BOP Health Care: What You (and Your Clients) Need to Know

BY ALAN ELLIS

The last two columns ("Health Care in the Federal Prison System," Summer 2008, and "BOP Designations Based on Medical Need," Fall 2008), explained to lawyers the recently promulgated Bureau of Prison (BOP) rules on the subject of health care for inmates, the impact the new rules have on the medical care provided to prisoners, and how an inmate's medical condition may influence in which facility the individual is placed. This column marks the last in the series and is intended specifically for the attorney to give to clients and their families and friends.

BOP policies are complex and difficult to understand—even defense lawyers find them taxing. Clients and families are more often than not lost in the bureaucratic maze of terminology and regulations, and they turn to their lawyers for explanations. This column consolidates the information from the previous articles and adds new information about how inmates with medical needs will be treated in the federal prison system. All three columns are available to Section members at www.abanet.org/crimjust/cjmag/home.html and to the general public at the author's Web site at www.alanellis.com.

BOP Medical Classification

There are four levels in the Bureau of Prisons medical CARE level classification system. A provisional care level is assigned by the Designation and Sentence Computation Center (DSCC), based primarily on information contained in the presentence investigation report. After arrival at the designated facility, the provisional care level is reviewed and a nonprovisional CARE level is assigned by BOP clinicians. These assignments depend on the defendant's physical and medical condition, clinical resources an inmate needs, and his or her ability to function daily without assistance.

ALAN ELLIS, *past president of the NACDL, practices in the area of prison matters with offices in Mill Valley, California, Ardmore, Pennsylvania, and opening soon in China. He is a coauthor of the* 2008 Federal Prison Guidebook *and the* Federal Sentencing Guidebook. *He is also a contributing editor to* Criminal Justice *magazine. Contact him at aelaw1@alanellis.com or go to www.alanellis.com.*

CARE level 1 inmates: This designation is made by the DSCC. These inmates are less than 70 years of age and are generally healthy, but may have limited medical needs that can be easily managed by clinician evaluations every six months. Examples of such needs include mild asthma, diet-controlled diabetes, and stable HIV patients not requiring medications. Level 1 institutions are located approximately one hour or more from community medical centers since medical care is not often needed.

CARE level 2 inmates: This designation is made by the DSCC. These inmates are stable outpatients who require at least quarterly clinician evaluations. Their medical conditions, including mental health issues, can be managed through routine, regularly scheduled appointments with clinicians for monitoring. Enhanced medical resources, such as consultation or evaluation by medical specialists, may be required from time to time, but are not regularly necessary. Examples of issues at this level include medication-controlled diabetes, epilepsy, or emphysema. Level 2 institutions have no special capabilities beyond those that health services staff ordinarily provide; however, they are within about an hour of major regional treatment centers (for example, Fort Dix and Fairton, New Jersey), thereby permitting more immediate attention to medical emergencies. Most BOP facilities are classified as CARE level 2 facilities.

CARE level 3 inmates: This designation is made by the BOP's Office of Medical Designation and Transportation in Washington, D.C. These inmates are fragile outpatients who require frequent clinical contacts to prevent hospitalization for catastrophic events. They may require some assistance with activities of daily living, such as bathing, dressing, or eating, but do not need daily nursing care. Other inmates may be assigned as "companions" to provide the needed assistance. Stabilization of medical or mental health conditions may require periodic hospitalization. Examples of these medical conditions include cancer in remission less than a year, advanced HIV disease,

severe mental illness in remission on medication, severe congestive heart failure, and end-stage liver disease. Level 3 institutions are located adjacent to level 4 institutions, that is, federal medical centers.

CARE level 4 inmates: This designation is made by the BOP's Office of Medical Designation and Transportation in Washington, D.C. These inmates require services available only at a BOP Medical Referral Center (MRC), which provides significantly enhanced medical services and limited inpatient care. Functioning may be so severely impaired as to require 24-hour skilled nursing care or nursing assistance. Examples include cancer on active treatment, dialysis, quadriplegia, stroke or head injury patients, major surgical treatment, and high-risk pregnancy.

The BOP operates six CARE level 4 MRCs:

- U.S. Medical Center for Federal Prisoners, Springfield, Missouri, provides care primarily for higher security level inmates, and includes a full dialysis unit as well as an inpatient mental health unit.
- FMC Rochester, Minnesota, is affiliated with the Mayo Clinic for complex medical requirements, and includes an inpatient mental health unit.
- FMC Lexington, Kentucky, generally manages lower security level inmates.
- FMC Devens, Massachusetts, includes a dialysis unit and an inpatient mental health unit, as well as the residential sex offender treatment program.
- FMC Butner, North Carolina, includes an inpatient mental health unit and can manage inmates at all security levels. It is the cancer treatment center for the BOP.
- FMC Carswell, Texas, is exclusively for female inmates and is the only FMC available for women. It includes an inpatient mental health unit.

