COUNCIL OF THE CITY OF PHILADELPHIA

PUBLIC HEARING

COMMITTEE ON PUBLIC HEALTH AND HUMAN SERVICES

and COMMITTEE ON PUBLIC SAFETY

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Room 696, City Hall
Philadelphia, Pennsylvania
Tuesday, October 8, 2002
10:00 a.m.

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RESOLUTION 010598 - Resolution authorizing City Council's Committees on Public Health and Human Services and Public Safety to hold a joint committee hearing to continue monitoring and investigating the quality level of medical and mental health care services that is provided or made accessible to prison inmates under the care of the Philadelphia Prison System, and further authorizing the Committee to issue subpoenas and such other process as may be appropriate to compel the attendance of witnesses and the production of documents in furtherance of the investigation to the full extent authorized by Section 2-401 of the Home Rule Charter.

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PRESENT:

COUNCILMAN ANGEL ORTIZ, Chair
COUNCILWOMAN MARIAN B. TASCO, Chair
COUNCILWOMAN BLONDEL REYNOLDS-BROWN
COUNCILMAN DARRELL CLARKE
COUNCILMAN W. WILSON GOODE, JR.
COUNCILWOMAN DONNA REED MILLER
COUNCILMAN FRANK RIZZO

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I N D E X

COUNCILMAN ORTIZ: Could the Clerk read the resolution, please?

THE CLERK: A resolution authorizing City Council's Committee on Public Health and Human Services and Public Safety to hold a joint committee hearing to continue monitoring and investigating the quality level of medical and mental healthcare services that is provided or made accessible to prison inmates under the care of the Philadelphia Prison System, and further authorizing the committee to issue subpoenas and such other processes as may be appropriate to compel the attendance of witnesses and the production of documents and furtherance of the investigation to the full extent authorized by Section 2-401 of the Home Rule Charter.

COUNCILMAN ORTIZ: Thank you.

I'd like to recognize Councilman Frank Rizzo, Blondel Reynolds-Brown is here also.

I want to welcome you and thank you for coming. And I want you to excuse me, but I'm under stress in terms on antibiotics. I seem to have some sort of bronchial condition. It has me really speaking with this very weird voice today.

Since January 2000, this committee has

been investigating the nature and scope of healthcare in our prison system. In that time, this committee has worked diligently to assess the degree to which PHS, the private provider of prison healthcare, has performed. What we found was astounding. There was a range of baffling mishaps and instances of neglect that puzzled the minds of all of us concerned with ensuring we complied with the most fundamental obligations we as a City have to the inmate population. We found there were a long list of administrative and medical care deficiencies that in some instances led to the unjustified and often unexplained deaths of too many inmates.

In April and May of this year, for example, there were two inmate suicides that were in part due to what City consultant Dr. Raymond Patterson described as an absence of policy or procedure which assure routine and timely comprehensive behavioral assessments. He suggested that some of these suicide cases were preventable if appropriate referrals had been generated. Dr. Patterson concludes in his most recent quarterly report that the inmate records he reviewed to date

clearly indicate a need for an integrated comprehensive treatment planning process.

This, of course, is not new to the City. In fact, it is the cornerstone of Managing Director's Estelle Richman's January 2000 report to this Council. More so, this committee's report which was approved by City Council this past June clearly outlined the elements necessary to ensure improvements in the delivery of prison health services. The report included recommendations for the new contract cycle in light of PHS' June announcement that it would not continue its role as health provider. As a result, an interim three-month, $8.9 million extension was negotiated with PHS. Meanwhile, a new request for proposal was written. That, in our opinion, was a significant improvement over a prior RFPs.

The new RFP included a comprehensive set of measurable goals and objectives and even clarified several of Council's prior concern about the lack of penalties for non-performance. Our understanding is that there was a mandatory bid conference and competitive bidders submitted their proposals.

Last week we learned that PHS had negotiated a new nine-month prison healthcare contract to the tune of $26.2 million. If you add to the three-month $8.9 million contract, then in effect we have increased the 2003 base contract from a Council-approved $28.3 million budget to a rate of $35.1 million, a startling 25 percent increase.

This Council needs to know the details justifying this increase, especially the realization of a contract with a firm who just three months ago increased its standing among its stockholders by alerting them that they would terminate what they define as a loss contract with the City. I am aware that according to the City consultants that monitor this contract, improvements have been made by PHS. We know much of this progress is a consequence of this Council's watchdog role and critical work of the City monitors, Dr. Griefinger and Dr. Patterson. But many challenges still remain and need to be addressed.

Over the last two years, we have learned much about our prison health service delivery system. We know that inmates obviously receive a different standard of care, too often unjustifiably

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substandard. The introduction of a private provider in the early '90s was a clear response to the long-term neglect evident when these services were under City management.

But much has changed over the course of the last few decades. On the one hand, we have learned that the privatization with its profit motive is not the panacea that some would make it out to be, i.e., Edison in the school system. On the other hand, the public sector has improved its capacity to deliver human services.

Our inquiry is not about placing blame on private providers like PHS, it is about what standard of care we as a City genuinely believe should be provided to the inmate population, many of whom are pretrial detainees. The preliminary results of our inquiry has convinced me that we as a City need to have a greater management control of the delivery of healthcare services. A private provider is obviously an interim measure. Therefore, it is time we explore alternative models to prison healthcare that make sense for a City like Philadelphia.

We also found that most private

providers are highly reluctant to be held accountable. Monitoring the progress of PHS has been dependent on the internal reports of the City consultants. But even they have expressed frustration over the City's and the provider's slow and inconsistent response to their recommendations. Obviously, City Council's observation that an independent oversight committee be established is well-deserved and long overdue.

Today, we are here to obtain some answers to the questions outlined in the aforementioned, as well as those questions we have submitted in writing to the City Administration. I don't expect an avalanche of responses, but our job is to continue the mandate set before us by this legislature as specified in Resolution 010598.

I want to, again, thank all the community activists for their support and guidance. I hope to count on their continued advocacy and expertise. From the Philadelphia County Prison Coalition, I want to thank in particular Asia Russel and Robert O'Brien who have been collaborating with this committee from the very beginning.

I also want to recognize the work of

Temple Professor Nina Gorman who has conducted a

preliminary literature review in her efforts to help us explore the structure and work of a prison health oversight committee. We will hear a summary of her report today.

I also want to extend my appreciation to those Administration officials here today who have consistently responded to our request for information. In particular, I want to thank City Solicitor's Office despite our constant struggle and from the Managing Director's Office Mr. Timothy Gill who has tried to be responsive to our requests for information. While we may not always agree on how and when things should get done, I acknowledge his cooperative spirit and support of our work. In the end, I am confident we all want the same thing: To ensure we fulfill a legal and moral obligation in providing quality prison healthcare.

Thank you all for being here.

Councilwoman Tasco, the Chair of the Health Committee has just arrived.

Please call the first witness. Timothy.

MR. GILL: Good morning, Mr. Chairman and members of the Public Safety Committee. I am

Timothy Gill, Deputy Managing Director, and it is my

pleasure to represent Managing Director Estelle Richman for the purpose of presenting our progress on the Philadelphia Prison System's healthcare and related operations issues.

With the benefit of your committee's request for information as an outline, we have prepared a sketch of the issues to present and have on hand a team of representatives to address your follow-up questions. With us today are members of the Managing Director's Office, Philadelphia prison system, Law Department, Office of Mental Health, and our medical services provider.

Although Prison Health Services was not a bidder in the RFP process, the RFP upon which the City's contract with PHS is based expressly reserves to the City the right to negotiate with providers who did not respond to the RFP. Specifically, Section 6.1 the City's reservation of rights states as follows: "In the event negotiations with any respondents are not satisfactory to the City, the City reserves the right to discontinue such negotiations at any time; to enter into or continue negotiations with other respondents; to enter into

negotiations with providers that did not respond to this RFP; and/or to solicit new proposals from

providers that did not respond to this RFP. The City reserves the right to enter into any contract with any respondent, with or without the re-issuance of this RFP, if the City determines that such is in the City's best interest."

The terms and conditions of the contract amendment have been forwarded to your office. The scope of services is based primarily on the 2000 contract with minor adjustments described in Exhibit PA-1. The duration of this contract amendment is nine months from 10/1/02 to 6/30/03.

