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CONCURRENT
RESOLUTION 91
(2020)**



**ADEQUACY OF
HEALTHCARE
PROVIDED IN
LOUISIANA
STATE PRISONS**

STUDY BRIEF
MAY 2021

LOYOLA
UNIVERSITY
NEW ORLEANS
COLLEGE OF LAW

LSU Health
NEW ORLEANS

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The Louisiana Department of Public Safety and Corrections (DPSC) is required to provide medical and mental healthcare - consistent with community standards - to approximately 16,000 people incarcerated in DPSC facilities.¹ This brief report, requested by Louisiana House Concurrent Resolution 91 (2020), identifies the challenges and obstacles for incarcerated people in receiving constitutionally adequate healthcare. This brief provides an overview of healthcare needs for incarcerated people and then identifies challenges for adequate healthcare services in terms of access, care delivery, and administration.²

Methodology

The authors reviewed material requested from DPSC and the Louisiana Department of Health (LDH), including handbooks, budgets, contracts, prior audits conducted by the American Correctional Association and DPSC,³ healthcare policies, and descriptions of healthcare programs. The authors conducted interviews of nine healthcare professionals involved in provision of care to currently and formerly incarcerated people at external healthcare facilities (e.g. hospitals and clinics). In addition, the authors reviewed court opinions, news reporting, and letters from incarcerated people. This brief does not assess the adequacy of healthcare provided by local sheriffs on behalf of DPSC to approximately 50% of the incarcerated people in Louisiana who are serving their sentence in a local jail.



¹ Over a third (6,000) are held at LA State Penitentiary ("Angola"). DPSC contracts with parish jails to hold approximately 16,000 other people. Although these people are also entitled to the same standard of care, the scope of HCR91 is limited to DPSC facilities.

² This brief does not address the impact of COVID-19 on DPSC facilities. Please see the report of the subcommittee LA Special Populations: Prisons for the Louisiana Covid-19 Health Equity Taskforce (June 2020) for a more detailed assessment of this topic.
<https://www.sus.edu/assets/sus/LAHealthEquityTaskForce/June-COVID-Task-Force-Subcommittee-Reports.pdf>

³ VOTE made a records request of LDH on April 6, 2020, receiving a response on Sept. 11, 2020; Information was requested by Rep. M. Landry from DPSC and LDH on Oct. 20, 2020; LDH response on Nov. 5, 2020, and DPSC on Dec. 21, 2020. Returns from DPSC were incomplete.

HEALTHCARE NEEDS

FOR INCARCERATED PEOPLE

DPSC is required to treat the mental and physical healthcare needs of people in its custody.⁴ Nationwide, incarcerated people are generally sicker than the general population, with roughly three to four times the rate of hypertension, diabetes, and serious mental illness. These patterns hold true in Louisiana, with a significant number of people in Louisiana prisons having health conditions that require continuous care and oversight. For example, in FY 2020, roughly 6,000 people had hypertension, over 400 had heart disease, about 1,200 had been diagnosed with diabetes, roughly 1,600 had COPD, and about 300 had cancer. In terms of communicable disease, over 400 people were living with HIV, and about 1,500 were living with Hepatitis C. Other conditions included serious mental illness, end stage renal disease (requiring dialysis), and pregnancy/childbirth. In FY 2020, the proportion of people on medication at any given facility ranged from 58% at David Wade to 95% at the Louisiana Correctional Institute for Women (LCIW). Similarly, the proportion of people with a substance use disorder ranged from 56% to 98% across prisons. LSU Health Sciences Center - New Orleans estimates that 40% of incarcerated individuals have experienced mental illness and 20% of incarcerated people have been diagnosed with a serious mental illness (SMI).⁵ Of those with SMI diagnoses, 41% suffer from schizophrenia.⁶

- **Allen (ACC):** Over 50% of incarcerated men have been diagnosed with hypertension.⁷
- **Dixon Correctional Institute (DCI):** Includes an in-house dialysis unit and over 40% of incarcerated men at Dixon qualify to receive a medical diet.⁸
- **Raymond Laborde Correctional Center (RLCC):** 32 medical related deaths occurred between 2015 and 2019, including the death of a 24-year-old who died of asthma. Heart attacks caused 11 deaths and 9 were cancer-related.⁹
- **Louisiana Correctional Institute for Women (LCIW):** Over 50% of incarcerated women had a prescription for a mental health condition, and there are approximately 30 pregnancies in a given year.¹⁰

⁴ The U.S. Supreme Court has held that the U.S. Constitution requires the provision of medical and mental healthcare to incarcerated people consistent with the level of care provided in community. See e.g. *Estelle v. Gamble*, 429 U.S. 97 (1976); *Farmer v. Brennan*, 511 U.S. 825 (1994); *Brown v. Plata*, 563 US 493 (2011).