Most federal prisons have a full-time medical staff on hand and/or contract medical staff from the community. A local community hospital provides contract services for inmates who are in need of inpatient care because of a medical emergency. Normally, prisoners in need of special medical attention due to complex health problems will be designated to one of the BOP's six major medical centers listed above. With the exception of the federal medical centers, which provide primary and inpatient care, all other BOP facilities provide outpatient care (otherwise known as "ambulatory care"). Most BOP facilities also have one or more contract hospitals in the surrounding community that provide secondary and inpatient care to inmates in "emergency situations" or when an inmate's medical needs cannot be adequately treated by medical staff at the prison facility.

Levels of Intervention

The BOP defines its scope of medical services according to five levels of medical intervention:

Medically Necessary – Acute or Emergent. Medical conditions that are of an immediate, acute or emergent nature, which without care would cause rapid deterioration of the inmate's health, significant irreversible loss of function, or may be life-threatening.

Medically Necessary – Nonemergent. Medical conditions that are not immediately life-threatening but that without care the inmate could not be maintained without significant risk of serious deterioration leading to premature death, significant reduction of the possibility of repair later without present treatment; or significant pain or discomfort that impairs the inmate's participation in activities of daily living.

Medically Acceptable – Not Always Necessary. Medical conditions that are considered elective procedures, when treatment may improve the inmate's quality of life. Relevant examples in this category include, but are not limited to, joint replacement; reconstruction of the anterior cruciate ligament of the knee; and treatment of noncancerous skin conditions (e.g., skin tags, lipomas).

Limited Medical Value. Medical conditions in which treatment provides little or no medical value, are not likely to provide substantial long-term gain, or are expressly for the inmate's convenience. Procedures in this category are usually excluded from the scope of services provided to bureau inmates. Examples in this category include, but are not limited to, minor conditions that are self-limiting; cosmetic procedures, for example, lepharoplasty—cosmetic surgery on the eyelids; or removal of noncancerous skin lesions.

Extraordinary. Medical interventions are deemed extraordinary if they affect the life of another individual, such as organ transplantation, or are considered investigational in nature.

It is the policy of the BOP to provide care that

its clinicians determine to be medically necessary. Those medical interventions that fall into the categories of "medically necessary, acute or emergent" or "medically necessary, nonemergent" are those the agency considers to be medically necessary. Those that fall into the classification of "medically appropriate but not always necessary" are considered elective and must undergo review by a utilization review committee before approval, and are unlikely to be approved and completed based on limited medical resources.

The utilization review committee members include the clinical director, health services administrator, medical trip coordinator, health care providers, director of nursing (if applicable), and a chaplain or social worker.

These committees typically convene every two weeks to consider the nonemergency referrals. The intent of these committee reviews is to establish an initial assessment of priority for recommended interventions and ensure that *no* services that fall outside the scope of those defined in BOP policy are provided.

Although there is no certainty that a utilization review committee will approve a specific recommendation for treatment, as long as the recommended intervention falls clearly within the category of "medically necessary – nonemergent," it is likely to be approved. Those that are within the category of "medical acceptable – not always necessary" are far less likely to be approved by the committee. Some institutions assign an initial priority for approved consultations/interventions using a numeric system (where 1 requires attention within one week, a priority 2 requires attention within two to four weeks, and a priority 3 can be delayed for a month or more), while others use a color code with similar requirements.

In order for an inmate to be seen by a medical specialist such as a cardiologist or neurologist outside the facility for a nonemergency condition, an escorted trip must be approved and arranged in advance. The number of correctional officers required for each escorted trip ranges from one to five or more, depending on the characteristics of the inmate involved. Because of staffing limitations, a facility will typically schedule a limited number of escorted trips each day, and generally, the number of inmates requiring such trips exceeds the number approved daily. As a result, Bureau of Prisons medical staff (generally the clinical director) establishes priorities to determine which inmates should fill the limited number of escorted trip "slots" available. These are clinical decisions based on the director's assessment of acuity. Thus, while an inmate may have received medical approval for specialty consultation/intervention, the delivery of that care depends heavily on the number of escorted trips available and the acuity of his or her condition. The likelihood that an inmate will receive regular escorted trips for medical specialist consultation over an extended period of time is diminished in light of these logistical variables. It is most likely that at some point the inmate's care, even if approved by the utilization review committee, will be interrupted as he or she is displaced by an inmate with more acute needs.