The City will monitor the contract. The monitoring process involves the established blend of external independent monitoring experts and internal daily operation evaluators. The specific components of this team remain independent medical and behavioral healthcare experts, correctional healthcare specialists, correctional nursing monitors, and objective oversight by an agency not connected to the prison system. The standards of care referenced match those established by the National Commission on Correctional Healthcare. Our

approach is adaptive in nature by working with the provider early on and continuously to address

problems with healthcare in a cooperative manner, rather than adversarial. We think the partnership approach has paid off in tackling difficult issues and has promoted flexibility in services that our patients benefit from. In Contract Amendment 0120146-04, the City reserves the right to conduct utilization review based on a community standard of care to help ensure that services will be provided in a cost effective manner.

PHS will not be required to fulfill the contractual requirements outlined in the RFP issued July 9, 2002. The current agreement is an amendment to PHS's 2000 scope of services with the modifications explained earlier.

In recent years, the medical services provider demonstrated dramatic losses suffered due to a variety of reasons driving escalating healthcare costs. In order to continue delivering medical services for our inmate population without losing money, City and PHS representatives negotiated terms of price and risk sharing that made it possible for them to provide services with

reduced threat of financial loss. The following is a budgetary and financial explanation of the contract and whether City Council approval will be

required.

COUNCILMAN ORTIZ: Excuse me. Could you explain that to me, that last sentence that you said because I have a series of questions, but --

MR. GILL: "The following is a budgetary" --

COUNCILMAN ORTIZ: No, the one, "In order to continue medical services for our inmate population without losing money, City and PHS representatives negotiated terms of price and risk sharing that made it possible for them to provide services with reduced threat of financial loss."

Explain that to me, please.

MR. GILL: The previous scenarios under which the contract was constructed with a full risk contract that capped the ability for compensation for either the services that were being provided, pharmacy, outpatient services, hospitalization or other services required by patients, then it was no matter what the cost external to the services PHS was providing, there was no mechanism for them to be

able to receive additional compensation. What we tried to do was acknowledge what's happening in the healthcare industry around the country, and that is

escalating costs that cannot be predicted or cannot be anticipated in affixed rate contract, the City would share and acknowledge if it's verifiable that those costs are escalating, would share in part of that expense.

COUNCILMAN ORTIZ: Go ahead, continue.

MR. GILL: For the period July 2000 through June 2002, PHS was reimbursed for actual costs of services up to a fixed price with an adjustment for increases in population above 6900 inmates and for costs per inmate in excess of $50,000 up to $200,000. For Fiscal Year 2001, the amount of reimbursement was $25.3 million; for Fiscal Year 2002, the amount was $28 million. For Fiscal Year 2001, PHS submitted invoices for actual costs of $27 million; for FY 2002, $32.6 million. Based on the invoices submitted, PHS showed losses of $1.7 million for Fiscal Year '01 and $4.6 million for '02.

Based on the contract for Fiscal Year 03, which consists of Amendments 0120146-3 and

0120146-4, the City is committed to pay up to $34.9 million in base compensation and up to $1.3 million in additional compensation for a total of $36.2 million.

In Amendment 3, covering the three-month period through September 30, 2002, base compensation was $8.7 million. Additional compensation consisted of an adjustment of approximately $2.79 per inmate per day for a population in excess of 69 hundred inmates as well as compensation for costs in excess of $50,000 per inmate. Total costs for the period, including additional compensation, are projected at just under $9 million.

In Amendment 4, covering the nine-month period through June 30, 2003, base compensation covers actual costs up to base compensation of $26.2 million. Additional compensation included, the current contract is $1 million for a total of $27.2 million.

In Amendment 4, additional compensation has been redefined. It no longer covers population in excess of 6900 inmates or costs per inmate in excess of $50,000. Rather, it covers costs in excess of what is included in base compensation, as

shown in Exhibit PA-4A for the following items: Malpractice insurance, hospital, specialty and ancillary services, pharmacy, lab testing for Hepatitis C, and hourly rates for eight employment

categories as shown on Exhibit PA-4B. Given the variability of the costs that are eligible for additional compensation, we believe that it is in the interest of both the City and PHS to share the risk on these line items.

In summary, the City budgeted about $30 million for Fiscal Year '03 for Prison Health Services. Based on the current contract, it could cost about $6 million more.

It is too early to say whether the PPS will be able to live within its Class 200 appropriation or whether the Administration will need to come back to City Council for a transfer ordinance in Fiscal Year '03. In addition, as we do every year, the Administration will include costs for correctional health services in its next five-year plan and Fiscal Year '04 Operating Budget.

The summer of 2002 was marked by record-setting heat waves. Although there were three unfortunate losses of inmate lives in July

2002, in one of them the excessive heat played a role. The other causes of deaths were cardiac death and end-stage alcohol liver disease. The facility in which excessive heat played a role in an inmate's death is not air-conditioned but utilizes all

methods possible to maximize air ventilation and drinking water availability.

Commissioner Costello has prepared a detailed response to the same issues, but in essence, increasing air ventilation in the housing areas is handled with a combination of open windows, fans, unit door opening management, and modified inmate uniforms to allow cooler clothing. Water is available in all cells with supplemental water coolers as needed.

To support prevention officials from the Philadelphia Prison System, Managing Director's Office, Health Department, and others were quickly and collaboratively to develop a directive implemented by PPS titled "Heat Alert Plans," which forms the basis of actions to take when excessive heat in the jail reaches emergency levels. A copy of the Heat Alert Plans has been forwarded to your office for review.

The Administration is aware of City Council's committee report on Resolution No. 010598 to establish an independent oversight board. However, we feel the current array of independent experts in the fields of medicine, medical

administration and behavioral health ensures appropriate levels of accountability, monitors complaints, and measures the performance of the prison health provider. Indeed, the monitors have noted improvements in many key areas with further work needed in others. The City will continue to monitor the healthcare services and work towards continuous improvement with the approach described earlier.

Our prison health service provider continues to exceed the minimum participation levels established by the City's Minority Business Enterprise Council. A current MBEC participation chart has been forwarded to your office.

Recently, there was an impromptu meeting held at the prison for employees represented by Union Local 1199C, which is the bargaining unit for nurses and related healthcare workers. The employees were frustrated by the lack of information

available regarding their future employment since the cessation of the contract for their employer was fast approaching. When a contract agreement was reached, the employees' concerns were answered. 1199C negotiates wages on behalf of its members and agrees to the terms and limits. These wages are

comparable prevailing wages in area healthcare settings.

The City has certain procedures to identify, track, counsel, and treat inmates with Hepatitis C currently in place. We have designed a medical intake system that requires the healthcare provider to repeatedly question the patient at different stages of the intake process as to the possibility of hepatitis exposure or the use of drugs related to hepatitis. In addition, all patients are given ample opportunity to request confidential counseling in testing either with the prison healthcare provider or through AACO.

Often, the first contact that a patient has with the prison healthcare provider is at the Police Administration Building where a medical screen is performed using pointed questions aimed at determining the patient's health status. Hepatitis

is one the items specifically asked of each and every patient seen at the PAB. At the intake facilities of the Philadelphia Prison System, the patient is placed in a holding cell in which there are bilingual signs reminding the patient to inform the prison healthcare provider of any medical

problems they may have. The receiving room nurses make regular rounds throughout the holding area to give patients ample time to notify staff if they are in acute need. The intake medical screen performed by an experienced RN also has pointed questions aimed at specific diseases. If at any time the patient states that he or she has hepatitis or asks to be tested, the inmate will be referred to chronic care for evaluation. Any patient showing signs of acute illness or being suspect of needing urgent care is immediately referred to the physician on duty for evaluation. Any patient identified as having HIV disease is routinely referred to chronic care and as part of the evaluation is screened for exposure to hepatitis.

After the medical intake screen, the patient will have an admitting history and physical performed by either a physician assistant or a

physician. As part of the routine history, there are several questions leading towards documenting hepatitis exposure. There are direct questions specifically about hepatitis as well.

Any patient documented as having Hepatitis C is referred to the chronic care system for evaluation and consideration for treatment. All

Hep C patients are screened for exposure to Hep A and B. HIV testing is strongly recommended. Liver enzymes and pigments are routinely examined. The patient is always counseled as to prevention and life-style modification.

The patient will be followed for alterations in the liver functions profile. Further discussion to consider medication includes genotyping, side effects, liver biopsy, and behavioral health examinations. Proper histology as documented by biopsy is essential to classify the patient in a medication protocol. As the medications are known to cause behavioral health problems, baseline behavioral health evaluations are necessary to diminish the potential for psychiatric morbidity.

