one regarding effective program approaches, and the second relating to the characteristics and needs of the participating states and target audiences.

The selection of 10 diverse states posed several difficulties for the program, for state diversity was reflected in a number of different kinds of needs ranging from the need for an overall plan for the health care system (Tennessee) to the need to examine and develop a continuing education plan for health care staff (Florida). The range and complexity of the needs identified by the states, on the one hand, and the fixed program resources, on the other, meant that priorities for the provision of technical assistance would have to be established. As a result of delineating these priorities, some of the initial problem areas identified by the states were not addressed by the program.

The diversity of the states was further reflected in the training needs of state staff. Although training needs are a function of individual experience and educational background, they also encompass job functions or responsibilities which reflect a state's organizational structure, programmatic priorities and service delivery capabilities. Given these differences, the CHCP workshop design faced the challenges of finding that level of presentation which combined practically with theoretical soundness, and which was neither too simple, nor too complex.

This was difficult to accomplish in the absence of information on the specific skill/knowledge needs of the participants. CHCP staff was further handicapped in this effort by their limited practical experience in correctional health care.

Although the two target audiences chosen for this program were appropriate, the implementation of change in correctional systems is dependent on the involvement and support of correctional administrators. Since in most systems, institutional health staff are administratevely responsible to the institutional warden or superintendent, involving correctional administrators as program participants would have helped to establish correctional health care as an area of concern in corrections, and it would have also helped to build support for change among correctional administrators. In the absence of significant correctional staff participation, health care providers and administrators had to take on this selling job alone. And as system insiders they could not bring to the effort the credibility and standing of the Michigan program staff.

As has been mentioned earlier, the program objectives were broadly stated in terms of improving the organization, management and delivery of correctional

health care services. Though appropriate to the problems of corrections, the statement of objectives failed to establish programmatic areas of emphasis, and instead communicated a message that was unrealistic in light of the severity and diversity of needs, and the limited program resources. The objectives also resulted in participant expectations that exceeded the bounds of feasibility, which led to disappointment when priorities and limits were eventually defined.

In light of the range of needs, as well as the commonality of needs among the 10 states, the program might have accomplished more if a few areas were addressed in greater depth. The initial site visits could have been used to collect information on both state needs and participant needs, and factored into planning for both training and technical assistance activities.

Although the training and technical assistance were relatively well integrated activities, and technical assistance provided follow-up on many of the areas addressed in training, there also were some discontinuities in the design of these two processes. The separate training efforts for administrators and providers, fed into a separate TA planning process. This was further exacerbated by the absence of a prescribed process for state staff to follow in developing a state TA plan. Thus only two states (Illinois and North Carolina) convened a meeting of provider and administrator workshop attendees to plan for TA, and only North Carolina successfully involved its workshop participants through the entire TA process. Although two other states (Florida and Nevada) elicitied written comments (and a few others had informal verbal exchanges) from attendess, these comments and recommendations did not become part of state process of planning for the delivery of TA.

The resources available to the program were from the beginning divided among the CHCP participating groups, who were responsible for specified program activities. The Office of Health Care coordinated the overall effort. With program responsibility shared among several groups, however, strong central leadership and direction was needed to assure consistency, program coherence and a unified program approach, and this was not adequately anticipated in the initial program design.

Most of the CHCP budget was also allocated to the participating groups, who relied on staff hired or assigned to this effort. That meant limited program flexibility for contracting with outside experts in response to state needs and requirements. In addition, though most of the staff had backgrounds in health care, they lacked breadth of experience in correctional health care as well as depth of

knowledge in the specific areas addressed by the program. Thus the program became a learning experience for CHCP staff, which also limited the number of problem areas which could be addressed as well as the depth of the analysis and the assistance which could be provided.

STATE FACTORS AFFECTING PROGRAM OUTCOMES

Although it is clear from the preceding material that the program had an effect on each of the participating states, it is also clear that specific factors in the states mitigated the program's potential for impact. Some of these factors were state specific; others were general and observable as key variables in a number of states. The primary factors included system stability, the decision making structure for health care, the qualities and characteristics of the leadership in health care, and the severity of the problems, outside pressures and commitment to change.