It is likely that the Bureau of Prisons will have access to the services of medical specialists that most inmates will require. In larger or higher security facilities, the wait for an approved outside consultation may be extensive, based on limited escort staff. In some instances, medically appropriate nonemergent appointments (specifically orthopedics) have been delayed for up to a year after the initial recommendation for consultation. Should such consultation occur, any intervention/treatment suggested by the medical specialist is considered a recommendation subject to the review and approval of the institution clinical director in compliance with the scope of services defined by agency policy and the national formulary. It is not unusual for an institution's clinical director to decline to pursue a recommendation made by a consulting specialist, particularly if that recommendation includes intervention that is seen as medically acceptable but not always necessary or includes a nonformulary medication.

Pretrial or nonsentenced inmates, and inmates with less than 12 months to serve, are ineligible for health services considered "medically appropriate – not always necessary," "limited medical value," or "extraordinary."

Primary Care Teams

The Bureau of Prisons has recently implemented primary care provider teams (PCPT). Under the PCPT model, each inmate is assigned to a primary health care provider who will be responsible for managing the inmate's health care needs. It is anticipated that when PCPT is fully implemented throughout the bureau, sick call will be eliminated. In a nutshell, under the PCPT model, upon

arrival at an institution each individual will be assigned to a primary care provider, and during the remainder of the inmate's stay at the institution, he or she will need to complete a request form any time he or she wishes to receive treatment and/or see the primary care provider under other than emergency medical circumstances.

The PCPT includes a staff physician, midlevel practitioners, and ancillary staff such as pharmacists, radiology technicians, and lab technicians.

The primary health care of the inmates is provided chiefly by the midlevel practitioners (physician assistants, nurse practitioners, or unlicensed foreign medical graduates) under the supervision of a staff physician. Upon arrival at the institution, inmates will be medically screened by one of the prison's medical staff. This process involves an interview and may include a brief physical examination. In addition, any medications the prisoner was taking prior to incarceration will be reevaluated by the prison physician, who will decide whether or not to prescribe the same or a similar medication. Prison pharmacies in the BOP do not dispense herbal medicines. A full history and physical are generally completed within 14 days of arrival at the designated facility.

The staff physicians are generally family practice or internal medicine specialists. They control an inmate's access to specialty medical care and review any recommendations made by medical specialists to determine whether they are within the scope of services and policy of the Bureau of Prisons before implementation.

In order for an inmate to receive care or treatment by a specialist, including physical therapy, the midlevel practitioner would have to identify the inmate's medical problem and alert the staff physician who would then decide whether to refer the inmate to a specialist if one is available.

If the staff physician determines that a referral to a specialist is warranted for a nonemergency condition, such as physical therapy, that referral must be approved by the utilization review committee.

The Bureau of Prisons seeks to obtain medical specialty care for its inmates through contracting with local hospitals. However, contracts with hospitals do not necessarily include services of specialty physicians. In fact, each facility of the Bureau of Prisons uses a variety of procurement practices to establish agreements with both hospitals and individual physicians and other medical specialists for specialty care. The success of establishing those agreements depends on the availability of any particular medical specialist or facility in the community in which the prison is located, the willingness of that provider or facility to travel to the prison and subject him/herself to the security requirements for entrance and the constraints of treating individuals in prison, the willingness of that provider to see inmates in his office/practice/facility, and, increasingly significantly, the ability of that specialty provider to obtain medical malpractice insurance when his or her practice includes inmates. The refusal of many malpractice insurers to cover practices that include inmate patients severely limits the number of specialty providers willing to treat inmates. The Bureau of Prisons does not indemnify contract medical specialists who treat inmates.

End of Life

The BOP has also implemented a policy to facilitate the creation and implementation of advanced health care directives and do not resuscitate (DNR) orders. Each BOP institution is to have an institution policy supplement covering advanced directives and DNR orders that is to include a copy of pertinent state laws; a sample standard form for inmate use if available from the pertinent state law; instructions for inmates to execute advanced directives, including the option of retaining private legal counsel at the inmate's expense. Bureau policy requires filing of an inmate's executed advanced directives in the inmate's health record. Each institution policy supplement must also provide DNR information that complies with the law of the state in which the institution is located; a statement that DNR orders will never be invoked while an inmate is housed in a general (nonmedical) population institution, which means that DNR directives may be implemented only at community health care facilities or BOP medical referral centers; and that copies of valid DNR orders be documented in the inmate's health record. ■