⁵ Rebecca Atkinson, Stephen Phillippi, Lauren Nguyen, & Sara Crosby Juneau, Study Brief: Severe Mental Illness among Louisiana's Incarcerated, LSU Health Sciences Center - New Orleans at 2 (March 2021).

⁶ Id.

⁷ ACC ACA Audit (2019-2020) at 43. ACA Average daily population: 827 people.

⁸ DCI ACA Audit (2017) at 14. ACA Average daily population: 1778 people.

⁹ On file with authors based on death in custody database. ACA Average daily population: 1694 people. RLCC ACA Audit (2019-2020) at 2.

¹⁰ LCIW ACA Audit (2014-2015) at 10-11. ACA Average daily population: 1063 people. LCIW's St. Gabriel facility flooded in August 2016, forcing roughly 1,000 women into other facilities, and does not currently house incarcerated women. The two primary facilities now are Jetson (previously condemned as a youth facility) and a wing at Hunt; the two hold roughly one third of all incarcerated women, with the other two-thirds spread across the state.

- **Louisiana State Penitentiary (LSP):** Prison doctors ordered specialty consultations 8,375 times over 12 months, but only completed 50% within that same time period.¹¹
- **Rayburn Correctional Center (RCC):** 90% of incarcerated men receive prescription medication.¹²
- **David Wade Correctional Center (DWCC):** 30% of incarcerated men have been diagnosed with an Axis 1 mental health disorder (excluding sole diagnoses of substance abuse).¹³
- **Elayn Hunt Correctional Center (EHCC):** 17% of the incarcerated population have been diagnosed with Hepatitis C.¹⁴

DPSC must provide appropriate care for a wide range of individuals ages 18 to 91, including time and resource intensive chronic care for many health conditions. State prison populations are overwhelmingly African American (70.3%) and male, (96.9%)¹⁵ with an average age 44.5 years old.¹⁶ DPSC is the primary provider of healthcare to the incarcerated population, but has also partnered with the Louisiana Department of Health (LDH) to offer targeted substance abuse treatment, screening for infectious diseases, medication assisted treatment for opioids, and treatment for Hepatitis C.¹⁷ As the Louisiana prison population ages, due to extended sentences, the prevalence of life sentences, and limited opportunities for early release, the provision of constitutionally adequate and ethically appropriate medical and mental healthcare will become more burdensome and costly for the agency.

In FY 2019, DPSC had roughly \$81 million in medical expenditures. That number increased to approximately \$96.3 million in FY 2020.¹⁸

¹¹ LSP ACA Audit (2019-2020) at 54. ACA Average daily population: 5544 people.

¹² RCC ACA Audit (2017) at 14. ACA Average daily population: 1311 people.

¹³ DWCC ACA Audit (2019) at 54. ACA Average daily population: 1218 people.

¹⁴ EHCC ACA Audit (2017-2018) at 41. ACA Average daily population: 1989 people.

¹⁵ DPSC, "Briefing Book: Demographics" (June 30, 2020) at 22. Notably, these percentages are higher than the overall population, which includes people housed in local jails. The overall population demographics are 67.5% Black and 95.3 male. Id. at 18.

¹⁶ Id. at 23.

¹⁷ Louisiana Department of Health, Letter, Re: HCR 91-LDH office of Behavioral Health/Office of Public Health Dept. of Corrections Initiatives (October 2020). On file with authors.

¹⁸ DPSC, Spreadsheet of professional services budget and expenditures; medical operating budget and expenditures for FY2020 and FY 2019. On file with authors.