Involvement in planning and implementing health care improvements requires an ability to focus and concentrate staff effort on the process of change. Where changes were observed or in process, a considerable amount of staff participation was also evident. North Carolina, for example, estimated that several hundred hours of staff time were involved in the work of its task forces, and these efforts have not yet been completed. That level of staff time allocation is only possible when the system is relatively stable, and not dealing with crisis or fighting brush fires.

Such system stability, however, was a relatively rare phenomenon among the 10 participating states, for a number experienced crisis resulting from changes in the department's leadership, inmate unrest, health care staff problems or a combination of these problems. During the year and a half of the program the following events occurred:

- Washington experienced considerable inmate unrest, an extensive lock-down in Walla Walla, and the appointment of a new Director of Corrections.
- Illinois also experienced a change in administration, and the resignation of the C.O. health care administrator and his staff.
- Rhode Island experienced a long period of inmate unrest in the period immediately preceding the start of CHCP; change in C.O. health care administrative staff, and a physician walk out leaving the system with no medical providers.

- Tennessee suffered from a long history of neglect and indifference, and the new Medical Director, who was hired about a week before the first administrator's workshop, had a large number of basic but critical system elements to address. During this time, a new more fiscally conservative Commissioner of Corrections was appointed.
- Wisconsin faced a totally new organizational structure for correctional health care, with very little precedence about how to make it work effectively. In addition, it was without a health care administrator for a substantial portion of this period.
- Nebraska and Colorado experienced turnover in central office health care administrators, and Colorado's health care system lacked leadership and a person in charge.

In most states, the central office health care administrator is a staff position. That means that changes to be instituted in the delivery of services at the institutional level require the concurrence and support of institutional administrators and health care providers, who are administratively responsible to the warden or superintendent of the correctional facility. This structure makes the change process slow and cumbersome, as well as, highly dependent on central office administrative stability, leadership, and persuasiveness. Such leadership was more evident in states which were stable and where the C.O. health care administrator was not new to the system. In North Carolina, for example, the health services administrator had been there six years, during which time he had been able to establish his credibility with both correctional and health care staff. This allowed him to begin to use his professional authority in a manner which suggested health care staff accountability to him, although the reality was quite different. In Washington, on the other hand, the system wide implementation of the POMR, involved a lengthy staff education, development and consensus building process to achieve the necessary support from the line staff. In those systems where the central office administrator has line authority (Nebraska, Wisconsin), other factors, like staff turnover and administrative reorganization, have operated to impede the full use of this authority to stimulate system wide change.

Several of the states (Rhode Island, Wasbington, Illinois, Tennessee, and Wisconsin) were under court mandates to improve health care. The medical administrator in Tennessee was able to use this mandate to obtain legislative appropriations for additional staff positions, the renovation of the prison hospital and the construction of a new surgical center. In Wisconsin, a legislative investigation was responsible for the reorganization of health care, and the transfer of this responsibility to the Department of Health. Although actions in other states were less clearly a result of legal pressures, the pervasiveness of concern about the potential for court intervention, was an important stimulus for change, as well as, in several cases, a motivating factor for participating in the program. The extent to which court pressures could be used to stimulate and gain support for change, however, was also affected by system stability and health care leadership.

The processes and outcomes of the CHCP effort were influenced by factors inherent in the program, as well as in the environment of correctional health care in the 10 states. All action oriented programs are similarly affected, and in designing such efforts, one is challenged to select program strategies and activities which can minimize the disposing conditions, and maximize the opportunities for success. The next chapter discusses some approaches that should be considered in future health care improvement efforts in corrections.

VII. RESOURCE MATERIALS

In addition to the training and technical assistance activities, the Correctional Health Care Program developed a number of resource materials on a variety of topics of interest to correctional health care professionals. These materials include 19 manuals and 5 videotapes, many of which were prepared for use in the workshops and technical assistance but also designed to be used independently. The manuals were written by CHCP staff, and expert consultants. Preparation of the manuals relied heavily on the knowledge and experience gained by CHCP staff while working with correctional administrators and providers in the field.

