A Report by a Panel of the

NATIONAL ACADEMY OF PUBLIC ADMINISTRATION

Assessment of the Bureau of Prisons' Organizational Alignment with Healthcare Mission

NATIONAL ACADEMY OF PUBLIC ADMINISTRATION®

October 2019

ABOUT THE ACADEMY

The National Academy of Public Administration (the Academy) is an independent non-profit, non-partisan organization established in 1967. Chartered by Congress in 1984, the Academy provides expert advice to government leaders in building more effective, efficient, accountable, and transparent organizations. To carry out this mission, the Academy draws on the knowledge and expertise of its over 900 Fellows—including former cabinet officers, Members of Congress, governors, mayors, and state legislators, as well as prominent scholars, business executives, and public administrators. The Academy assists public institutions address their most critical governance and management challenges through in-depth studies and analyses, advisory services and technical assistance, congressional testimony, forums and conferences, and online stakeholder engagement. Learn more about the Academy and its work at www.NAPAwash.org.

A report by the

NATIONAL ACADEMY OF PUBLIC ADMINISTRATION

October 2019

Assessment of the Bureau of Prisons' Organizational Alignment with Healthcare Mission

STUDY PANEL MEMBERS

Kristine Marcy*, *Chair*
Thomas Garthwaite, M.D.*
Gary Glickman*
Harold Clarke*
Barton Wechsler*

**Academy Fellow*

Officers of the Academy

Jeffrey Neal, *Chair of the Board*
Norton N. Bonaparte, Jr., *Vice Chair*
Teresa W. Gerton, *President and Chief Executive Officer*
Myra Howze Shiplett, *Secretary*
Jonathan Fiechter, *Treasurer*

Study Team

Brenna Isman, *Director of Academy Studies*
Roger Kodat, *Senior Project Director*
Jonathan Tucker, *Senior Research Analyst*
Adam Darr, *Research Analyst*
Kyle Romano, *Research Associate*

National Academy of Public Administration
1600 K Street, N.W.
Suite 400
Washington, DC 20006
www.napawash.org

October 2019
Printed in the United States of America
Academy Project Number: 102235.001

Foreword

The mission of Federal Bureau of Prisons (BOP) is "to protect public safety by ensuring that federal offenders serve their sentences of imprisonment in facilities that are safe, humane, cost-efficient, and appropriately secure, and provide reentry programming to ensure their successful return to the community." As part of this mission, BOP must effectively deliver medically necessary healthcare to inmates in accordance with proven standards without compromising public safety concerns. BOP's Health Services Division (HSD) is responsible for providing medical, dental, social, and psychiatric mental health services to inmates at BOP-operated institutions.

In 2018, HSD contracted with Chirality Capital Consulting to undertake an independent expert assessment to identify opportunities to improve organizational alignment and strengthen data analytics capabilities. The National Academy of Public Administration (the Academy) is one of three subcontractors to Chirality Capital Consulting. Our part of the larger assessment included the following two elements:

1. Assessing the alignment of BOP's organization structure and lines of authority with the demands of effective and efficient management of healthcare operations; and
2. Providing effective-practice guidance to HSD on strategic planning and change management that supports the successful implementation of changes recommended by the Academy and its project partners.

The Academy assessment was undertaken by an expert Panel of Academy Fellows supported by a professional study team. The Panel recommends a staged approach to realigning authority over healthcare staff and resources at BOP institutions, beginning with the seven Federal Medical Centers (FMCs). This realignment is essential if BOP is to cost-effectively increase its capacity to provide care internally and thereby avoid the significantly higher cost of external medical services that are the largest driver of BOP medical costs. Increasing this capacity, both through more efficient utilization of medical beds and strategic investments in staff and facilities, will become even more important as the inmate population ages and requires more advanced and longer-term care.

The accompanying Panel report presents effective practices in strategic planning and change management. It also provides illustrative examples intended to guide BOP in successfully implementing changes recommended by the Academy and its project

partners related to data analytics. This report includes a case for change that encompasses both the rationale for HSD line authority over the FMCs and for strengthened data analytics capabilities that will be required to cost-effectively increase BOP's capacity to provide medical care internally.

I appreciate the support of HSD and BOP leaders and other stakeholders who provided important insights and context that inform this report. I extend my sincere thanks to the Academy Fellows who served on the Panel and provided invaluable expertise and thoughtful guidance to the professional study team that undertook this project. We anticipate that BOP leaders will find herein recommendations and effective practice guidance that support their efforts to provide medically necessary healthcare to inmates more effectively and efficiently.

Teresa W. Gerton
President and Chief Executive Officer
National Academy of Public Administration

Contents

THIS PAGE INTENTIONALLY LEFT BLANK

Executive Summary

The National Academy of Public Administration (the Academy) is one of three subcontractors to Chirality Capital, a company which has contracted with the Health Services Division (HSD) of the Federal Bureau of Prisons (BOP) to undertake an assessment of four critical functions that underpin BOP's statutory mandate to deliver medically necessary healthcare to federally incarcerated inmates:

1. the effectiveness of the organizational structure of the BOP inmate healthcare system **(the Academy's focus)**;
2. its capacity to collect, analyze and act on operational and financial data;
3. the need to develop a financial cost accounting model that would enable optimal fiscal stewardship and maximize cost avoidance; and
4. the need to acquire a data integration system that would inform strategic planning, judicious allocation of healthcare resources, and evaluation of operational and fiscal performance.

The Academy's part of the larger assessment includes the following three deliverables:

1. Alignment of BOP's organization structure and lines of authority with the demands of effective and efficient management of healthcare operations;
2. HSD's approach to strategic planning; and
3. HSD's plan to support effective implementation of recommended changes.

This is a report of a Panel of five distinguished Academy Fellows and constitutes the Panel's assessment related to the first deliverable. A second report, to be submitted subsequently, will address the second and third deliverables described above.

The Panel's findings and recommendations are summarized under three topic areas:

1. Opportunities to improve HSD's ability to manage healthcare as a system and address issues at individual institutions;
2. Opportunities to address key support service challenges; and
3. Opportunities to improve the coordination of mental healthcare.