The diagnosis and preparation for

medications may take months, which for some patients may mean they are discharged from PPS before receiving medications and treatments. This is not uncommon considering average length of stay for inmates at PPS is approximately 77 days. Many of these patients will only be partly evaluated for medication protocols. Comparison of our county

system to that of the federal or state system is inappropriate, as our length of stay is much shorter limiting our ability to coordinate the long-term diagnosis and treatment required for Hep C. State correctional facilities have patients for years which allow comprehensive planning and guaranteed treatment follow-through.

As the documentation of the health risks of Hep C in prison settings is still emerging, the City hopes to develop policy to most effectively deal with the issue that includes PPS, the Department of Health, AACO, and community providers to ensure long-term treatments.

The Managing Director continues to explore alternative funding and programmatic models for correctional health services. While no successful alternative model has been found at this

point, we continue to explore options. There have been some discussions regarding a nonprofit model that could be patterned after similar agencies in other jurisdictions and health-related fields. As this is quite preliminary, it would not be appropriate to venture into details not thoroughly analyzed for public debate. We will keep you informed of developments in this area.

Finally, the June Drs. Griefinger and Patterson reports have been sent to your attention. There are no September reports, as the monitors have not performed inspections. They are scheduled for the end of this month.

This concludes my testimony at this time. Our team of representatives will remain for as long as necessary to address the Public Safety Committee's follow-up questions. Thank you.

COUNCILMAN ORTIZ: Thank you, Tim. One question to begin with. The City put out an RFP, and in that RFP they made certain requirements that each individual that submitted a bid had to abide by. However, the contract that you have given PHS is not based on the RFP that was put out, but is just an amendment to the old contract and it doesn't

reflect any of the requirements of the RFP in there. Why was that?

MR. GILL: Well, although I stated that the City exercised its right to be able to do that, I'd like to give you a little bit of information as to what was the reasoning for us to exercise that right. And primarily, because of submissions that we had received for the 2002 RFP, we had only

received two bona fide submissions. The pricing that was part of those proposals, the limitations and the restrictions that the respondents had insisted needed to be a part of their involvement with Philadelphia's Prison System made them not as attractive as the potential for using the incumbent provider with the set of scope of services which we had already been prepared to utilize until the year 2004. The ability for the incumbent to have a better handle on what the related costs or associated challenges are of providing services in Philadelphia coupled with the improvements noted by Drs. Griefinger and Patterson in their services and their performance and their ability to more closely meet the financial needs of the City of Philadelphia made it a good decision to entertain having PHS be

able to enter in the negotiations with the City and see if we couldn't come to an agreement or a pricing structure or a risk-sharing structure that would benefit both the City and the patients in the prison system.

COUNCILMAN ORTIZ: But you put out an RFP, and I have it here and it's kind of big and heavy. And in my weakened condition it's really testing my arm here.

MR. GILL: Don't drop it on your foot.

COUNCILMAN ORTIZ: And then you in essence obviate all of the new conditions of this RFP, which I think were quite an improvement over the other RFP of prior years. And then you give PHS an added contract for two months and then just amend the old contract without having any of the conditions of the RFP included. And I don't understand that. Can you give me -- what were the other companies that submitted bids? Do you have their names?

MR. GILL: Correctional Medical Services and Wexford.

COUNCILMAN ORTIZ: And what else, Wexler?

MR. GILL: Wexford, W-e-x-f-o-r-d.

COUNCILMAN ORTIZ: And why were they rejected really?

MR. GILL: Well, as I stated earlier --

COUNCILMAN ORTIZ: Why was Correctional Medical Services rejected?

MR. GILL: Well, we had begun analysis with a team of evaluators from around the City agencies. I don't have all the specific points of

rejection from each of them. But in essence, essentially in part pricing structure and also --

COUNCILMAN ORTIZ: When you say pricing structure, give me an example. They wanted more than $36 million that we're giving PHS?

MR. GILL: Yes, that is correct.

COUNCILMAN ORTIZ: What?

MR. GILL: Their pricing was above 36 million.

COUNCILMAN ORTIZ: Why was their pricing higher?

MR. GILL: In my years of experience in bidding out contract work, I never know why contractors assign the pricing that they do or their basis for which --

COUNCILMAN ORTIZ: Did they meet every other condition of the RFP?

MR. GILL: No. Actually, both respondents submitted quite a bit of exceptions to the RFP, which bidders are welcome to do. Although the City sets standards and the City applies what it thinks is appropriate for conducting business, the structure of pricing, the services to be provided and such, contractors are allowed to submit what they believe are their exceptions to what we want.

And both of them had considerable amount of exceptions.

COUNCILMAN ORTIZ: What was the base that was put forward by the City to these other companies? Was it $36 million or less or what? And how high did they come in?

MR. GILL: We did not project a target figure, if that's what you mean by a base. We did not project a target figure for them to come in at.

COUNCILMAN ORTIZ: How much higher than PHS did they come in?

MR. GILL: The terms and conditions of each of the respondents were -- they're a mixture of the exceptions. I'm not trying to be vague. It's

just that the mixture of their exceptions and what they wanted to share in costing aggregates doesn't allow for an even number to compare to, but both were significantly higher than 36 million.

COUNCILMAN ORTIZ: Were there any requests for a re-bid to these companies telling them that they were too high and to re-formulate their bids?

MR. GILL: No, that was not requested.

COUNCILMAN ORTIZ: And did we make the

request of PHS to meet the requirements of the RFP? Obviously we did. The other bidders were bidding according to the RFP. Obviously, PHS did not make a bid, right?

MR. GILL: No, they did not submit a bid for the 2002 RFP.

COUNCILMAN ORTIZ: So you just extended to them a contract without them going through the RFP and the requirements of the RFP as put forward by the City?

MR. GILL: Just to be accurate, it was an amendment, not an extension. It was an amendment to the existing 2000 agreement which the City had already had in place --

COUNCILMAN ORTIZ: It was an amendment to their contract?

MR. GILL: Yes.

COUNCILMAN ORTIZ: But, again, you did not require them to, in essence, meet the requirements of the RFP?

MR. GILL: Not the 2002. They are meeting the requirements of the 2000 RFP.

COUNCILMAN ORTIZ: The 2000 RFP, but not the RFP that was put forward?

MR. GILL: That's correct.

COUNCILMAN ORTIZ: What were the exceptions and the liabilities that you're talking about?

MR. GILL: I'm not prepared. I don't have them with me. But we can surely get them to your office.

COUNCILMAN ORTIZ: You say that PHS is going to, in your testimony, meet the standards of the NCCHC. Is there a time line for them to meet those standards?

MR. GILL: Well, I guess the short answer is I wish it was yesterday. But we are working with them on an ongoing basis that those are

met. We've received renewed commitments from their corporate structure that they will work with us and get them as quickly as possible, but I do not have a date that I can tell you is the exact deadline for which they will be meeting all of them. It's the guidelines that --

COUNCILMAN ORTIZ: They have nine months. What's the time line you're giving them?

MR. GILL: Like I was about to say, the guidelines are what we're using as a basis for which they will be referring to that they will meet those

requirements. And, again, I don't have an exact deadline for that.

COUNCILMAN ORTIZ: And if they don't meet the deadline, are there any penalties for that?

MR. GILL: Well, if you mean structured penalties for financial penalties, the City does reserve the right to do that if it feels as though that the contractor is unresponsive and not working.

COUNCILMAN ORTIZ: Where does the City reserve the right in the contract?

MR. GILL: I don't have the section, but I think I've referred to that in previous responses to your office, Mr. Chairman, that there is a

section in the RFP that the City reserves that right to impose liquidated damages if it deems necessary that the contractor is not responding.

COUNCILMAN ORTIZ: In the lifespan of PHS history with the City, has there ever been any penalties that the City has --

MR. GILL: No.

COUNCILMAN ORTIZ: Never?

MR. GILL: Never.

COUNCILMAN ORTIZ: Will PHS be required to provide 24 hours per day, 7 days a week medical services?

MR. GILL: Yes.

COUNCILMAN ORTIZ: And for Hepatitis C, will PHS be required to provide a comprehensive set of protocols designed to manage chronic diseases, including within 30 days of contract? Have they provided a set of protocols to deal with Hepatitis C and other chronic diseases?

MR. GILL: They have not submitted a set of protocols, but if I understand what you mean by protocols correctly, the basis for which they'll systematically address the Hepatitis C issues, it is our intention to bring the Health Department, AACO,

community providers and consult with Dr. Griefinger on what his experiences have been in his work, I believe, the CDC in helping us develop exactly what model works best for us in our county jail system. There are other protocols that we're aware of that exist at the state level or perhaps the federal level where their environment allows for longer term of care because their patients are with them longer. We need to develop a much more complicated network that involves outside providers outside of the jail walls so that we can make sure that the continued care happens even when they're out of my

jurisdiction. So that protocol is not firmly in place, but that is our intention to work quickly to have that in place. It's a very topical item right now. It's an emerging medical condition and issue that we want to try and get ahead of the curve on.