Following is a list of the manuals, with brief descriptions of their contents.

Correctional Health Care: An Annotated Bibliography

Prepared by CHCP staff and student assistants.

This bibliography provides an introduction to the literature relevant to health care programming in correctional institutions. Approximately 300 articles, reports and books are cited and annotated. An unannotated supplement referencing approximately 150 items is also included. Material is organized according to the following categories: general works; standards and goals; legal issues and prisoners rights; organization of health care services; dental services; mental health services; studies of prison health services and inmate health status; essays and commentaries; and related material. 113 pp.

Correctional Health Care Facilities: Planning, Design, and Construction

Prepared by an architectural firm experienced in designing health care facilities in Michigan prisons.

This manual discusses the how-to's of facility planning, evaluation and acquisition for correctional health care programs. It describes each step in the process, suggests who should be involved at each step and outlines a general time frame. The manual is designed to assist correctional health administrators in meeting their own specific facility needs rather than offering standard solutions. 174 pp.

Dental Health Programs for Correctional Institutions

Prepared by a public health dentist with experience in correctional institutions.

This document presents a comprehensive and detailed discussion of the requisite components of an effective correctional dental health program. The manual is directed toward correctional health administrators and dental directors, and emphasizes both the structural and administrative aspects of the dental program. Chapters include material on: the overall role of dental care in correctional health; problems and constraints concerning the provisions of dental care in the correctional setting; professional staffing; facilities and equipment; the organization of the dental division in the correctional setting; alternative approaches to providing comprehensive dentistry; establishing priorities for care; and quality assurance. An extensive appendix is included containing such information as: sample policies and procedures; potential sites for personnel recruitment; model dental records; standards for dental care in corrections; suggestions for publications to be included in a prison dental library; and the names and addresses of all dental schools, dental auxiliary schools, dental societies, and state dental boards in the United States. 353 pp.

The Development of Policy and Procedure Manuals for Correctional Health Programs

Prepared by CHCP staff.

This manual discusses the how-to's of writing a policy and procedure manual for a correctional health care program and describes the manual's uses as a management tool. Recommendations are made concerning the planning, writing and implementing of policies and procedures. Additionally, an outline is offered as a model for a policy manual. Suggestions are made for content of each policy and the details that the policy might require for procedures in that area. Each policy cites the AMA and/or ACA Standards to which the policy relates. 83 pp.

Diet Manual for Correctional Health Care

Prepared by the nutrition consultant for the Michigan Department of Corrections, Office of Health Care.

This manual represents the therapeutic diet program for the Michigan Department of Corrections. It has been prepared for use by medical, dental, nursing and food service staff as a guide for ordering and interpreting the therapeutic diets needed

as part of a total health care plan. The diets and sample menus have been planned to meet the known nutritional requirements of the Recommended Dietary Allowances of the National Research Council as closely as therapeutic restrictions permit. This manual can be used in correctional institutions of various sizes and can be modified for use in other correctional systems. 116 pp.

Establishing Health Education Programs

Prepared by CHCP staff.

The program development manual is designed to provide a step-by-step guide to the establishment of a health education program in the correctional setting. The model discussed is based on the concept of using community health educators to assist the institutional health care staff in initiating such a program. The manual outlines strategies for planning, developing, implementing, and evaluating a health education program in corrections. 126 pp.

Establishing Protocol-Directed Health Care

Prepared by CHCP staff.

This manual is concerned with the establishment of protocol-directed health care programs in corrections. It is intended to provide specific strategies and procedures for planning, developing, implementing, and evaluating protocol programs. Topics addressed include: correctional health care and the role of non-physician care providers; the characteristics of clinical protocols; advantages, limitations, and applicability to the correctional setting; the role of physicians in protocol-directed health care; and medical-legal implications for the use of protocols. Recommendations are also made for writing protocols and/or adapting those already written to suit a particular clinical setting. 90 pp.

Establishing Staff Development Programs

Prepared by CHCP staff.