ACCESSING HEALTHCARE

DPSC is responsible for providing comprehensive medical and mental healthcare to people incarcerated in DPSC facilities, including adequate routine, emergency, and chronic disease care. In FY 2020, DPSC reported providing 28,641 routine sick call visits,¹⁹ while there were 32,348 on-site emergencies, and 1,723 offsite emergency room visits. This review revealed several major barriers in access to care that may explain the high numbers of emergency visits.

Medical co-pays

Medical co-pays are required to access healthcare at all state prisons, including \$3.00 for a sick call visit (including dental), \$6.00 for an emergency visit, and \$2.00 for a prescription. Individual prison policies also allow for a \$3.00 charge for mental health requests.²⁰ DPSC policy states that healthcare shall be provided regardless of ability to pay, however, these charges are still assessed as a debt against an incarcerated person's account. The real-world minimum wage equivalent of these rates for incarcerated people who earn incentive wages of \$.02/per hour is: \$1,087.5 for a routine visit, \$2,175 for an emergency visit, and \$725 for a prescription.²¹

Some facilities specifically note exceptions to prescription charges (psychotropic, infectious disease, and work-related injuries) or medical services (annual exam, immunizations, x-rays, etc), while others do not.²² These fees may incentivize people to delay or avoid receiving healthcare services. People granted parole are also expected to pay for mandatory infectious disease testing prior to release at ACC, though the facility manual does not indicate the cost of the required testing.²³ Prescription fees may also be assessed for medically necessary aids or prosthetics, including glasses and dentures.²⁴

Preventative medical care

For medical visits, policies only provide for annual wellness exams for individuals over 50 years old and internal audits indicate that this policy is not consistently followed. Younger incarcerated people do not receive annual exams. Outside providers agreed that *"It doesn't sound like they have*

¹⁹ DPSC, "Briefing Book: Medical and Mental Health" Department of Medical and Mental Health" (Jul 2019 - Jun 2020) at <https://s32082.pcdn.co/wp-content/uploads/2020/08/8d-Medical-Quarter-4-8.10.20.pdf>

²⁰ See e.g., ALC, "Offender Orientation Manual" (Nov. 2020) at 5; DWCC "Offender Orientation Manual" (undated) at 29.

²¹ This calculation is based on the number of hours an incarcerated person would have to work multiplied by the federal minimum wage (since Louisiana does not have a state minimum wage). For example, to earn three dollars, an incarcerated person would have to work 150 hours at two cents an hour. Multiplying the number of hours required by \$7.25 provides the real-world minimum wage equivalent.

²² Compare EHCC, "Orientation Information" (July 2018) at 13 (noting prescription exceptions); DWCC "Offender Orientation Manual" (undated) at 28-29 (noting medical visit exceptions) with RCC "Offender Handbook" (Nov. 2019) at 3 (no exceptions listed).

²³ ACC, "Offender Orientation Manual" (Nov. 2020) at 21.

²⁴ DWCC "Offender Orientation Manual" (undated) at 29.

access to preventive care... the overwhelming story that we get from people is that it just doesn't exist." Another provider stated that, "I'm not sure that at the facilities that they were doing regular health checkups... Like colonoscopies, there's no way that every 50-year-old was getting sent to us for a colonoscopy."

Physicians agreed that because of the lack of preventive and timely care, "...the patients that are coming from certain prisons tend to be a great deal sicker," and that "there's a greater percentage of the incarcerated population that comes in with later disease." Healthcare providers said one of the most significant preventive services lacking is "age-appropriate cancer screening. It's clearly mandated. It's one of the clearest public health guidelines in this country and that is not happening on a sustainable basis as far as I can tell with people who are incarcerated."

Another illustrative statement by a healthcare provider was,

"I think the most obvious and most alarming example of that is cancer. I've seen way more cases of obvious, advanced, cancer than I think anyone should see with this... It's not something that you would have had happen if the person was not incarcerated. Horrible stories of young people with end-stage cancer that could have been treated. People with things like colon cancer and lung cancer which are incredibly treatable, by the time they come to us it's metastatic, everywhere."