I. Opportunities to improve HSD's ability to manage healthcare as a system and address issues at individual institutions

While HSD is responsible for the effective and efficient delivery of healthcare to federal inmates in BOP-operated institutions, it lacks the line authority to manage healthcare operations as a system and to directly address issues at institutions. This significantly hinders HSD's ability to contain costs, maintain quality, and manage risk.

In the absence of line authority, HSD must rely on the cooperation of Wardens and staff under the correctional line of authority to ensure that appropriate medical care is provided to inmates. While Wardens and institutional staff generally try to work cooperatively with HSD to accomplish what they all see as an important mission, such an arrangement is inefficient and uncertain. HSD must spend time reaching agreement on issues and marshaling support for action among Wardens and staff in the correctional line of authority. Ultimately, action is contingent on the voluntary support of Wardens and staff, who change over time. Also, Wardens and staff have competing priorities and the organization of authority over healthcare staff and resources at institutions under individual Wardens hinders the management of healthcare operations as a system. This arrangement is particularly ill-suited to addressing complex, system-wide healthcare issues.

Based on effective practices research, including the examples of state correctional systems, the Panel concludes that line authority over healthcare staff and resources offers the greatest potential to ensure the effective and efficient management of healthcare operations. Moreover, this can be successfully implemented without compromising the ability of Wardens to exercise the operational control over facilities needed to maintain the safety of personnel and inmates.

However, the Panel recommends a staged approach to realigning authority over healthcare staff and resources at BOP institutions. Such an approach offers three advantages: (1) it mitigates risk by minimizing disruption and provides time to adjust to the unintended consequences attending change in large, complex systems; (2) it provides the time to build adequate administrative capacity at HSD Central Office; and (3) it provides an opportunity to demonstrate the value of realigning authority over healthcare staff and resources and assuages concerns, thereby lessening opposition to realignment.

The first step in the staged approach should be the transfer of line authority to HSD over healthcare staff and resources at the seven Federal Medical Centers (FMCs) and co-located Medical Care Level 3 facilities where there are critical interdependencies (e.g.,

shared staffing) that would not be disrupted by placing such institutions under separate administration. FMCs serve inmates who are the most ill and they account for the largest concentration of healthcare staff and resources, including all medical beds. Moreover, the efficient and proactive management of these beds is critical to the ability of HSD to ensure the appropriate level of care for inmates internally and minimize the cost of external medical services.

An additional opportunity to improve HSD's ability to manage healthcare as a system and to address issues at individual institutions is the realignment of the Regional Health Services Administrators (RHSAs) under the National Health Service Administrator in HSD. RHSAs are a critical link between HSD and the regions in that they are responsible for deploying regional Medical Asset Support Teams (MAST) teams to address critical medical needs at institutions in the region. RHSAs are familiar with the healthcare challenges facing institutions in the region and are well positioned to direct the activities of the MAST teams. However, the shared authority over MAST team members between the RHSAs, who report to the Regional Directors, and the Chief Professional Officers, who report to the Medical Director at HSD, sometimes leads to conflicts. Realigning the RHSA under the National HSA would help avoid conflicts through improved communication under a unified authority structure, and it would begin laying the groundwork for the transfer of line authority to HSD over healthcare staff and resources at institutions beyond the seven FMCs.

While line authority is the most direct way to coordinate activities within an organization, the combination of data and technology offers an alternative and complementary means for coordination. Performance metrics and dashboards currently being developed by HSD's data analytics group have the potential to serve as powerful ***non-authority*** tools for encouraging the alignment of Warden efforts with healthcare mission priorities by providing insights and feedback on both directions of needed changes and progress toward improvement goals. Timely, meaningful and accurate data can also stimulate both collaboration and healthy competition with their peers.

The continued progress of HSD's data analytics program (a topic being separately considered by our project partners) will require sustained support by BOP leadership both in terms of obtaining additional staff and resources, and to ensure the appropriate prioritization of efforts by BOP headquarters support components. To help ensure sustained focus, the Panel recommends that the development of healthcare data analytics capabilities should be included in a BOP strategic plan. It should be one objective of a broader strategic goal to improve the capacity of BOP to deliver healthcare to inmates effectively and efficiently.

II. Opportunities to address key support service challenges

The Academy study team sought to identify specific support service challenges that most greatly hinder the ability of HSD to effectively and efficiently perform its healthcare mission. It also sought to identify those challenges where a clear path forward is apparent, but where the support of BOP leadership is needed to provide resources and to ensure action by responsible parties outside HSD.

With these considerations in mind, the Panel focused its recommendations in two support service areas: (1) data analytics (addressed above); and (2) attracting and hiring medical professionals. With regard to the latter, the Panel makes two recommendations. The first concerns providing the support HSD needs to implement Title 38 authority (recently granted by the Office of Personnel Management) in a timely manner. Title 38 authority will enable BOP to offer more competitive compensation to physicians and dentists, which is critical to ensuring quality of care and avoiding unnecessary costs associated with external medical services. However, implementing Title 38 will take substantial time and, more importantly, the focused effort of HRMD, amidst competing demands. Also, implementation will take substantial HSD staff time to coordinate and support HRMD. Therefore, the Panel recommends that BOP leadership prioritize the implementation of Title 38 authority and provide additional resources needed. Also, the Panel supports HSD's intent to seek Title 38 authority for other medical professionals including, but not limited to, advanced practice providers, physician assistants, and nurse practitioners, after the successful implementation of Title 38 for physicians and dentists.

The second concerns addressing a critical weakness in the current process used to onboard qualified medical professionals. A major pitfall identified is the disqualification of candidates for failure to provide the necessary documentation to obtain certification for hiring by institutions. To address this, the Panel recommends that Regional Medical Recruiters be given the authority to view applicant files to help ensure that all the required documentation and qualifying information are provided before being considered for certification.