COUNCILMAN ORTIZ: Will there be a time line on that also?

MR. GILL: I believe we're meeting with Dr. Griefinger in about two weeks to begin that process.

COUNCILMAN ORTIZ: We've got testimony here from inmates that they have requested sick

calls, and activists, and they were not seen within 24 hours of that request. Is that going to change? If an inmate makes a sick call request, will he be seen within 24 hours of the request?

MR. GILL: I'm aware that there are isolated incidents when with the shear volume of sick call requests that are put in place in various institutions that there are times when a patient may not be seen within that 24 hours, but they are -- the sick call requests are reviewed by a health professional no less than an RN, and they are categorized and utilized as a way of getting to the most urgent and emergent patients possible. I know

that there has been some review of the sick call requests by PPS operations and that they found that in general that the responses have been pretty good. But if there are specific patients that have chronic issues of not being able to get the sick call, our office would like to know that so that we can make sure that it's the facility that we address as their medical team is not getting to the patients quickly enough. But I think in general, the results have been pretty good in getting to sick call.

COUNCILMAN ORTIZ: What will PHS do to

ensure segregation medical lock-in inmates are visited by a healthcare professional every day to determine need for medical attention?

MR. GILL: Well, we have some representatives who oversee that portion of the operation in medical, and I think that they could probably give you a better insight as to what their process is now.

COUNCILMAN ORTIZ: And if you're identified with a chronic illness such as Hepatitis C --

MR. GILL: I'm sorry? Did you want that question on segregation answered?

COUNCILMAN ORTIZ: Yes. Were you looking to somebody?

MR. GILL: Yes.

DR. HELENDER (ph): Good morning.

COUNCILMAN ORTIZ: Excuse me. I want to say that Councilman Darrell Clarke is here and Councilman Wilson Goode.

Go ahead.

DR. HELENDER: I'm Dr. Richard Helender. I'm the Regional Medical Director for Prison Health Services at the Philadelphia Prison System.

COUNCILMAN ORTIZ: You know the question?

DR. HELENDER: The question is how are we going to ensure that patients that are kept in isolation are seen every day.

COUNCILMAN ORTIZ: Right.

DR. HELENDER: We have a process now, one of the RNs in each jail has a log that she keeps. She visits each and every patient in that log every day and documents the visit. That's done seven days a week. And the log is available for review.

COUNCILMAN ORTIZ: All right. And the inmates identified with chronic illnesses, Mr. Gill,

are they seen? What's the time line for their appointments, two days, three days, two weeks?

MR. GILL: That's something I'd like the medical director to respond to as well.

DR. HELENDER: Inmates are put into our chronic care system as urgently as is necessary. The current RFP allows us 30 days to see them in their first visit. That will allow us to get the more ill of the patients in quicker.

COUNCILMAN ORTIZ: 30 days?

DR. HELENDER: 30 days.

COUNCILMAN ORTIZ: So you're suffering from Hepatitis C and you have been identified, you have to wait 30 days?

DR. HELENDER: Excuse me. I may have misspoke.

I'm right 30 days. I didn't mean to interrupt you. I'm sorry.

COUNCILMAN ORTIZ: An inmate that is identified with chronic illnesses, he is going to be seen in the chronic care clinic within 30 days?

DR. HELENDER: Yes, sir.

COUNCILMAN ORTIZ: Not two weeks?

DR. HELENDER: It may be 72 hours, it

may be the next day depending upon the urgency of the need. The physician who is seeing that patient, making the referral or the physician's assistant he determines the urgency for the visit. That patient may be seen the same day by a physician in chronic care. We don't necessarily wait 30 days. We get them in as quickly as is needed.

COUNCILMAN ORTIZ: So if an inmate is referred to you and then you make a determination, you tell him to come back according to your

determination, two weeks, 30 days?

DR. HELENDER: Correct.

COUNCILMAN ORTIZ: Is the HIV clinic going to operate three days per week or more? And will an inmate not have to wait more than seven days for an appointment with the infectious disease clinic physician?

DR. HELENDER: I'm sorry, which clinic?

COUNCILMAN ORTIZ: HIV clinic. Do you have that?

DR. HELENDER: We have an infectious disease clinic, yes. She's on campus five days a week -- I'm sorry, four days a week.

COUNCILMAN ORTIZ: How long does somebody have to wait for an appointment?

DR. HELENDER: I don't -- again, we get them to see her as quickly as necessary. It may be two weeks, it may be a little bit longer, it may be a lot shorter.

COUNCILWOMAN BROWN: Point of order.

COUNCILMAN ORTIZ: Yes, ma'am. Councilwoman Blondel Reynolds-Brown.

COUNCILWOMAN BROWN: Thank you, Mr. Chairman.

Follow-up question. You said she's on campus five days a week?

DR. HELENDER: No, I'm sorry. I misspoke. It's four days a week.

COUNCILWOMAN BROWN: For how many hours, one hour or eight hours?

DR. HELENDER: No less than eight hours. Usually longer.

COUNCILWOMAN BROWN: So eight hours per day, four days a week?

DR. HELENDER: Correct. At least eight hours a day.

COUNCILWOMAN BROWN: And you said that the backlog is one to two weeks?

DR. HELENDER: I didn't say there was a

backlog, no.

COUNCILWOMAN BROWN: It takes two weeks to see patients?

DR. HELENDER: It may not, no.

COUNCILWOMAN BROWN: So the determining factor is?

DR. HELENDER: The urgency of the need. There are patients that come in -- we're specifically talking about HIV here. There are

patients that come in that need to be seen the next day or the next two days. If she's on campus in the intake housing that day, they may be seen that day. If they're stable, it may take two weeks. It may take a little bit longer.

COUNCILWOMAN BROWN: Thank you.

Thank you, Councilman.

COUNCILMAN ORTIZ: We've had testimony here from inmates that that was not the case in terms of HIV and others, that they had to wait to be seen by a doctor for more than a week. And you're telling me that that is going to be changing?

DR. HELENDER: No, I'm not going to tell you that's going to be changed. There are cases where a patient will wait longer than a week to be seen by a physician. That's not going to change.

The patients are seen as needed. If they need to be seen emergently, they're seen by the physician on duty that day. There will be patients that wait longer than a week to see the physician. If they need to be seen sooner, they'll be seen sooner.

COUNCILMAN ORTIZ: What staffing is present every day? What's your staffing? How many doctors are there, how many nurses are there?

DR. HELENDER: In the individual jails or on campus in total?

COUNCILMAN ORTIZ: What's your staffing daily in terms of -- and how many patients do you see a day in each of these clinics?

DR. HELENDER: In each of the jails there is a physician Monday through Friday 8 to 4.

COUNCILMAN ORTIZ: 8:00 to 4:00?

DR. HELENDER: 8 a.m. to 4 p.m.

COUNCILMAN ORTIZ: And available after that, by phone or whatever?

DR. HELENDER: No. In several of the jails there are physicians available 4:00 to 12:00 and in two of the jails there are physicians around the clock. This is both the chief medical officer as well as clinic physician. Several of the jails

have two physicians from 8:00 to 4:00. This does not take into account our independent consultants. These are our staff physicians. There's always a physician on campus, at least one.

COUNCILMAN ORTIZ: And registered nurses?

DR. HELENDER: Many registered nurses. I can't give you that number.

COUNCILMAN ORTIZ: On duty --

DR. HELENDER: Around the clock.

COUNCILMAN ORTIZ: Twenty-four hours a day?

DR. HELENDER: Yes, sir.

COUNCILMAN ORTIZ: Seven days a week?

DR. HELENDER: Absolutely. 365 days a year.

COUNCILMAN ORTIZ: Thank you.

DR. HELENDER: You're welcome.

COUNCILMAN ORTIZ: Mr. Gill, obviously, there are no differences between this new contract and the old contract, right?

MR. GILL: There are --

COUNCILMAN ORTIZ: This amendment.

MR. GILL: Well, there are some changes, as I referred to in testimony, that are described in

the exhibits that were part of the documents that I had sent to your office earlier.

COUNCILMAN ORTIZ: Are there any liability differences?

MR. GILL: Do you mean insurance?