Dental care

For dental visits, DPSC policies do not provide for annual preventative exams or cleanings, other than a dental assessment at intake or transfer. Instead, a sick call visit is the only way to initiate dental care and potentially reduce the need for more significant dental treatments, such as oral surgery. LSP, for example, does not have a dental hygienist on staff, though cleanings are reportedly available through sick call.²⁵ Allen, with a population of over 800 people, only completed 142 dental treatment plans in a 12 month period, perhaps because Allen only employs a part-time dentist and part-time dental assistant 2 days a week.²⁶ In addition, at the time of an internal audit, DWCC did not have a dentist or dental assistant on staff.²⁷ Dental care is particularly important because of the length of sentences, the effectiveness of preventative care, and the prevalence of dental disease within correctional health.²⁸ At least one prison policy prohibits dental prosthetics unless the incarcerated patient is unable "to take in adequate nutrition [and] is impaired without them."²⁹ Given the national reliance on extractions as the primary form of dental care provided in correctional settings, this policy exacerbates the lack of access for preventative dental health.

Sick call process

In some prisons, sick call forms must first be obtained from non-medical staff, rather than being freely available.³⁰ In addition, in some but not all prisons, these forms are submitted to non-medical

²⁵ LSP ACA Audit (2019-2020) at 16.

²⁶ ACC ACA Audit (2019-2020) at 43.

²⁷ DWCC C-05-003 Audit (Feb. 2020) at 3.

²⁸ See Joseph Costa, "Dental Care in Corrections," 60 *Disease-a-Month* 221-223 (2014).

²⁹ LCIW Policy 4-05-004 (Nov. 2017) at 11.

³⁰ LCIW, "Orientation Handbook" (2019) at 17; Hunt RDC "Orientation Information" (October 2020) at 20

staff³¹ instead of a lockbox accessed only by healthcare staff. This lack of confidentiality might inhibit patients from revealing sensitive physical or mental health concerns. ACC also specifically informs incarcerated people that signing up for sick call “does not ensure a visit with a healthcare practitioner,” which may incentivize incarcerated people to use the emergency process to ensure their medical issues are addressed.³² At DWCC, the information manual indicates that incarcerated people only have a 15 minute window - from 5:00am to 5:15am - to submit a sick call request.³³

Potential disciplinary charges

“Malingering” disciplinary charges are allowed when healthcare staff (who are sometimes an EMT supervised by a security staff member) determine that an emergency request was improperly filed.³⁴ Risk of disciplinary action, including forfeiting earned good time credit, loss of visitation or canteen privileges, for example, may inhibit incarcerated people from requesting medical services. In addition, an incarcerated person’s account may be charged for “restitution” for misuse of the emergency process, i.e. costs incurred if the prison determines the issue was not an emergency.³⁵ It is unclear whether and to what extent “malingering” is currently being charged in DPSC prisons.

³¹ See e.g., DWCC “Offender Orientation Manual” (undated) at 30.

³² ACC, “Offender Orientation Manual” (Nov. 2020) at 4.

³³ DWCC “Offender Orientation Manual” (undated) at 30-31.

³⁴ See e.g., HC-02; LCIW 04-05-004 (Nov. 2017) at 7; LCIW, “Orientation Handbook” (2019) at 17; EHCC, “Orientation Information” (July 2018) at 13; but see RCC C-05-003 audit (Oct. 2018) (noting a September 2018 memo issued by Secretary LeBlanc indicating that “malingering” charges shall be removed from policies until the “Disciplinary Rules and Procedures for Adult Offenders” is updated.)

³⁵ See e.g., DWCC “Offender Orientation Manual” (undated) at 28.

III

HEALTHCARE DELIVERY

Beyond access to healthcare, actual delivery of healthcare services may impact the adequacy of DPSC provided healthcare. At LSP, approximately 30% of health-related grievances filed by incarcerated men were granted by LSP officials, indicating that healthcare delivery may be limited or subject to delay.

Patients in segregation

For people housed in segregation, current policies and practices negatively impact the delivery of healthcare. Sick call for people in segregation is conducted at the cell door, instead of the infirmary, which means people in segregation are denied privacy during these health-related encounters.³⁶ Cell-side treatment may also impact the provision of preventative care. One health professional talked about the differences in healthcare for people in segregation, saying, “*Well, it depends on where it’s at. If you’re in the general population, you’ll get a thorough checkup from time to time... in cell blocks at Camp J, a maximum security area... you didn’t get the same attention.*”