The Panel also calls out important support service challenges that need to be addressed, but that do not lend themselves at this time to a clear recommendation for action and/or fall outside the administrative expertise that the Academy was called on to provide. These challenges include: (1) the lack of an integrated, reliable database on healthcare staffing at institutions; and (2) impediments to issuing/revising policy.

III. Opportunities to improve the coordination of mental healthcare

Responsibility for mental healthcare programs at BOP is divided between HSD and the Reentry Services Division (RSD). HSD oversees psychiatric mental health services to inmates at BOP institutions, delivered via HSD's Telepsychiatry Program and staff psychiatrists. RSD includes the Psychology Services Branch, which oversees psychologists providing mental health services and reentry mission related services such as drug abuse and sex offender treatment programs. The study team sought to identify opportunities to improve coordination of mental healthcare.

The Panel found different views of the challenges to coordinating mental healthcare and of how serious the challenges are. Three issues were identified:

1. Conflicts between psychologists and psychiatrists regarding diagnosis and drug treatment;
2. Consultations by psychologists with psychiatrists on diagnosis and drug treatment creating an unsustainable workload on psychiatrists; and
3. Conflicts between physicians and psychologists regarding diagnosis and drug treatment.

Given the lack of a clear, consistent definition of the coordination challenge, the Panel concludes that the prudent course would be to focus initially on efforts to better understand the coordination challenge and identify possible solutions. The Panel recommends creating a new working-level mental healthcare group to address the clinical coordination issues identified. A working-level group is best suited to enabling the frank and open discussions needed to explore issues, consider options, and build support for possible solutions.

This recommendation should be considered as an initial, incremental step and should be revisited after the other recommendations have been implemented. This will provide time to better define issues and build support for action and enable greater leadership focus.

A complete list of the Panel's seven recommendations is provided below, organized by the section of the report where the recommendations are presented.

List of Panel Recommendations

Section 3: Opportunities to Improve HSD's Ability to Manage BOP Healthcare Operations as a System and Address Delivery Issues at the Institution Level
Recommendation 3.1: BOP leadership should commit to a long-term plan of incrementally transferring HSD line authority over healthcare staff and resources at institutions, with the decision to approve each additional transfer based on an assessment of the previous transfer's effectiveness based on established performance metrics. **Recommendation 3.2:** The BOP Director should begin by transferring line authority over healthcare staff and resources at each of the seven FMCs from the responsible Regional Directors to the Assistant Director at HSD. **Recommendation 3.3:** BOP leadership should transfer the Regional Health Services Administrators and the regional staff reporting to them under the authority of the National Health Services Administrator in HSD's Central Office. **Recommendation 3.4:** BOP leadership should make the improvement of healthcare data analytics capabilities as part of a BOP strategic plan under the broader strategic goal of improving the capacity of BOP to deliver healthcare to inmates effectively and efficiently.
Section 4: Challenges Related to HSD's Dependence on Other BOP Headquarters Divisions for Support Services
Recommendation 4.1: BOP leadership should prioritize the implementation of Title 38 pay authority for physicians and dentists and provide HSD with additional staff resources, as needed, to support the implementation of Title 38. **Recommendation 4.2:** BOP leadership should provide HSD with adequate additional staff dedicated to the task of shepherding applicants for professional medical positions through the lengthy and complicated hiring process. These positions should have the authority to access candidate applications to help ensure that candidates are not disqualified due to inadequate documentation of qualifications.
Section 5: Opportunities for Improved Coordination of Mental Health Services
Recommendation 5.1: RSD and HSD should create a new, working-level mental healthcare group to further explore clinical coordination issues, consider options, and build support for possible solutions. The Committee should be co-chaired by the Chief

Psychiatrist at HSD and his/her counterpart at RSD. To help ensure action on issues, leadership of the Committee should shift between HSD and RSD on a regular basis and the Committee's work should be guided by clear goals and measures of progress accompanied by a requirement to report on progress against these goals to BOP leadership.

THIS PAGE INTENTIONALLY LEFT BLANK

Section 1: Introduction

The mission of Federal Bureau of Prisons is "to protect public safety by ensuring that federal offenders serve their sentences of imprisonment in facilities that are safe, humane, cost-efficient, and appropriately secure, and provide reentry programming to ensure their successful return to the community."[1] As part of this mission, the Bureau of Prisons must effectively deliver medically necessary healthcare to inmates in accordance with proven standards without compromising public safety.

As of March 2019, BOP is responsible for over 180,000 Federal inmates in three groups: 151,000 inmates in 122 BOP-operated prisons (institutions); 10,800 inmates in other types of facilities, including 200 Residential Reentry Centers (RRCs) sometimes called "halfway houses;" and 18,500 Federal inmates in privately managed facilities.[2]

BOP's Health Services Division is responsible for providing medical, dental, social, and psychiatric mental health services to inmates, including healthcare delivery, infectious disease management, and medical designations at BOP-operated institutions. Another division, the Reentry Services Division, is responsible for psychologist-provided mental health and drug treatment programs at BOP-operated institutions. RSD is responsible for healthcare for inmates in Residential Reentry Centers (RRCs).

Most healthcare inside BOP-operated institutions is delivered by BOP-employed staff to include Public Health Service (PHS) Commissioned Officers that are detailed from the Department of Health and Human Services. Inmates are transported to an outside medical facility whenever BOP institutions are unable to provide needed care. Healthcare to Federal inmates in RRCs and privately managed facilities is provided under contract (this assessment focuses on healthcare provided to inmates in BOP-operated institutions).

While HSD is responsible for healthcare at BOP institutions, on-going healthcare services provided at individual institutions fall under the direct authority of Wardens, rather than under HSD.

---

[1] https://www.bop.gov/about/agency/ (accessed December 2018)

[2] See the following link for Federal inmates population statistics; https://www.bop.gov/about/statistics/population_statistics.jsp Link accessed 3/22/19.