COUNCILMAN ORTIZ: Yes, for PHS, right.

MS. KRITZ: Good morning. My name is

Cheryl Kritz. I'm with the City Solicitor's Office.

COUNCILMAN ORTIZ: Good morning.

MS. KRITZ: There were modifications made to the insurance requirements that are reflected on Exhibit PA3 of the amendment.

COUNCILMAN ORTIZ: State them for the record, please.

MS. KRITZ: The primary modification was in the area of professional liability insurance which was a decision made in conjunction with the City's Office of Risk Management. Unfortunately, they're not here today. But they were in response to the market conditions in the insurance industry as of late and they are reflected principally in Section D3 on Exhibit PA3 of the amendment. There were also modifications made to the general liability insurance limits as well.

COUNCILMAN ORTIZ: What is the cost of that? I mean, what does that reflect, those changes?

MS. KRITZ: Modified limits.

COUNCILMAN ORTIZ: And what are those limits?

MS. KRITZ: Under general liability, the

limits for the period October 1st to December 31st of '02 remain the same as in the prior contract. And as of January 1, '03, the limits were modified to $1 million per occurrence and 5 million general aggregate. And that was the result of negotiation between the City's Office of Risk Management and PHS.

COUNCILMAN ORTIZ: You never entered into any negotiations with the other bidders, right, in which these limitations and so on were discussed?

MS. KRITZ: I recall that there were discussions between the City's Office of Risk Management and the risk managers of at least one of the other bidders.

COUNCILMAN ORTIZ: Is there a way that you can provide us with a comparison of the rejected bidders with PHS?

MS. KRITZ: A comparison of the two

bidders compared to the PHS?

COUNCILMAN ORTIZ: Yes. I mean, you gave PHS basically the same contract, you didn't follow the RFP. I'd just like to see what --

MS. KRITZ: Sure. I'm sure we can work something up for you.

COUNCILMAN ORTIZ: I'd like to see that.

We increased -- the contract of PHS is an increase of around 25 percent over the overall contract of 2002, right? Or 2001 to 2002? I mean, it goes from 28 to 36 million or 38 million. Which is it? I saw two figures, Timothy, 36 million point something or 38 million something.

MS. STEIKER: This is Ellen Steiker, Deputy Managing Director from the Director's Office. Good morning.

COUNCILMAN ORTIZ: Good morning.

MS. STEIKER: The contract for FY '02 had reimbursements, as was mentioned in the testimony, of 28 million. And this resulted in a loss for PHS of $4.6 million because the costs that -- their actual costs as submitted on invoices to us were $32.6 million. So really, when you look at an increase year-to-year you need to be looking at

what --

COUNCILMAN ORTIZ: Excuse me. Go head.

MS. STEIKER: When you're looking at a year-to-year comparison, what you need to be looking at is what it costs in FY '02 to run the contract as opposed to what we paid.

COUNCILMAN ORTIZ: You know what was surprising, you said that PHS had a $4 million loss so we're compensating for that loss. You know, I would imagine that if you contract for service, you have to provide that service. And were all the monitoring reports that we got -- each of the reports actually made it clear that throughout the life of PHS's contract with the City of Philadelphia from '96 to now, they never had a full staffing of medical services. I mean, that was the one constant in all of the monitoring reports, that the staffing levels -- that PHS never achieved full staffing levels of their program. And they get a contract and it's 25 percent increase. It goes from $28 million to around 36 to $38 million. I don't know which one it is. Is it 38 or 36?

MS. STEIKER: Thirty-six million is what the current contract is.

COUNCILMAN ORTIZ: And for that, is that

just a reflection of the market in terms of the increase of health services or PHS committing itself to have full staffing through the life of this contract and provide new services? What are the differences? Or is this just a reflection of the

market?

MS. STEIKER: Both the previous contract and the current contract reimburses Prison Health Services for actual costs. The difference between the previous contract and the current one is in the previous contract reimbursement was capped at a fixed amount which last year was approximately $28 million. There was some areas where there was additional compensation, and that was based on the population and on certain catastrophic costs above 50,000 up to 200,000. So those were the only instances where you could pay actual costs above the fixed amount.

Under the current contract --

COUNCILMAN ORTIZ: It is based on 6900 population of inmates, right, the contract?

MS. STEIKER: That was the previous contract, yes.

COUNCILMAN ORTIZ: And this new contract

does not have a base of 6900?

MS. STEIKER: This contract does not base additional compensation on population. We changed the structure under which we provide additional compensation. And the basis of

additional compensation was listed in the testimony and also in the contract amendment, but I can summarize what some of the differences are, if you'd like.

COUNCILMAN ORTIZ: Yes, please.

MS. STEIKER: Under the current contract, we pay base compensation -- actual costs up to base compensation of $26.2 million. In addition, if certain categories of costs exceed the amount that's in the budget --

COUNCILMAN ORTIZ: Like what are those categories?

MS. STEIKER: The categories are those categories that had the most variability and uncertainty to them. And because they were uncertain and variable, it was difficult to come to an agreement on what would be a fair amount under a fixed price contract. So we felt that we would rather just look at the actual cost of those services, and if there were some amounts that

exceeded the base compensation that we would reimburse PHS for those amounts. And those were malpractice insurance, hospital specialty and ancillary costs subject to PHS submission of actual

claims documentation acceptable to the City. Pharmacy costs, cost of lab testing for Hepatitis C, and hourly rates for the following positions: Registered nurse, licensed practical nurse, physician assistant, nurse practitioner, psychiatrist, master's level social worker, psychiatric aid, medical records' clerk, and medical assistant.

COUNCILMAN ORTIZ: Those are not definable costs? A psychiatrist and -- that's not definable. Don't you usually employ a psychiatrist for a certain salary, or what?

MS. STEIKER: We actually believe -- the City, when we went into this negotiation believed that the budget for base compensation is reasonable and we do believe, in fact, that it will probably be adequate to cover these costs. However, there was an uncertainty related to providing service when there were absences for vacation or because of vacancies. And often, when you get a replacement in

a very quick turnaround, you may end up paying a premium for those costs.

COUNCILMAN ORTIZ: So the City picks up the premium, not PHS?

The thing is, that I thought the variable would be and the increase in cost would be in terms of the healthcare market, in terms of drugs increase in price, medicine, all types of medicine increase in price, and I thought that sort of a variable, given the way the market is today. But what you're describing to me, I think PHS says we're a company. We have these people. We have these doctors, these nurses, and we're going to deliver services to you for $36 million. And we have psychiatrists available. We have nurses available. We will hire those nurses within the spectrum and the scope of $36 million. And those will be available 365 days during the year and 7 days a week. But I didn't know that they're going to come to the City and say, "You know, we really don't have a psychiatrist. We're going to need to go out and hire one and we're going to add that cost to the contract."

I thought that was part -- shouldn't that be part of the contract? Shouldn't that be

part of what they have to provide?

MS. STEIKER: We agree that pharmacy and hospital specialty ancillary as well malpractice are

the largest --

COUNCILMAN ORTIZ: No, you're talking staff.

MS. STEIKER: I understand that. I just wanted to say that we agree that pharmacy, hospital specialty, ancillary and malpractice represent the largest variable costs, and we have a process at the end of the year to reconcile all of these costs and come to a fair resolution of any additional compensation.

COUNCILMAN ORTIZ: And they're insured for malpractice, right? PHS is insured for malpractice?

MS. STEIKER: That's correct.

COUNCILMAN ORTIZ: And the City is insured, right?

Are we carrying the cost of their malpractice insurance?

MS. STEIKER: We do cover the cost in this contract, yes.

COUNCILMAN ORTIZ: We cover the cost of

their malpractice insurance?

MS. STEIKER: For the Philadelphia operation, that's correct.

COUNCILMAN ORTIZ: Shouldn't that be a risk that they take? Why should the City be liable for that?

MS. STEIKER: This --

COUNCILMAN ORTIZ: I mean, they come in to provide a service and supposed to provide it in the most professional manner. Why should the City take the risk of their malfeasance?

MS. STEIKER: The City is taking the risk on the costs of it because at the time that we put together the amendment, those costs weren't known for the period starting January 1. So we could not come to an agreement on what a fair cost would be.

COUNCILMAN ORTIZ: So they can mess up and without any concern as to what because we're going to pick up that.

MS. KRTIZ: I wanted to add, Councilman, that under the contract PHS also agrees to indemnify us for their own acts or omissions, so we are sharing in the cost.

COUNCILMAN ORTIZ: To what level?

MS. KRTIZ: It's not limited by their insurance.