Healthcare for people in segregation is particularly significant, as segregation can pose unique threats to medical and mental health. In several facilities, internal DPSC audits noted incomplete medical records for people held on extreme suicide watch, including a failure to check circulation and blood flow every 2 hours, for a medical assessment prior to the use of restraints, and for 12-hour checks by mental health providers while a person is on extreme watch.³⁷ After incident reviews of the use of medical restraints, required by DPSC policy, also do not appear to be consistently completed.³⁸

Chronic and specialty care

None of the prisons completed 100% of specialty care plans ordered by healthcare professionals within the prior 12 months and at least one prison, Allen, failed to ensure that even 50% of specialty plans ordered by a healthcare professional were completed.³⁹ Even where DPSC policy provides for certain mandatory visits and tests for chronic disease patients, audits that included random chart reviews indicate that multiple patients were not provided timely care, particularly for hypertension and diabetes.⁴⁰ Numerous internal audits, which sample a relatively small number of

³⁶ See e.g., LCIW, “Orientation Handbook” (2019) at 17.

³⁷ See e.g., RLCC C-03-005 (Dec. 2018); RLCC C-03-005 (June 2019);

³⁸ RLCC C-05-003 Audit (June 2019) at 16.

³⁹ See ACC ACA Audit (2019-2020) at 43; DCI ACA Audit (2017) at 44; EHCC ACA Audit (2017-2018) at 46; DWCC ACA Audit (2019) at 49; LCIW ACA Audit (2014-2015) at 45; LSP ACA Audit (2019-2020) at 54; RCC ACA Audit (2017) at 50; RLCC ACA Audit (2019-2020)(health care outcomes not included in audit)

⁴⁰ See e.g., DWCC C-05-003 Audit, “LA DPS & Corrections Medical Chart Review” at 3 (Sept. 2018); EHCC C-05-003 Audit (April 2019) at 2; LSP C-05-003 Audit (July 2019) at 3; RCC C-05-003 Audit (Oct. 2019) at 15.

charts, consistently found evidence of failures to provide policy-required follow-up.⁴¹ For example, all diabetic patients shall receive a chest x-ray and EKG every other year according to DPSC policy, but a 2019 audit at LSP reviewed a chart where the patient had not received those services since 2015.⁴² More broadly, the trial judge in *Lewis v. Cain* found that LSP failed to provide services for patients requiring specialty care, including failure to schedule and track specialty appointments; failure to comply with testing and diagnostic requirements; failure to execute appropriate follow-up care as ordered by specialist; and failure to coordinate care.⁴³

Prison policies specifically treat outside specialty care orders as “recommendations” unless prison healthcare staff deem the orders to be “medically necessary.”⁴⁴ In addition, LCIW policy notes that “Louisiana Correctional Institution for Women physicians (including dentists) are not obligated to follow an instruction by private physicians, hospitals or other healthcare providers.”⁴⁵ This deference to general medicine healthcare staff employed by the prison over the orders issued by an specialist outside medical provider disrupts continuity of care and is a common concern among outside healthcare providers. Interviewees noted the difficulty of communicating with DPSC to ensure that patients discharged from the hospital receive follow-up care. One explained,

“Here, it’s almost like we’re sending recommendations into the wilderness. We’ll send them out with a set of discharge orders and we’ll say we want them to be on these antibiotics and these medications and have these follow-up appointments. Then it’s sort of up to the facility to decide if that’s going to happen or not...I think the follow-up piece is really alarming. There’s no accountability about that whatsoever.”

Another physician said, *“The ongoing assumption is really among all the doctors is that pretty much no follow-up appointment will happen and no follow-up care will happen and everything that we want to do, we have to get done in the hospital.”* One doctor said regarding follow-up, *“Sometimes it falls through the cracks... they just won’t come. I’m sure it’s not because the patient didn’t want to come and see an oncologist... I think there’s some system level barrier that is preventing them from being able to do that.”*

Behavioral health

On-site times for psychiatrists vary. One is present every two weeks at RLCC, while one is at ACC one day a week.⁴⁶ At DCI, the psychiatrist is onsite 6 hours a week and 30% of the population is on the mental health caseload.⁴⁷ At DWCC, there are five staff members delivering mental health services, but one of them is a correctional officer.⁴⁸ It is unclear whether the correctional officer has appropriate training in behavioral health.