In response to the rising cost of healthcare, BOP has undertaken a variety of initiatives aimed at providing more efficient and effective healthcare to inmates. However, studies by the DOJ Office of Inspector General (OIG) and the Government Accountability Office (GAO) have found that BOP has not assessed the cost-effectiveness of these initiatives. A 2017 GAO report finds that BOP lacks certain data needed to understand and control its healthcare costs[3]. OIG reports have identified weaknesses in the administration of medical services contracts and the monitoring of healthcare providers[4]. GAO and OIG reports also point to the failure of BOP to address these deficiencies and the consequent risk of higher healthcare costs. While these studies call out important problems and offer recommendations for action, they give limited attention to the underlying organizational challenges that have hindered effective and efficient delivery of healthcare services by BOP.

Project Origin and Scope

The National Academy of Public Administration is one of three subcontractors to Chirality Capital, a company which has contracted with BOP to undertake an assessment of four critical functions that underpin BOP's statutory mandate to deliver medically necessary healthcare to federally incarcerated inmates:

1. the effectiveness of the organizational structure of the BOP inmate healthcare system **(the Academy's focus)**;
2. its capacity to collect, analyze and act on operational and financial data;
3. the need to develop a financial cost accounting model that would enable optimal fiscal stewardship and maximize cost avoidance; and
4. the need to acquire a data integration system that would inform strategic planning, judicious allocation of healthcare resources, and evaluation of operational and fiscal performance.

[3] United States Government Accountability Office. 2017. "Bureau of Prisons: Better Planning and Evaluation Needed to Understand and Control Rising Inmate Health Care Costs." Report to Congressional Requesters. https://www.gao.gov/assets/690/685544.pdf.

[4] United States Department of Justice. Office of the Inspector General. 2017. "Procedural Reform Recommendation for the Federal Bureau of Prisons."

The Academy's part of the larger assessment includes the following three deliverables:

3. Alignment of BOP's organization structure and lines of authority with the demands of effective and efficient management of healthcare operations;
4. HSD's approach to strategic planning; and
5. HSD's plan to support effective implementation of recommended changes.

This report constitutes the Panel's assessment related to the first deliverable. A second report, which will be submitted in several months, will address the second and third deliverables described above. Thus, this is the first of two Academy project reports.

Regarding the first deliverable addressing alignment of BOP's organization structure, the Panel examines steps that can be taken to enhance the overall quality, effectiveness, and efficiency of providing healthcare to inmates. The Panel was asked to focus more specifically on opportunities for improvement in the following three areas.

1. HSD's control over healthcare staff and resources as it relates to managing healthcare operations as a system and addressing issues at individual institutions.
2. Responsiveness of BOP support services to the particular needs of the healthcare mission.
3. Coordination between HSD and RSD on providing mental healthcare.

This is a report of five distinguished Fellows of the Academy. The research supporting the Panel's report was completed by a four-member Academy study team, working under the Panel's direction (brief biographical information on each member of the Panel and Academy study team can be found in Appendix A).

As noted, the Academy Panel's work fits into a broader set of tasks described in a master contract concluded between BOP and a prime contractor (Chirality Capital), which oversees subcontractors including the Academy, Adfinitas Health, and Federal Consulting Alliance (FCA). This group is henceforth referred to as "the Academy project partners."

Study Approach and Methodology

The Academy study team adopted a research methodology that focused on three work streams: BOP-related issues; best practices in public administration; and comparative analysis with other organizations and agencies. In the first work stream, we sought to

understand the challenges managing a healthcare system in the BOP environment. In the second work stream, we reviewed effective practices research for insights that might inform recommendations for change. In the third work stream, we looked at the experience of comparable organizations, such as other correctional and healthcare systems, for insights to inform recommendations.

The BOP asked for comparisons with at least two other government agencies and one large non-governmental healthcare system. Based on research and discussions with HSD and the Academy's project partners, the Panel determined that state correctional systems provided the most salient comparison for the assessment of the organizational structure of BOP's healthcare system. Thus the Panel considered the experience of four well-regarded state correctional systems.

Our research methodology included both documentary review and interviews. With respect to documentary review, the study team reviewed written materials on relevant topics prepared by BOP and other research organizations, academic articles on organizational structure and operations, and other research completed by auditors, such as the GAO and the OIG. The sources are either cited in footnotes in this report, or are noted in a bibliography found in Appendix D.

The study team conducted interviews with more than 40 individuals (see Appendix C for the list of interviewees during the course of this segment of our overall BOP project). The study team met with current and former BOP employees who are assigned to headquarters, Regions, and institutions. In addition, the study team met with representatives of GAO, other agencies and state correctional officials, associations, and others who focus on organizational structure and operations.

Organization of the Report

This report is organized into five sections. Section 2 provides background information on BOP and HSD as context to the report's research, findings, and recommendations. Section 3 discusses opportunities to improve HSD's ability to manage healthcare as a system and address issues at individual institutions and thereby better contain costs, maintain quality and manage risk. Section 4 addresses opportunities to address key support service challenges affecting HSD's ability to ensure effective and efficient management of healthcare operations. Section 5 focuses on challenges related to the coordination of mental healthcare.

Section 2: Background

This section provides an overview of BOP and HSD, providing basic information on the organizational structures and lines of authority. This is important context for understanding the environment in which the HSD operates, and recommendations made in Section 3-5. It is organized as follows:

- Overview of BOP's Organization
  - BOP Central Office
  - BOP Regions
  - BOP Institutions
- Overview of BOP's Health Services Division's (HSD) Organization
  - HSD Central Office
  - HSD Regional Staff
  - Health Services Unit at the Institutions

Overview of BOP's Organization

BOP is led by a Director who is appointed by the Attorney General[5] and a Deputy Director. The Deputy Director has sixteen direct reports: the leaders of six geographic Regions that oversee BOP facilities and institutions within each Region and ten staff offices, which represent BOP's Central Office in Washington, D.C. Figure 1 shows the current BOP organizational structure.

[5] At the time of this report, the Director position is vacant. There is a current Acting Director.