This manual is concerned with the establishment of staff development programs in corrections. It is intended to provide specific strategies and procedures for planning, developing, implementing, and evaluating staff development programs. Staff development is the intervention or training of staff that eminents from the recognized needs of the program or organization and will enhance

the staff's skills to meet the program or organizational needs. The manual discusses a rationale for staff development programs in communications and in stress assessment and management. An overview of the literature in both areas is also included as well as a list of reference materials, resource materials, and an annotated bibliography. 128 pp.

First Aid and Emergency Procedures Handbook

Prepared by health care staff at a Michigan correctional institution and edited by CHCP staff.

This handbook is designed to be used by correctional officers and other non-medical correctional staff in the event of a resident injury or other medical emergency. The handbook tells the user what to do for the resident until medical attention can be obtained. 20 pp.

Information Systems for Correctional Health Care Programs

Prepared by CHCP staff.

This manual is designed to serve as a basic reference on information systems for correctional health care programs. Categories of information needed in the operation and management of correctional programs are defined, and general concepts in the use of information for program management are discussed. The functional analysis method for designing specific management information needs is described, and illustrations of the design process for both manual information systems and computer-based systems are presented. 113 pp.

Informed Consent in Correctional Health Care Programs

Prepared by CHCP staff.

This manual is a discussion of the major issues relevant to an understanding of the principles and practices involved in informed consent to treatment and refusal of consent to treatment as it applies to the correctional health care setting. Sample policies and consent forms are included as well as a state-by-state analysis of the laws relating to informed consent for minors in the CHCP participating states. 60 pp.

Make-Buy Decision Analysis for Correctional Health Care

Prepared by a management consultant.

This manual presents an overview of the make-buy decision analysis model. The discussion is directed to medical directors and health

administrators and describes the various elements to be considered when deciding between providing or purchasing services. An example of a make-buy decision on pharmacy services in a correctional institution shows how the model can be applied. A glossary of terms is included. 42 pp.

Mid-Level Practitioners in Correctional Institutions: An Analysis of Legislation

Prepared by CHCP staff

This manual analyzes the current status of legislation and conditions of practice in the CHCP participating states concerning nurse practitioners and physician assistants. 111 pp.

Nursing Procedures Manual

Prepared by the Directors of Nursing services in Michigan correctional institutions.

This manual is a reproduction of the nursing procedures manual developed for use by Office of Health Care staff at the Muskegon Correctional Facility in Michigan. The procedures are presented in two parts. Part I covers basic nursing skills, and Part II covers advanced correctional nursing skills. It is offered as a sample guide to the development of nursing procedures in other institutions. 336 pp.

Pharmacy Services in Correctional Institutions

Prepared by CHCP staff.

This manual presents an overview of the organizational and administrative requirements for operating pharmacy programs in correctional institutions. The discussion is directed to medical directors, health services administrators, and pharmacists, and covers all aspects of pharmacy management. Information is included on: goals and standards; legal requirements; pharmacy organization and location; procurement of pharmaceuticals including purchasing, inventory control, and storage; drug distributions systems; roles of pharmacists and technicians in pharmacy practice and patient care; and pharmacy administration including personnel and budget management. An extensive bibliography on pharmacy management and administration is included. Selected reference materials are supplied in the appendix covering professional standards and practice

guidelines, policies and procedures for pharmacies in correctional institutions, and a self-evaluation instrument. 152 pp.

Problem-Oriented Medical Records in Correctional Health Care

Prepared by a health records consultant to the Washington Adult Corrections Division.

This manual has been designed to accomplish two major ends, namely: to give the prison health care professional a convenient reference for understanding the problem-oriented medical record approach, and to give people who will have responsibility for medical records a step-by-step model that will help them implement the process in prison settings. 60 pp.

Quality Assurance: A Brief Overview for the Correctional Health Care Administrator

Prepared by CHCP staff.

This manual provides an overview of how quality of care is measured and of different approaches for achieving desired levels of quality. Discusses how the correctional health care administrator can develop a quality assurance program, and describes how the essential components of such a program can be brought together. 19 pp.