Some outside providers expressed that there did not seem to be adequate behavioral health services for incarcerated people. One said, *“I also am suspicious that psychiatric concerns are*

⁴¹ See e.g., RLCC C-05-003 Audit (Dec. 2018).

⁴² LSP C-05-003 Audit (July 2019) at 3.

⁴³ *Lewis v. Cain*, Opinion, 15-cv-00318, Rec. Doc. 594 at 89 (E.D. La, 3/31/21)

⁴⁴ LCIW 04-05-004 (Nov. 2017) at 10.

⁴⁵ LCIW 04-05-004 (Nov. 2017) at 12.

⁴⁶ ACC ACA Audit (2019-2020) at 11; RLCC ACA Audit (2019-2020) at 16.

⁴⁷ DCI ACA Audit (2017) at 17.

⁴⁸ DWCC ACA Audit (2019) at 16.

undertreated within the system on a whole." Another talked about issues related to opioid use disorder, explaining

"... it's wildly mismanaged in terms of nobody being offered medication assisted treatment and just sort of put into withdrawal with no symptom management at all, which can in and of itself be life-threatening from seizures and severe dehydration. And is not the standard of care and is not even the national standard of care in departments of corrections across the country."

Mental health needs within prisons are significant, but internal auditors have documented the failure to consistently develop treatment plans and document individual follow-up.⁴⁹ At DCI, 99% of incarcerated men have a diagnosis of an Axis 1 mental health disorder, excluding sole diagnoses for substance abuse.⁵⁰ At LSP, 17% of incarcerated men have active treatment plans for a diagnosed mental disorder (excluding substance abuse). At RLCC, auditors noted a pervasive lack of documentation in their screening of mental health records, including lack of follow-up within required time frames, and in one case, a treatment plan that stated "no diagnosis" for mental health, despite the incarcerated patient's prior diagnosis as having schizophrenia.⁵¹

Clinical care

There are concerns expressed by external healthcare providers, incarcerated people, and the federal court, that clinical care in DPSC prisons focuses too heavily on episodic treatment of complaints compared to holistic healthcare that provides timely diagnoses, full and complete treatment through follow-up care, and specialty care for chronic or long-term illnesses.

Based on their interactions with incarcerated patients, external healthcare professionals generally agreed that *"I think it's definitely a substandard system. There's the healthcare that everybody else gets, and then there's the healthcare that incarcerated people get. I think there's very clear and specific instances in which the standard of care is not met..."*

Emergency care

Outside healthcare providers expressed concern that prisons waited too long to transport critically ill patients to hospitals and that they did not take patients to the nearest healthcare facility when unable to treat patients onsite. As one physician explained, *"(Prison transport vans) bypass all the closer hospitals, to come here with their dying patients...I do think that there are times where it would be appropriate to do things like stop for emergency lifesaving care ... upon exiting the facility, and coming to care, and not driving for hours to get here."* Statements by healthcare providers appear consistent with federal court findings that LSP failed to provide medical evaluations by qualified providers for inpatient/infirmiry care and failed to timely treat and/or transport to the hospital when required.⁵² In addition, at least one prison policy notes that some incarcerated patients may be permanently housed in the infirmary.⁵³ This raises the question of whether these patients' medical needs would be better served through medical parole.

⁴⁹ See e.g., RLCC C-05-003 Audit (June 2019) at 21-22.

⁵⁰ DCI ACA Audit (2017) at 44.

⁵¹ See e.g., RLCC C-05-003 Audit (June 2019) at 32.

⁵² *Lewis v. Cain*, Opinion, 15-cv-00318, Rec. Doc. 594 at 123 (E.D. La, 3/31/21)

⁵³ LCIW 04-05-004 (Nov. 2017) at 9.

Medication delivery

Policies regarding medication delivery, or “pill call” is not uniform across DPSC facilities. In some cases, security staff, as compared to healthcare staff, deliver medication to people in restrictive custody.⁵⁴ Some facilities allow some people to keep their own medication “on person,” to take as directed. Prison policies also vary significantly on policies regarding over-the-counter medication, such as Tylenol or aspirin. Only one prison provides free and contemporaneous access to over the counter medication.⁵⁵ All other prisons require an incarcerated person to either purchase over-the-counter medication from the canteen (with limited hours) or place a sick call request and receive a “prescription.” The latter option would incur the co-pays detailed above.