BOP's Current Organizational Structure

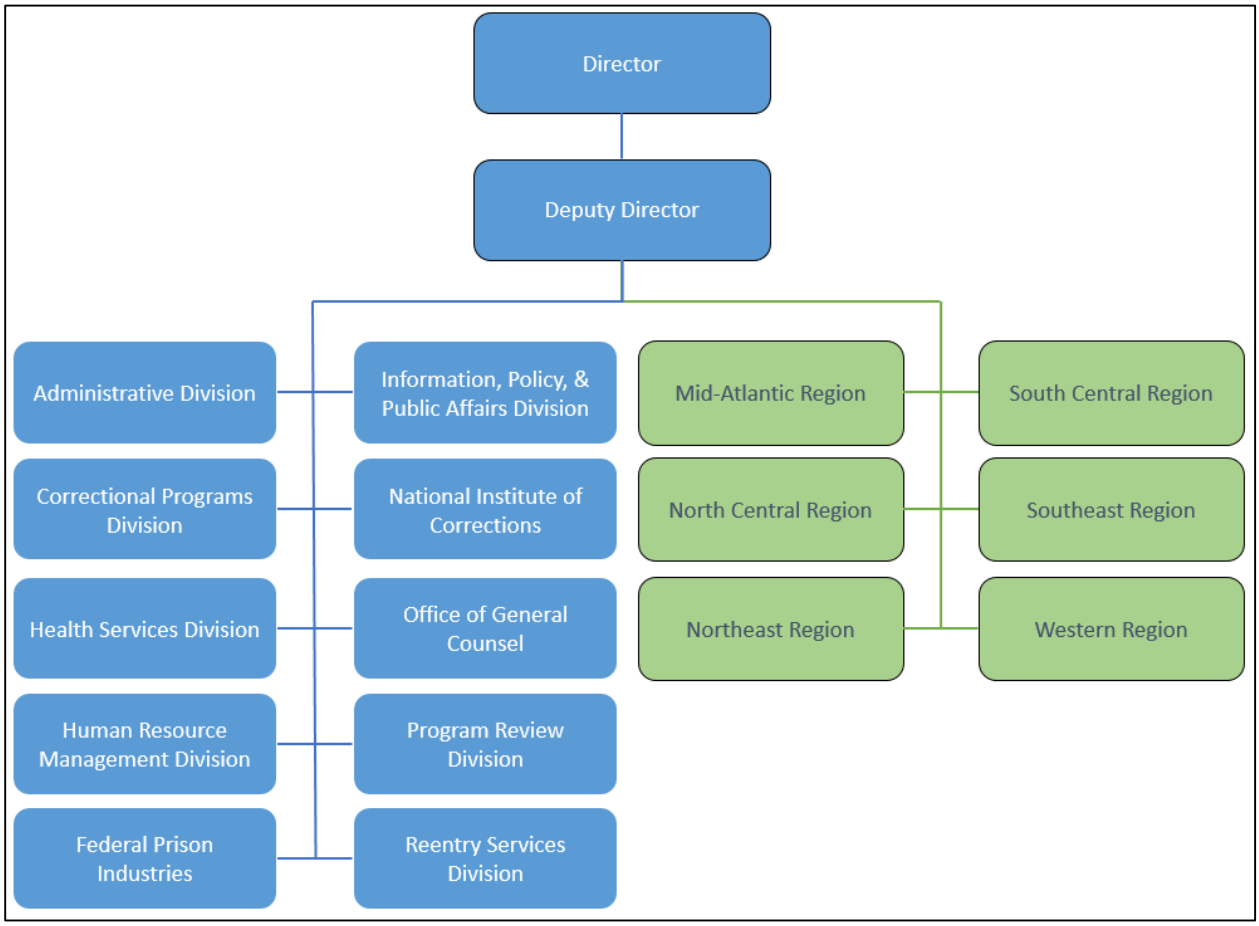

Figure 1: BOP Organization Chart

BOP Central Office

The ten staff offices that compose BOP Central Office include three mission focused offices, five mission-support offices, and two special program offices. The three mission-focused offices are:

- **Correctional Programs Division (CPD)** – inmate management, correctional programs, and inmate systems management;
- **Health Services Division (HSD)** – medical, dental, psychiatric, food/nutritional programs, occupational safety and environmental health; and
- **Reentry Services Division (RSD)** – chaplaincy, psychology, and reentry coordination and assistance.

BOP's five mission-support offices provide critical services to CPD, HSD, and RSD, as well as BOP leadership, in carrying out its mission. These are:

- **Administrative Division (ADMN)** – budget development, finance, and procurement;
- **Human Resource Management Division (HRMD)** – traditional personnel management;
- **Information, Policy, & Public Affairs Division (IPPA)** – information technology, policy management, public affairs, and research and evaluation;
- **General Counsel** – legal, policy, and management issues; and
- **Program Review Division (PRD)** – program analysis and review to evaluate program performance.

The remaining two special program offices are the National Institute of Corrections and Federal Prison Industries. The National Institute of Corrections[6] plays the critical role of providing research and statistics regarding the U.S. prison population and corrections. Federal Prison Industries is responsible for providing vocational training and programming to BOP's inmates.

BOP Regions

As shown in Figure 2, BOP has six Regions. The Regional offices provide oversight of, and assistance to, the 122 institutions and approximately 229 RRCs that operate across the country. Each Region is headed by a Regional Director (Senior Executive Service)[7] who reports to the Director of BOP, and is responsible for overseeing between 20-23 institutions. Regional Directors serve as an important interface between the Director of the Bureau of Prisons, and the Wardens of BOP's institutions. Each Regional office has a staff of around 47 employees who are a mix of mission and mission support personnel.

[6] The National Institute of Corrections is an agency within BOP that is headed by a Director appointed by the U.S. Attorney General. A 16-member Advisory Board provides policy direction to the Institute. It provides training, technical assistance, information services, and policy/program development assistance to Federal, state, and local corrections agencies.

[7] The Senior Executive Service is an experienced corps of dedicated federal employees who serve as the executive management of federal agencies. Senior Executives provide for institutional stability and continuity across Administrations, and serve as a vital link between political appointees, frontline managers, and the federal workforce of approximately two million employees.