Resident Guide to Self-Care

Prepared by two physicians in Michigan correctional institutions and edited by CHCP staff.

This manual is designed to be used by correctional residents in treating minor, self-limiting health problems. Treatments described include the use of some over the counter preparations, exercise and proper health habits. Each treatment specifies at what point the resident should contact health services about the problem. This manual can be used by residents in correctional institutions of any security level with some modification for security restrictions. 57 pp.

Sample Policy Manual for Correctional Health Care

Prepared by the Policy Committee for the Michigan Department of Corrections, Office of Health Care.

This manual contains sample policy directives for health care services. These are actual policies, in draft form, of the Office of Health Care of the Michigan Department of Corrections. 121 pp.

In addition to the resource manuals, five video tapes on selected topics related to correctional health care were produced. These were based on lecture presentations for the Provider's Workshops and were modified for taping. They are:

Trends and Issues in Correctional Health Care - Jay K. Harness, M.D.; Director, Office of Health Care, Michigan Department of Corrections.

An overview of major issues effecting recent developments in correctional health care. Topics addressed include: historical perspectives in correctional health care, the relationship between health care and security functions, the development and implementation of correctional health care standards, the accreditation process, staff recruitment, and organizational alternatives in correctional health care.

The Correctional System: Organized to Fail? Opportunities for Change - Ellis MacDougall; Director, Arizona Department of Corrections; Phoenix, Arizona.

Review of current trends and issues in the criminal justice system. Includes a discussion of specific implications for the future of correctional health care.

The Health Record: Principal Document in a Health Record System - Judy Groty, Registered Record Administrator, Michigan Hospital Association; Lansing, Michigan. Formerly: Health Record Consultant; Office of Health Care, Michigan Department of Corrections.

An introduction to the need and application of a health record system with specific reference to the correctional health care setting. Includes discussion of the adaptation of POMR within the Michigan Department of Corrections.

Protocol-Directed Health Care - Barry W. Wolcott, M.D.; Chief, Operational and Emergency Medicine; Uniformed Services University; Bethesda, Maryland.

The review of a protocol-directed health care program currently being used in a military health care facility. Provides specific information regarding strategies for planning, developing, implementing, and evaluating clinical protocol programs with recommendations for adapting protocols to the correctional health care setting.

Helping Him: Methods for Medical Care in Prison Facilities - Richard Huff, D.O.; Medical Director, Muskegon Correctional Facility, Michigan Department of Corrections.

Discussion of life-crisis index and its implications for correctional health care service delivery.

Copies of the manuals and video tapes accompany this report. Information on obtaining copies of these materials can be had by writing to the Program to Improve Medical Care and Health Services in Correctional Institutions of the American Medical Association.

VIII. SPECIAL PROJECTS

In the course of the Correctional Health Care Program, a number of special projects were undertaken which indirectly affected other program activities. These special projects are described below.

INTERDISCIPLINARY COURSE DEVELOPMENT

Development of an interdisciplinary course outline related to correctional health care delivery was drafted by the CHCP/MSU project staff. The proposed content of the course centered on the practical concerns of health care professionals in the correctional setting. The curriculum tentatively includes a general overview of trends and issues in corrections and correctional health care, and the consideration of selected topics relevant to the various professional roles and service delivery methods found in corrections. The course would be jointly sponsored by the Colleges of Human and Osteopathic Medicine and the School of Criminal Justice at Michigan State University. The intended target audience would be students of the health care professions, criminal justice and other human services programs.

NURSING SCHOOL STUDY

A survey was undertaken by CHCP/MSU staff of all state supported and accredited baccalaureate schools of nursing to determine if any school utilized correctional facilities as sites for clinical experiences for students, and/or included correctional health care content in their curriculum. One hundred and forty-seven questionnaires were sent to the nursing schools; 114 responses were received and there was one refusal. Eighteen schools or 16% of the respondents indicated that the health care needs of jail and prison inmates were addressed somewhere within the undergraduate curriculum. An additional 4% reported that they had plans to incorporate that kind of segment in their program in the near future. Approximately 25% of the responding schools do use some kind of correctional facility as a site for clinical experience.