⁵⁴ ACC ACA Audit (2019-2020) at 11.

⁵⁵ DWCC “Offender Orientation Manual” (undated) at 31; but see EHCC “Orientation Information” (July 2018) at 14.

IV

HEALTHCARE ADMINISTRATION

Release planning

In 2009, DPSC partnered with the Louisiana Department of Health STD/HIV/Hepatitis Program (SHHP) to implement the medical release planning program for people living with HIV. The program aims to ensure access to case management services and medications for HIV post-release. In FY 2019, the program served 88 people across all eight DPSC facilities.⁵⁶ In addition, as part of Louisiana's Hepatitis C elimination plan, DPSC and LDH recently began an innovative new program to treat people for Hepatitis C during incarceration. Between January 15, 2020 and June 30, 2020, a total of 389 incarcerated people received medication to treat Hepatitis C.⁵⁷ DPSC is also collaborating with the Louisiana Office of Behavioral Health on multiple grant-funded programs focused on improving treatment for substance use disorder.⁵⁸ In addition, since 2017, LDH has collaborated with DPSC to enroll those who are eligible in Medicaid prior to being released.⁵⁹

License status for healthcare providers

DPSC failed to provide a requested list of its healthcare providers' names and current license status for this report. The Louisiana Board of Medical Examiners can and does issue "institutional permits" to limit the practice of providers to certain institutional settings, including correctional settings, as part of its disciplinary sanction process.⁶⁰ This practice is directly contrary to guidelines issued by the National Commission on Correctional Health Care arguing that all healthcare providers should be "fully licensed" without qualification or restriction.⁶¹ DPSC stipulated in federal court that "Each of the doctors on LSP's staff had a restricted license or was restricted to practicing in institutional settings at the time they were hired by LSP."⁶² At the same time, the federal court also found that LSP failed to maintain credential files for providers to ensure all providers were appropriately licensed and supervised.⁶³

⁵⁶ Louisiana Department of Health, Letter, Re: HCR 91-LDH office of Behavioral Health/Office of Public Health Dept. of Corrections Initiatives (October 2020). On file with authors.

⁵⁷ Id.

⁵⁸ Id.

⁵⁹ https://ldh.la.gov/assets/medicaid/DOC/Justice-involved-pre-release-enrollment-program-manual_10192017.pdf

⁶⁰ 46 La. Admin. Code Pt XLV, 397.

⁶¹ National Commission for Correctional Health Care, Position Statement, adopted by the Board of Directors Nov. 1999 and reaffirmed Oct. 2012 at: <https://www.ncchc.org/licensed-health-care-providers-in-correctional-institutions>

⁶² *Lewis v. Cain*, Opinion, 15-cv-00318, Rec. Doc. 594 at 5 (E.D. La, 3/31/21); see also *Lewis v. Cain*, Oct. 9, 2018 Testimony of Mike Puisis at 217-218; Louisiana State Medical Society, Board of Governors Meeting, "Minutes" (June 6, 2018) at https://cdn.ymaws.com/lsms.org/resource/resmgr/bog_minutes/june_2018.pdf

⁶³ *Lewis v. Cain*, Opinion, 15-cv-00318, Rec. Doc. 594 at 40, 123 (E.D. La, 3/31/21).

Medical records

Medical records are paper, though some internal DPSC audits indicate that an electronic health record system for DPSC is forthcoming. Paper records create obstacles to continuity of care in the case of intra- and inter-system transfers. Outside healthcare providers noted that the lack of electronic records is challenging because they do not have access to patients' paper medical records when patients come to the hospital or post-discharge. Facilities also provide different types of records for people being transferred between prisons, with some facilities providing the entire medical record, while others only send a medical summary. These paper medical records are often not complete. Some prison policies do not integrate infirmary records with a patient's complete medical records.⁶⁴ In addition, numerous internal reviews of patient medical records indicate that providers failed to file lab results, complete evaluations, or otherwise lack required documentation.⁶⁵

Staffing vacancies and activities

Continuing staff vacancies and high rates of turnover in medical staff, as noted in internal audits, creates gaps in care for incarcerated patients. One facility lacked two nurses for close to a year and internal audits continuously list vacancies among health care providers.⁶⁶ In FY 2019 and 2020, the majority of prisons spent less than their authorized budget for professional services, which can include radiology, psychiatry, dentistry, specialized counseling, and other services.⁶⁷ In addition, authorized budgets for professional services for FY 2020 are less than the authorized budgets for FY 2019, reflecting an overall drop of \$1.7 million in both budget and expenditures for professional services.