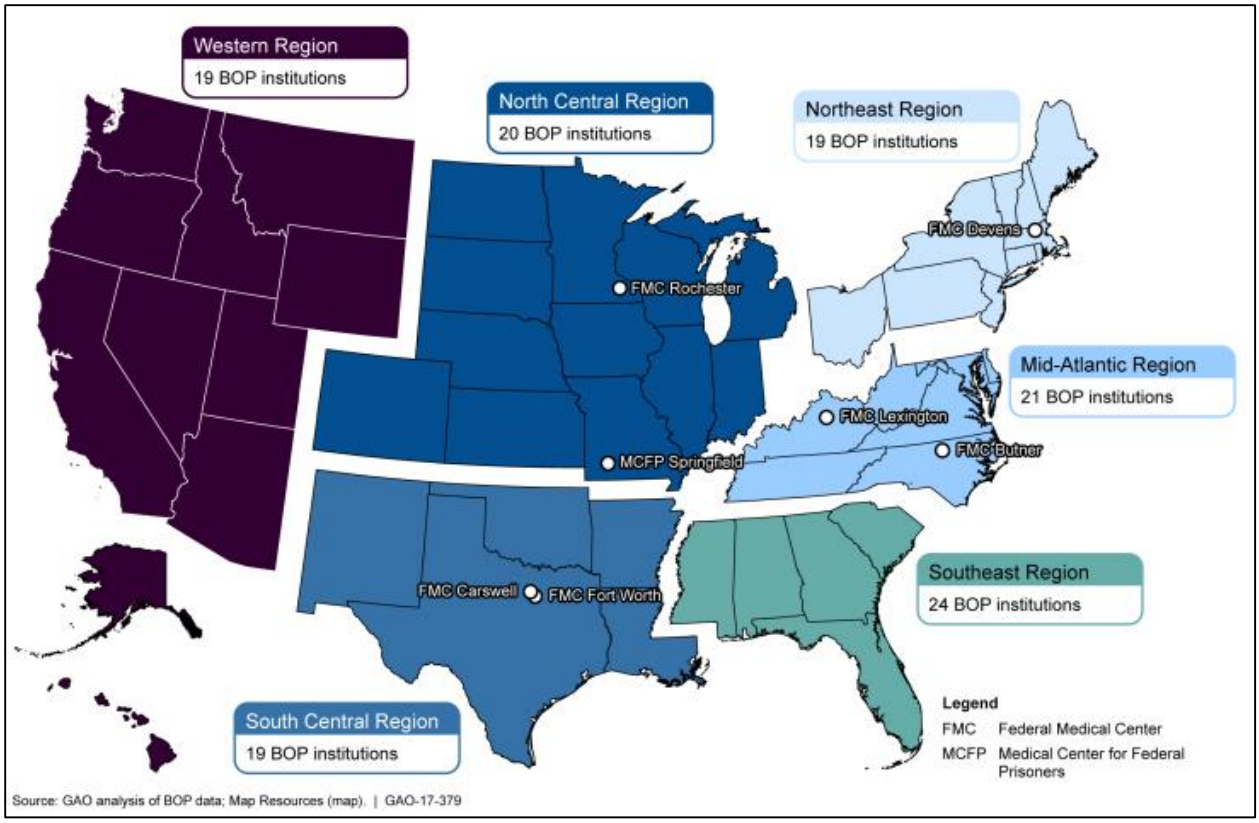

Figure 2: BOP Regions[8]

BOP Institutions

BOP institutions are classified by security levels – minimum, low, medium, and high. Each institution is overseen by a Warden and Associate Warden(s). The Warden is responsible for all services, staff, and resources that are provided within their institution. Every staff member within a BOP institution, with very few exceptions, works under the authority and direction of the Warden. This includes health services staff. Thus, Health Services Unit employees located at institutions are not under the direct authority of HSD Central Office or Regional leaders, but rather have dotted line connection with HSD, and otherwise are managed by Wardens and Regional Directors. The institutions operate their own support services including human resources and recruiting, information & technology management, and contracting support; all of which are ultimately directed by and responsible to the Warden.

[8] United States Government Accountability Office. 2017. "Bureau of Prisons: Better Planning and Evaluation Needed to Understand and Control Rising Inmate Health Care Costs." Report to Congressional Requesters. https://www.gao.gov/assets/690/685544.pdf.