COUNCILMAN ORTIZ: To what level do they --

MS. KRITZ: It's not limited by anything.

COUNCILMAN ORTIZ: It's not limited by anything. Okay. Thank you.

Any other questions?

COUNCILWOMAN TASCO: Yes, I have a question.

COUNCILMAN ORTIZ: Yes.

COUNCILWOMAN TASCO: In Mr. Gill's testimony, in terms of the bidding process for the contract, he stated that PHS was not a bidder and that the City has the reservation of right to negotiate with vendors who may not have bid on the contract. Is that standard practice?

MS. KRTIZ: Standard practice to include that type of language or standard practice to pursue that course?

COUNCILWOMAN TASCO: Standard practice to include that language? Is this the only contract we had this language in with the City that you know

about, and is it standard practice to include this language when you're putting an RFP out to include

this language?

MS. KRTIZ: From my perspective in solicitations that I've worked on for the City, this is the standard reservation of rights that we include. I can't say categorically that it's included in all our RFPs because the Law Department isn't involved in all our RFPs by the City.

COUNCILWOMAN TASCO: They are not.

MS. KRTIZ: We're working on that.

COUNCILWOMAN TASCO: Did you say the Law Department is not involved in all of the RFPs sent out? They do not review them?

MS. KRTIZ: If we're asked to, we do.

COUNCILWOMAN TASCO: So an RFP can go out without your knowledge or approval?

MS. KRTIZ: That's changing with the advent of the CRC, and we're working on that piece of it. I'm just saying that in terms of standard reservation of rights language that many of us in the commercial law practice offer to our clients, that's included.

COUNCILWOMAN TASCO: Thank you.

COUNCILMAN ORTIZ: You stated that PHS

meets the numbers in terms of MBEC, the minority

subcontractors. Could you detail to me what minorities contractors are within the new contract and could you identify who they are and what they provide? Are they women? Are they Latino, black, African American?

MR. GILL: I don't have that breakdown in front of me, but I believe we submitted that as an attachment to the recent documents that we had sent to your office the other day. And it does list the names of the companies and the categories for which they fulfill the MBEC participation.

COUNCILMAN ORTIZ: Do you know what the percentages are?

MR. GILL: They should be listed right on the chart. It's pretty easy to follow.

COUNCILMAN ORTIZ: YS Contract Pharmacy, Bumbe and Simmons, there's no detail what --

MR. GILL: I thought that chart did reflect what MBEC requirement they were fulfilling, but I can get a clarification for that.

COUNCILMAN ORTIZ: There is no clarification, no. It doesn't say whether it's African American owned or you know.

MR. GILL: We do have that information.

If it's not on that chart, I will get that to you, if the Councilman wishes that.

COUNCILMAN ORTIZ: Yes, we do.

MS. KRTIZ: I also just wanted to add, Councilman, you had asked earlier about damages that the City was authorized to pursue. They're on Page 71 of that thick packet.

COUNCILMAN ORTIZ: This?

MS. KRTIZ: Yes.

COUNCILMAN ORTIZ: But this is the RFP.

MS. KRTIZ: Yes. There's a section in the RFP that describes damages that the City is authorized to pursue upon the occurrence of various things, and one of those is expressly the imposition of damages. But the RFP becomes part of the contract.

COUNCILMAN ORTIZ: All right. Thank you very much.

Any further questions? Any other questions?

Councilman Goode.

COUNCILMAN GOODE: Mr. Gill, at the end of your testimony you stated you're exploring other models for providing correctional health services,

and among them are non-profit models but you said you didn't feel at liberty to discuss those models. Why is that?

MR. GILL: Only to the extent that without having done enough in-depth analysis as to what the options are available to us, what the structure of those organizations may look like or how the formation of them would affect the care and delivery of services, we're not really at a point where we can sit down and kind of hash out what the details may be, what it might look like, and have a more meaningful conversation about it. We're hoping to be in that arena sometime soon and that would be a better time for us to be able to sit down and discuss with the Council as to what the implications are and what our options are.

COUNCILMAN GOODE: Well, without even comparing those models with existing models here, have you found any advantages to non-profit models in other cities?

MR. GILL: Well, I think that one of the biggest advantages is that if you're able to establish a non-profit agency that employs and maintains the employment of all the line staff, all

the worker bees associated with the work that's being done, they have more consistency and more continuity of their work rather than being concerned with whole new contracts coming in, you know, either on specific periods of time. There's different ways that some non-profits organized with just changing the management team or keeping the same management teams in place, you know, different economies of purchasing power, ability for grants or fund-raising or funding revenues but, you know, one of the most important aspects that other jurisdictions or other models have shown is the consistency of the employees being able to stay on a year-to-year-to-year basis and they look at more long-term commitments with their job rather than seeing turnover on an annual or a biannual or some other yearly basis that they would otherwise see.

COUNCILMAN GOODE: Thank you.

Thank you, Mr. Chairman.

COUNCILMAN ORTIZ: Thank you.

Thank you very much, Tim. Thank you.

Commissioner Costello.

MR. COSTELLO: Good morning, Mr. Chairman.

COUNCILMAN ORTIZ: Identify yourself for the record, please.

MR. COSTELLO: Thomas J. Costello, C-o-s-t-e-l-l-o, Commissioner of Prisons.

COUNCILMAN ORTIZ: Thank you for that protocol that you gave us on this part of the committee hearing.

MR. COSTELLO: You're welcome.

COUNCILMAN ORTIZ: Commissioner, there have been reports that the number of women being arrested has jumped significantly and that we're now looking at 200 women being arrested per week in the City of Philadelphia. How many of those end up in your system?

MR. COSTELLO: Basically, we've seen over the last few weeks -- or the last month about a 10 percent increase in the overall population. It's hard to say exactly how many of those arrested come to the facilities. I don't know what the numbers are. But we have seen a significant rise over the last month or so, but over the last week the population has decreased significantly.

COUNCILMAN ORTIZ: Will you provide us with a breakdown of race and age in the individuals

that are being arrested coming in? And you said the increase is 10 percent?

MR. COSTELLO: Recently there has been an increase of 10 percent over the last fiscal year. And again, the female population has fluctuated up and down between 850 and 925 is the record number, over the past, we'll say, the last six to eight weeks. And again, ironically over the last week, the population is below 900 now, but it was 925 a couple weeks ago.

The breakdown as far as this last fiscal year as far as the population is 71.8 percent African American, 16.7 percent white, 10.6 percent Hispanic, 0.5 percent Asian, and 0.4 percent unknown.

COUNCILMAN ORTIZ: Are you currently overcrowded? What's the population?

MR. COSTELLO: I have the exact figures for you, Councilman. I'll give you the numbers as of last night.

COUNCILMAN ORTIZ: How many women?

MR. COSTELLO: 880 as of last night, midnight.

COUNCILMAN ORTIZ: How many is the

facility supposed to hold?

MR. COSTELLO: How many?

COUNCILMAN ORTIZ: How many is the facility supposed to hold?

MR. COSTELLO: The rate of capacity right now is about, probably for the female population, a little over 900.

COUNCILMAN ORTIZ: We have a projection for the new women's facility. Do you have a date of when that will be available?

MR. COSTELLO: Yes. The projected opening date we'll actually admit female inmates to the new facility is March 30th of next year.

COUNCILMAN ORTIZ: March 30th of next year.

PHS also provides the medical services to those individuals, right?

MR. COSTELLO: They would provide it for that facility, that's correct.

COUNCILMAN ORTIZ: Is there any coordinated effort between PHS and your administration to provide for a disaster plan specific to each institution which includes response, triage, and treatment of mass casualties.

MR. COSTELLO: We do have a master plan. It is headed by Deputy Commissioner Grooms who meets with them on a regular basis and schedules drills with them whenever necessary. They are part of the overall team.

COUNCILMAN ORTIZ: What's the current population of inmate population system right now in the system?

MR. COSTELLO: The overall population for inmates under the responsibility of the Commission of Prisons is 7966 as of midnight last night.

COUNCILMAN ORTIZ: 7966?

MR. COSTELLO: Yes, sir.

COUNCILMAN ORTIZ: How many of those are on pretrial?

MR. COSTELLO: Basically, the percentages that we are running on legal status is 60.5 percent pretrial or detentioner; 4.3 percent sentence deferred, those have been found guilty but are awaiting sentencing; and 33.2 percent sentenced, serving a sentence within the county.

COUNCILMAN ORTIZ: Do you have a breakdown by race of those 60.5 percent that are

waiting for trial?