DEMONSTRATION PROJECTS

Two demonstration projects were initiated by staff: a model to provide health education in the correctional setting was implemented at Huron Valley

Women's Facility, MDOC, and a model to implement the use of triage protocols was introduced at Muskegon Correctional Facility, MDOC.

HEALTH EDUCATION

The delivery model for the health education program was based on the concept of utilizing community resources in the prison setting. The Washtenaw County Health Department agreed to coordinate the prison health education program, and arrange for community health educators to conduct classes at the prison in their respective specialty areas. These subject areas were determined after consulting with the prison health care staff, administrative staff and inmates. Classes were held once a week for ten weeks and lasted approximately 1 1/2 hours each. Upon the recommendations of both staff and inmates, the classes were conducted in the study room of the participating housing unit. This allowed the regular housing unit staff to provide security at the sessions without necessitating the use of additional personnel or overtime. One health services staff member sat in on each class to help monitor the class and assure consistency between information presented in class and clinic policy and practice.

The classes were designed to increase information gain and to help improve the women's feelings about themselves. To this end several educational tools were employed. Involvement of the class was essential so activities were designed to be fun, interesting, and informative (e.g., learning to perform a self-breast exam, exercises, etc.). Participants were given the opportunity and were encouraged to express personal feelings and concerns about their health and this contributed significantly to the learning experience. Feedback was solicited weekly to help improve classes and to test the quality and quantity of learning; this, too, gave the women an additional sense of commitment to the program.

An evaluation of this model program was conducted at its conclusion. The results showed a significant knowledge gain by the participants which was measured by their ability to apply the information they received to practical situations (e.g., the women were asked to explain how a contraceptive method worked and how they and a partner would utilize it). They also were questioned about self-reported behavior and attitude changes. Their responses indicated that indeed some behaviors had been affected (weight loss, changed nutritional habits, increased exercise) and that their overall concept of themselves had improved.

This model program could be readily adapted to larger and/or male institutions. In a male setting, an emphasis on body building, nutrition, and weight control would seem to be most appropriate. It is also recommended that the men have classes in physiology (male and female), contraception, and veneral disease. The Huron Valley women requested some additional topics that would seem applicable to the male setting as well: smoking, drug abuse, foot care, masturbation, sexuality, stress and loneliness, suicide, eye care, infection, aging and homosexuality. Further detail on this program can be found in Appendix J.

TRIAGE PROTOCOLS

The impetus for establishing a demonstration project implementing triage protocols at Muskegon Correctional Facility came from the investigation by MSU staff of the protocols developed and in use at Brooke Army Medical Center, Fort Sam Houston, Texas. With the assistance of MSU staff, the Medical Director and Nursing Administrator at Muskegon designed a pilot program which called for the use of protocols in the sick call process. The program was implemented initially in one housing unit with protocols for a limited number of conditions. As acceptance of the program grew and experience indicated no adverse effects, the program grew both in number of residents served in this manner and the variety of protocols used.

UTILIZATION OF OFF-SITE INPATIENT SERVICES

A study was conducted on off-site inpatient admissions with the Michigan Department of Corrections for a six-month period to identify patterns of utilization. Individual health records were reviewed for all inmates from Huron Valley Women's Facility, the State Prison of Southern Michigan (Jackson), the Michigan Training Unit, the Michigan Reformatory and the Riverside Correctional Facility who were admitted to an off-site inpatient service between January 1, 1979 to June 30, 1979. Information collected includes age, sex and race of the inmate; admitting and discharge diagnosis; service unit; hospital and physician of record; and length of stay. This type of information can be used in planning for the adequate yet effective provision of inpatient services, projecting reasonable funding allocations to cover necessary off-site inpatient care. Analysis of this data could also assist in the identification of factors which affect the health status

of specific categorizations of inmates. The data collected for this study includes a number of inmates who were hospitalized as a result of a methanol poisoning incident at the State Prison of Southern Michigan. Data was analyzed both with and without these cases.