Overview of HSD's Organization

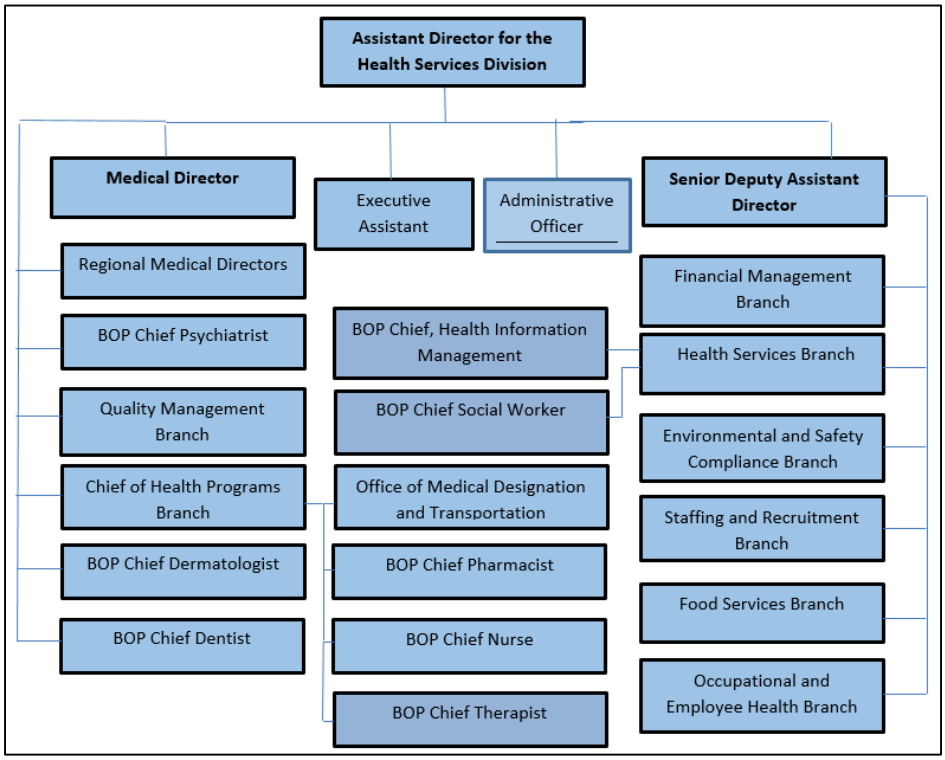

Figure 3: HSD Organization Chart

HSD Central Office

As noted in Figure 3, the **Assistant Director (AD) for Health Services** leads HSD's Central Office. HSD's Central Office is responsible for establishing goals and objectives for the health services system, to include both medical and mental health programs, and for evaluating performance against those goals and objectives each year. It also takes the lead on revising policy relevant to the delivery of health services at BOP, and it issues clinical guidance to health services staff at the Region, as well as at the institutions.

The **Senior Deputy Director for Health Services,** who reports to the AD, is responsible for setting the direction and strategy of non-clinical medical operations, to include health services (healthcare administration), financial management, occupational and employee health, environmental and safety compliance, clinical staffing and recruitment, and food services. Working for the Senior Deputy Director is the **National Health Systems Administrator (NHSA)**. The NHSA serves as an important role for health services administration and health information management; this is especially

important as it relates medical data management and managing health services as a system.

Reporting to the Assistant Director is the **Medical Director**, who is considered the final authority over clinical medical decisions and is responsible for providing direction, strategy, and clinical guidance for all clinical operations within BOP. Reporting to the Medical Director are eight **Chief Professional Officers**: Chief Psychiatrist, Chief of Health Programs, Chief of Quality Management, Chief Dermatologist, Chief Dentist, Chief Pharmacist, Chief Nurse, and Chief Therapist. The Chief Professional Officers oversee the specific clinical operations within their field; they ensure clinical practices are up-to-date and are considered the resident expert in their discipline.

HSD Regional Staff

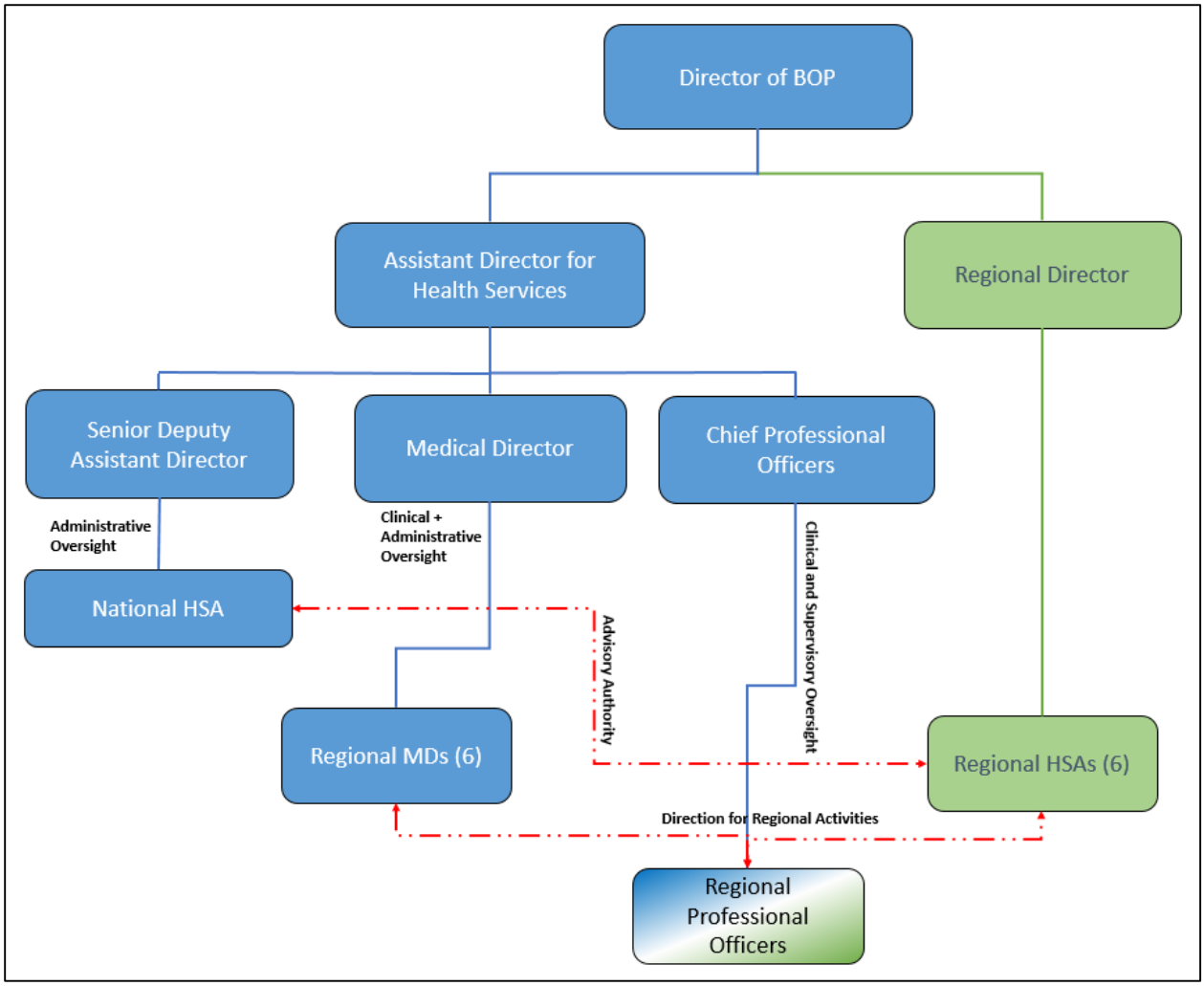

Figure 4: HSD Central Office and Regional Staff

As indicated in Figure 4, **Regional Medical Directors (RMDs)** are considered HSD Central Office staff, but are located at a field institution within that Region. RMDs report solely to the Medical Director at HSD's Central Office.