MR. COSTELLO: I do not, Councilman, but I can get that information to you.

COUNCILMAN ORTIZ: What's the average stay of an individual in pretrial?

MR. COSTELLO: The average stay over all -- we actually include -- because of the number of admissions that we get over the year, we do not break it down specifically to detentioner. We break it down according to male, female, and all inmates. The average stay for males right now 79.3 days; female is 57.1; and if you take both male and female populations together, it would be 76.1.

COUNCILMAN ORTIZ: So the average individual is 79 days?

MR. COSTELLO: For males, yes 79.3, that's correct.

COUNCILMAN ORTIZ: Thank you, Commissioner.

There's an estimate that a local director for prison services of the Defenders Association has given us an estimated count of inmates with Hepatitis C in the Philadelphia Prison System. It's 4 to 600. Is this a conservative

estimate or is it more in line of the reality of the existence? Maybe you can answer that, sir.

DR. HELENDER: Do I need to reintroduce myself?

COUNCILMAN ORTIZ: We got information that the current population of inmates with Hepatitis C ranges from 4 to 600; is that true?

DR. HELENDER: I'm Richard Helender, the Regional Medical Director. The number of 4 to 600 is probably the number given of people that we know to have tested positive for Hepatitis C, and that's probably high. It's probably less than 400 known to have tested positive for Hepatitis C.

COUNCILMAN ORTIZ: That is high?

DR. HELENDER: I would say that the number of people tested positive now for Hepatitis C is less than 400, yes.

COUNCILMAN ORTIZ: What about HIV?

DR. HELENDER: We currently have somewhere in the neighborhood of 200, perhaps a little bit more in our HIV clinics.

COUNCILMAN ORTIZ: And of those that are tested, how many are in the treatment for the disease for Hepatitis C?

DR. HELENDER: In terms of treatment, they're all being evaluated at this point in a development treatment protocol. They're all being evaluated.

COUNCILMAN ORTIZ: Thank you.

MS. GORMAN: Thanks for giving me this opportunity. I'm a criminal justice professor with a master's in forensic psychology at Temple University.

COUNCILMAN ORTIZ: Identify yourself for the record, please.

MS. GORMAN: Nina Gorman. I'm a professor of criminal justice at Temple University with a Master's degree in psychology with a criminology specialization. And I'm also wearing another hat here as a co-coordinator of the Prison Health Advocacy Project, a small group of advocates and current prisoners. The members we have now, though, are Howstale State Prison who have been at Philadelphia State Prison and they've given us some feedback and their recommendations for the contract and Civilian Review Board proposal. So I would like to give a synopsis of what we recommended back in August for adherence to the contract for

Pennsylvania state law that applies to Philadelphia County facilities and all county and local facilities in the State of Pennsylvania.

Specifically, Title 37-Law III, Subpart B, Chapter 95 of the Pennsylvania Code for recommending enforcement and stipulations in the contract that specify -- that back up this code by having written specifications that all inmates receive a healthcare screening. This is 95.232, Section 1, that they receive a healthcare screening by a person with healthcare training within 24 hours of admission and that within 24 hours of admission all inmates determined to be not in good health are supposed to receive an assessment by a healthcare professional. So we know this would be cost saving because folks who are identified at intake with having chronic disorders or being in crisis, the sooner the better that they can get the treatment that they need so it doesn't deteriorate into needing hospitalization.

And we know from my interviews of prisoners as a case manager for an AIDS agency and also in our interviews of folks up at Howstale that the nurses don't always have the proper emergency

room training at intake. Nurses specialize in ER care, and we question the extent of this training. They should be able to recognize all the chronic disorders and all the symptoms of emergency, such as fever, chills, and be able to connect them with diagnosing the major chronic disorders and should be versed in how to treat emergencies as well.

We're also recommending that written local policy specify -- to support the Pennsylvania Code, section 95.232(4), that written local policy shall specify routine screening procedures utilized for infectious disease, acute illness and suicidal risk. So we're not just talking about guidelines here. The guidelines for -- whatever guidelines that PHS has have of its own or back in the APA or other accrediting organizations. But we're talking about specific symptoms that need to be addressed for screening chronic care and also intake. Some jails in other states, for instance, have a form that's used by both corrections officers and another form by healthcare workers and some used by both where they can be trained effectively to screen for suicide.

Currently in the Philadelphia system,

from our understanding, they're just using a referral form that COs can access and other staff of the prison to refer someone if they're having a suicidal risk, but there's no requirement to document if an inmate complains to a guard or other staff member of wanting to commit suicide. There's nothing that needs to be done, to our knowledge, to hold that CO or staff member accountable that this is the information they've been given and what they did with that information. So an ounce of prevention can be worth a pound of cure with such documentation.

We're also advocating that the contract include stipulations where access to emergency care 24 hours a day is included. Now, we're recommending that this be included with specifics, including a triage nurse. Now, as a social worker over at the detention center for this AIDS agency I was working with, I often went over there, there was no nurse triaging. So the chronic care nurse was -- the person in chronic care who was assigned to do emergency, she would have to stop what she's doing to go out into the waiting room to try to find who's there then. And more than once I had to escort

someone back to her because the only person that was

out there with us was a corrections officer. I had to escort an asthmatic back there having a severe asthma attack. Because she can't be in two places at one time. So this is what we're recommending for emergency care.

And also that healthcare coordinate security, that that be a requirement internally, because if guards are understaffed, they don't always have the time to escort up to medical. That should not be a responsibility of security to have medical staff to escort inmates up to medical. This has been a chronic problem for many years.

Also, you mentioned access in the hole. The prisoners we've spoken with are recommending visiting status for the Civilian Review Board, that we have unlimited access to all medical units. And this in some states has been helpful, at least with monitoring for healthcare. For instance, we could go in as visitors and check that log book for folks that are checked in the hall and check the log book for those that are referred up to medical.

We're also recommending that 95.242, the extraordinary occurrences stipulation of the

Pennsylvania Code be adhered to. That an

extraordinary occurrences report is supposed to be completed with the occurrence of death, including suicide and homicide, serious injuries and any use of physical force, according to the state stipulation.

And in addition to that, or in order to support that, we're recommending the enforcement of the disposition of a Lester v. Schuler case on inmate assaults or reports of guard assaults on inmates and also of inmates assaults on inmates as well, which is more common actually.

I know from being a volunteer for the Prison Society that those injury investigation referrals are not being completed. So if an inmate complains that they've been beaten, for instance, by another inmate or by a guard, they're supposed to go to medical and tell medical that, and medical is supposed to fill out an injury investigation referral which gets forwarded to, I believe, the Prison Society and some administrator in the prisons and elsewhere. And if they don't want to fill that out because they don't believe that the inmate's been beaten, they're supposed to fill out a

defamation of injury investigation referral. So the Prison Society can give you more information on that

and how there's been very poor compliance. And the compliance goes up and down depending on the pressure they get.

And we also recommend an inclusion of a stipulation on treatment services with staffing, especially mental health staffing. The Pennsylvania Code asserts that the jails with an average daily inmate population of 175 or more shall have, in addition to the treatment supervisor, one qualified counselor for every 75 inmates over the first 75.

Now, we know that the model proposed by PHS -- I'm not sure what's going to be in this contract, but the model proposed is the crisis case management model and a residential treatment model for mental health. So this is very worrisome to us because it appears to eliminate outpatient counseling. And we know from testimony from Anthony Hightower from our group previously and from other documentation that we've gotten that mental healthcare is being triaged by a clerk with no mental health training for parts of the procedure of assessment. And often folks are not getting the

counseling that they need. So we're recommending that those staffing provisions be in place.

And also, focussing on residential treatment model is very controversial because for one thing, it's very expensive. It's the most expensive model. And also, it's debated whether or not folks with severe mental health problems like psychosis should be treated in a jail or not. If they're that bad off, shouldn't they be treated possibly in a mental health facility?

And just a couple more of these things and then I'll get on to a brief review of the civilian review.

Also, we're recommending enforcement of Pennsylvania Code 95.243(10), if an inmate is found to be psychotic or otherwise mentally disturbed, he or she shall not be treated in a jail but shall be transferred to a mental health facility in accordance with the provisions of the Mental Health Act.

Now, in some states they're dealing with this prospect of transfer by having workers from the Defenders Office and a worker from the City's public mental health system, not to mention sometimes

workers from the City's health system right on staff at intake so the folks having severe health problems or mental health problems or minor charges, minor

misdemeanors and a combination of health or mental health problems can immediately be transferred to either a mental health facility or some negotiation can be made with the Defenders Office and the lawyers there to get them out so they don't even have to come into the system so that they won't be the responsibility of the system to treat. So this could be a win-win situation for everyone concerned.