PHYSICIAN SATISFACTION STUDY

Since the recruitment of qualified physicians is one of the major problems facing correctional health care administrators, a study was undertaken to determine what factors are related to job satisfaction among physicians currently working in prison settings. A survey was sent to every physician working 12 hours or more a week in a prison in this country regardless of whether the physician is employed as a civil servant or on a contractual basis. Confidential responses are being analyzed now and the results will be published at a future date. The implications of this study could have substantial impact on the manner in which administrators of correctional health programs approach the problem of recruitment not only of physicians but other health care professionals as well.

IX. CONCLUSION

Late in the project period discussions were held between CHCP administrators and LEAA officials to consider the possibility of continuation for the Correctional Health Care Program. LEAA officials expressed the desire to combine both of their major programs addressing correctional health care issues: the American Medical Association's Jail Project and the Correctional Health Care Program. Administrators from the AMA and CHCP met on several occasions to discuss the nature of a "marriage" between the two programs, and general agreement was reached prior to the termination of the CHCP grant. The key to this joining of projects was to lie in the role of state medical society staff. These people had been recruited to work with health care problems in jails; they would not be trained to work the state's department of correction in much the same way. While CHCP would continue to provide central office coordination and technical assistance initially, over time increasing reliance would be placed on state level staff. It was hoped that the established state networks would be strong enough to continue to function as federal funding was phased out.

Funding for this joint effort was expected to be made available in the Spring of 1980. Because most CHCP staff was scheduled to terminate at the end of December, 1979, the AMA agreed to retain a limited number of CHCP staff members as consultants to prevent the loss of experienced staff. During the transition phase these people were to plan for the coordination of the new program, to re-establish contact with the project states, assess the ability of the states to contribute to the financing of the program, and plan the training schedule for jail project staff. In late March, following negotiations with the project states and substantial planning, LEAA officials, responding to the need to limit spending, announced they would not continue funding the Correctional Health Care Program although limited funds would continue to be available for the AMA's Jail Project. This decision came as a surprise and a great disappointment to those involved in CHCP.

The Correctional Health Care Program represented the single most comprehensive reservoir of knowledge on health services in prisons. The experience of the staff in dealing with the diversity of correctional systems and the problems they face has not been duplicated anywhere. This experience is a result of months of

training, in-depth study and interaction with several state departments of corrections. The termination of this program has resulted in the dissipation of a very talented staff, and to attempt at some future date to assemble a comparable resource would be an exceedingly difficult task.

From the states' perspective, the Correctional Health Care Program was a federal program designed specifically to assist them with problems that have resulted to a large extent from federal court pressures. In those states that already had strong management, CHCP provided credibility to their plans and generated enthusiasm and interest among line staff to implement new programs. In other states, CHCP was able to supply the management technical support to help establish a plan for achieving the necessary improvements. CHCP was able to do this in a constructive, non-threatening way, providing support without undermining the state administration. In many states, the momentum for change will be lost in the absence of this support. The need for technical assistance is still great, and most states will not be able to obtain this assistance without CHCP.

The initiation of any new program is inevitably an expensive undertaking. The program plan is usually a "best guess" strategy; but until the program is implemented, it is not possible to know what will work and what won't. Start up costs must include a great deal of staff training and resource development. However, once a program is well underway, the cost of continuing it can be greatly reduced. The budget for the Correctional Health Care Program grant was $1.1 million. This was considered to be an expensive program given that it would directly affect a limited number of states. A major thrust of the program was the development of resources, resources which had not existed before. As a result of CHCP, these resources do not exist. And while the continuation plan did call for the development of additional resources, the program would be based primarily on the use of those already developed. By relying on the CHCP experience in developing a continuation program plan it was possible to develop a program that could be equally effective yet far less expensive than the original CHCP grant. The integration with the AMA Jail Project would have allowed a broader audience to reap the benefits of CHCP without incurring substantial additional costs. To those involved in CHCP, both staff and clients, the decision not to continue funding the Correctional Health Care Program seems to be very short-sighted. The problems continue to exist, but the states no longer have a comprehensive resource to which they can turn for assistance.

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