Several facilities, including LSP, rely extensively on EMTs to provide assessments for routine sick calls, which is beyond the scope of an EMT's practice and training.⁶⁸ As one healthcare staff member explained, *"They have to get approval from the overseer before they actually get to see a physician."* Furthermore, external healthcare providers noted that this system is problematic because patient concerns are not taken seriously, stating *"They have told the guards or whoever's in charge of medical personnel that they weren't feeling better or they weren't getting better and nothing was done."*

Expired supplies

DPSC internal audits found that several facilities did not replace expired supplies, including items which indicated recent use.⁶⁹ Several of these expired supplies implicate emergency, life-saving care, including defibrillator pads which lose the ability to conduct electricity to jump-start the heart after expiration. DPSC auditors also found expired insulin,⁷⁰ which results in decreased potency dosing for incarcerated people with diabetes. Other expired supplies included IV fluids, sterile wound supplies and sterile saline.

⁶⁴ RLCC ACA Audit (2020) at 17; LCIW 04-05-004 (Nov. 2017) at 8.

⁶⁵ RLCC C-05-003 Audit (June 2019) at 12.

⁶⁶ See DWCC C-05-003 Audit (Sept. 2018) at 24;

⁶⁷ DPSC, Spreadsheet of professional services budget and expenditures; medical operating budget and expenditures for FY2020 and FY 2019.

⁶⁸ See e.g., LSP, "Offender Orientation/Information Manual" (May 2020) at 29; *Lewis v. Cain*, Opinion, 15-cv-00318, Rec. Doc. 594 at 87(E.D. La, 3/31/21)

⁶⁹ See e.g., RLCC C-05-003 audit (Dec. 2018)

⁷⁰ RCC C-05-003 Audit (Oct. 2018) at 13.

V

CONCLUSION

Incarcerated people are not free to seek the healthcare they need in community and rely on DPSC as their sole source of medical and mental healthcare. This review indicates that there are several substantial issues with healthcare delivery, access, and administration with the DPSC system. A federal court recently held in *Lewis v. Cain* that healthcare at LSP constitutes cruel and unusual punishment and that it violates the 8th Amendment, the Americans with Disabilities Act, and the Rehabilitation Act.⁷¹ LSP, of all the state prisons, has the highest overall budget for medical and mental healthcare and is the preferred placement for incarcerated men with significant health needs. With over a third of DPSC's incarcerated people held at LSP, and with similar policies and practices across other facilities, the federal lawsuit is likely to impact the entire healthcare system operated by DPSC. Further research is needed to better understand the impacts of DPSC's current system of healthcare delivery, and additional oversight is necessary to ensure that people incarcerated in Louisiana receive appropriate healthcare services.

⁷¹ See generally, *Lewis v. Cain*, Opinion, 15-cv-00318, Rec. Doc. 594 (E.D. La, 3/31/21)

VI

RECOMMENDATIONS

To address the challenges to adequate healthcare delivery in state prisons that are identified in this report, Governor John Bel Edwards should create **a high-level, authoritative coordinating committee, composed of representatives from DPSC, LDH, external medical and behavioral health providers, experts in public health and incarceration law and policy and currently and formerly incarcerated patients.** This committee should be granted authority to:

- Develop, implement, and/or regularly monitor standardized healthcare policies and practices across all state prisons including medication access and delivery, processes for accessing care, and availability of comprehensive physical and behavioral health services, including preventative care.
- Develop implement, and/or regularly monitor healthcare staffing plans at each facility to ensure availability of appropriate, credentialed healthcare providers to meet patient needs.
- Review and monitor the impacts of medical co-pays on access to care and DPSC budgets.
- Assess the feasibility of developing partnerships with community-based providers to deliver healthcare services to incarcerated people.

AUTHORS

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**ADEQUACY OF
HEALTHCARE
PROVIDED IN
LOUISIANA
STATE PRISONS**

**STUDY BRIEF
MAY 2021**