And then lastly, we also recommend for the Pennsylvania Code enforcement of the housing stipulations that recommend each inmate have access to toilet facilities and ventilation. We know sometimes there's painting done or construction and the ventilation, poor as it is, is not accommodated under these circumstances. And people have been triple bunked and four to a cell, making a dangerous situation especially for violent offenders.

And we know also that this lack of coordination with security between mental health and security poses for dangerous situations. I had one client that in order to get into protective custody

because he was being assaulted by an inmate, he had to go into a cell, he had to be double celled in protective custody in isolation with a rapist. And

it wasn't until I intervened that we were able to stop that situation.

And also let me just backtrack a minute. In reference to access to emergency care 24 hours a day, we wanted to recommend that that include, not only a triage nurse in DC, but also training of corrections officers in emergency care, and especially mental health emergencies. We know they do get some training as far as dealing with assault of inmates, but how much of that training is with or by mental health professionals that are really the experts in the area of dealing with mental health emergencies, assault of inmates. And that kind of training literature support is most effective if it's done with security, not in addition to security. It's done with and by the security personnel of the prison, preferably with mental health specialists of security -- having mental health specialists in security also, security personnel.

And I'm wrapping it up here. In

addition to housing, food is a health requirement. Even though PHS may not have influence over that, they do have influence over adherence to diet, the diet orders get fulfilled. We saw this as being a

problem repeatedly in the Philadelphia Health System when I worked there where my dialysis patients weren't getting their proper food, some of the HIV patients weren't getting their proper food. And we know that more than once riots in the food cafeteria over increasingly small portions and also of spoiled food being served, which is a health risk especially to folks with poor immune systems.

So that's basically it as far as the contract that we wanted to emphasize the recommendations that we had submitted back in August for that.

Now I wanted to shift on -- unless some questions, I wanted to shift on just a very brief review of my findings on civilian review boards at least that has to do with police. But I understand we're going to have a whole separate hearing dealing with so I wasn't going to spend too much time on that today.

COUNCILMAN ORTIZ: Thank you. You've

heard the testimony on the contract as detailed by Mr. Gill and the City Solicitor's Office. What's your impression of the contract? And have any of the reforms that we were advocating been included in

that?

MS. GORMAN: I don't know. My understanding is that the behavioral measures that were proposed with a new contract by City Council weren't included in this new contract. So I would think any kind of measurable objectives would be helpful. And especially it seems dangerous at intake to have folks coming in. It's both a cost skyrocketer to have folks not diagnosed. Remember my previous testimony as a social worker, I had five clients who had PCP pneumonia, and I think about three of them didn't get diagnosed at intake. One of them ended up costing the City over a hundred thousand dollars, he was told, because he had to keep going in and out of the hospital. And also not having screening recommended by the doctors funded and delays in processing of them where it has to go to Harrisburg, it may take a week, two weeks, three weeks to come back to get approval. I had one client that was in there for a misdemeanor of

marijuana possession -- that's the one I was talking about that cost so -- and he ended up, not only getting PCP pneumonia that wasn't diagnosed until late, but also having a heart infection that almost killed him because Dr. Peppi's (ph) recommendation

for a heart culture or some kind of culture having to do with diagnosing that infection were declined. And I've had others that were at risk, too, for not getting the funding and the approval quickly enough.

I had one that went to an ENT doctor and obstructions from old scar tissue in his throat that the ENT doctor said almost killed him also, you know, from delays in getting that diagnosed and treated with a biopsy.

So anything having to do with -- we would support the increase in funding because it's well known from the staff there that they are underfunded where they may have to -- one nurse, for instance, may be over at the detention center working with maybe a case load of 12, 15 clients on a night. And so when I would call her as a social worker to advocate for someone, she would barely have time to -- she would try to, but she'd barely have time to try to address someone that had a

problem.

COUNCILMAN ORTIZ: Thank you.

MS. GORMAN: But I wanted to give a review on the civilian review boards. The inmates that we interviewed, about 40, are most concerned

that they won't be paid attention to or the civilian review board will be, you know, just a show to look good or a way to pass the buck. They're also emphasizing for the contract reduction in sick call and medication line waits, which I think were supported by Griefinger as well as immediate healthcare for intake. We're recommending 12 hours.

And mainly my findings for the civilian review boards, because these are based on police, were that if you don't include something in the contract about the oversight mechanisms that you're going to use, included the CRB, that the risk of non-compliance or weak effectiveness is a lot stronger.

Also, we're recommending that there be a feedback loop, and this is pretty standard for the CRB to give recommendations to the monitored agency like the police, but we're recommending according to the findings of Landau and Lewis that, not only the

monitored agency get the recommendations, but also the executive branch of the City and also the legislature.

COUNCILMAN ORTIZ: Any review board that is established, and given the Charter that we have, really depends on the executive and how much

authority the executive, the Mayor, would give to that review board. We've seen that with the Police Review Board that we have at the present time. And really, the ability of it to really monitor the cases that come up in terms of the police has been very limited. Unless we get a Charter change in order to be able to do something along those lines, it really depends on how much authority the Mayor and how much concern the Mayor has on the issue and how much authority he would give it.

MS. GORMAN: Both Colleen Lewis and also Goldsmith and Stenning, other researchers of civilian review boards internationally and nationally recommend not deriving power from the executive or from a particular legislature.

COUNCILMAN ORTIZ: But the thing is that according to Charter, that's the only way we have in the City of Philadelphia.

MS. GORMAN: Well, the other alternative is to amend the City Charter, which is what some do recommend, to amend the City Charter. And this way, the civilian review board is not at the whim of, like, the Mayor. As you remember back in -- I think it was like '82 the Police Advisory Board got

dissolved by the Mayor, because it depended on his power, as a Christmas present to our Police Department. It's been associated with executive power derivation with demise of civilian review boards such as in Washington, D.C. So I would recommend a revision of the City Charter. Otherwise, if the legislature comes in and is not friendly to it, they can also dump it as well.

So we would recommend some teeth, some monitoring system where the civilian review board would not have legal powers, because it's very costly, it causes a lot of tension, a lot of fractiousness and very lengthy, it's responsible for backlogs such as what happened in Washington, D.C. But rather be a body to hear complaints from the public and the staff, possibly anonymously if they prefer, if they would opt to do so, and to forward those recommendations to the contract monitor and

the legislature and the executive who would then have the responsibility, especially the legislature and the contract monitor, to enforce them. And if there's patterns of serious medical neglect, those would be the situations where penalties would be recommended and enforced.

COUNCILMAN ORTIZ: Thank you.

Mr. Gill, one thing before we leave and recess. I would like from PHS a listing of the staffing levels that they have and will have available.

MR. GILL: Deployment by facility?

COUNCILMAN ORTIZ: By facility.

MR. GILL: Sure.

COUNCILMAN ORTIZ: And the ratios in terms of population and so on, how many nurses per so many inmates and so on, mental health and so on down the line. And if you can, I would like to see a breakdown of the staff by race and gender.

Councilwoman.

COUNCILWOMAN BROWN: Thank you. I would like to add on to that request, if I could, a question first. Is there any type of staff audit that's performed either internally or externally

with regards to the system to measure what we hear actually reflects what's written on paper?

MR. GILL: What do you mean a staff audit? Do you mean the composition of the staff?

COUNCILWOMAN BROWN: No. For example, we heard today that the nurse works four hours a week, eight hours a day. Is there a practice, for

lack of a better word, where just as we have financial audits there's a staff audit to see if the information we see on paper parallels the reality?

MR. GILL: Well, internally I can double-check with their managing team to see if that's something that they do on a regular basis. I do know that they do their own reviews for quality assurance as to what staff utilization is, but I can verify that.

COUNCILWOMAN BROWN: I would appreciate it.

Thank you, Councilman.

COUNCILMAN ORTIZ: Thank you very much. So if you can do that and send it to the Chair, please. Thank you very much.

This committee stands recessed until the call of the Chair.

(Council adjourned at 12:07 p.m.)

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C E R T I F I C A T I O N

I HEREBY CERTIFY that the foregoing proceedings of the Council of the City of Philadelphia of Tuesday, October 8, 2002, were reported fully and accurately by me, and that this is a correct transcript of the same.

RE: COMMITTEES ON HEALTH AND HUMAN SERVICES and PUBLIC SAFTEY

Lisa C. Bradley, RPR
and Notary Public