With the exception of RMDs, **Regional Professional Officers** operate under a dual or hybrid supervisory arrangement. HSD Chief Professional Officers provide clinical and supervisory (e.g., leave, hours worked, priorities) oversight of Regional Professional Officers. However, the Regional HSAs have the authority to deploy Regional Professional Officers as members of Medical Asset Support Teams (MAST) to address the medical needs of institutions in the region.[9]

Regional HSAs (RHSA) do not report to the NHSA and are not considered HSD Central Office employees. RHSAs report solely to the Regional Director and serve as an advisor on all matters related to healthcare delivery at the institutions. The Regional Directors have line authority over the RHSAs and therefore provide day-to-day direction to RHSAs. The NHSA has advisory authority over the RHSAs; meaning the RHSAs can choose to seek advice and practice from the NHSA, but are not required to follow it.

Health Services Unit at the Institutions

The delivery of health services at the institutions is carried out by the Health Services Unit (HSU). Every institution has an HSA and a Clinical Director (CD) who oversees the clinical providers based in the institution. The clinical and administrative staff in the HSU report to the Warden and Associate Warden of the institution. HSD provides policy and clinical guidance, but lacks line authority over HSU staff and resources.

Healthcare Staffing and Organization in the Field

With the exception of 94 Central Office employees, an estimated total of over 3,800 work within the HSUs of the institutions —over 3,100 civil service staff and about 700 Public Health Service (PHS) Commissioned Officers detailed from the Department of Health and Human Services. These HSU staffs fall under the line authority of Wardens.

[9] Since 2009, Regional Professional Officers have been organized into Medical Asset Support Teams (MAST) aimed at promoting an interdisciplinary approach to the medical needs of institutions in a region. For instance, MAST teams are often deployed to institutions to help prepare for program reviews.

BOP designates its institutions as a medical care level 1, 2, 3, or 4, depending on the level of medical and mental health services provided. The lowest level of medical care is 1, and the most advanced level of medical care is 4. BOP has seven Medical Referral Centers (MRCs), also commonly called Federal Medical Centers (FMCs).[10] The FMCs are primarily responsible for providing level 4 medical care, but in some cases also provide level 3 medical care as well. The seven FMCs account for the greatest concentration of HSU staff at institutions, including 257 of the 700 PHS officers and 908 of the 3,114 civil service healthcare staff.[11]

Each FMC has a specialized mission designated by HSD. FMCs are intended to serve the whole system, and not individual Regions. They do not align with BOP Regions as can be seen on the map of FMCs in Figure 2. For example, there are no FMCs in the Western Region and two in the South-Central Region.

Important HSD Horizontal Relationships

Similar to many federal agencies, BOP's HSD relies on other BOP Central Office Divisions to provide a range of support services including finance, contracting, hiring, IT, and policy. As one would expect, providing support to a health services mission requires specialized capabilities including knowledge of medical practices and healthcare administration. Doing so is made more challenging when the mission is to support a large, nationwide healthcare system operating within a corrections environment. The unique combination of health and corrections adds challenges that require HSD to maintain and depend on close collaborative relationships with BOP's support services, Regions, and institutions.

Also, as noted in Section 1, HSD must collaborate with the Reentry Services Division (RSD), which is responsible for an important piece of BOP healthcare, psychologist-provided mental health programs in BOP institutions.

[10] Six of the medical referral centers are named Federal Medical Centers (FMCs) and one is named United States Medical Center for Federal Prisoners. According to BOP, there is no relevant difference in the nature of these seven institutions. So, all are referred to as FMCs in this report.

[11] Information obtained in a data request by the project staff to HSD.

In recognition of the necessity to coordinate across Divisions and with 122 institutions to accomplish its healthcare mission, BOP established the Health Services Governing Board (the Governing Board) in 2005. The Governing Board seeks to facilitate greater coordination between HSD, BOP's support services, RSD, Regions, and institutions. It is chaired by the Assistant Director for Health Services, and the BOP Deputy Director is a permanent member of the Board. The Board has six subcommittees: (1) Finance and Resource Allocation, (2) Medical Staffing, (3) Information Management and Biotechnology, (4) Clinical Care and Risk Management, (5) Reentry Committee, (6) and an Executive Committee. By charter, it is required to meet once a year.

THIS PAGE INTENTIONALLY LEFT BLANK

Section 3: Opportunities to Improve HSD's Ability to Manage BOP Healthcare Operations as a System and Address Delivery Issues at the Institution Level

The Health Services Division is responsible for providing healthcare to federal inmates in BOP-operated institutions. However, the Panel finds that HSD's lack of line authority over healthcare staff and resources is significantly hindering its ability to ensure the effective and efficient delivery of healthcare to federal inmates at BOP-operated institutions. In this section, we discuss the following:

- Challenges related to HSD's lack of line authority over healthcare staff and resources.
- Opportunities (authority and non-authority) to improve HSD's ability to ensure effective and efficient management of BOP healthcare operations, to include:
    - Extending line authority to HSD over healthcare staff and resources across the system;
    - Extending line authority to HSD over just the seven FMCs initially
    - Moving Regional HSAs under HSD's chain of command; and
    - Using performance metrics (non-authority tool) to enable HSD to encourage the alignment of Wardens with healthcare mission priorities

Lack of Line Authority over Healthcare Staff and Resources Hinders HSD's Ability to Manage Healthcare Operations

While HSD is responsible for the effective and efficient delivery of healthcare to federal inmates in BOP-operated institutions, it lacks the authority to manage healthcare operations as a system and directly address issues at institutions. This significantly hinders HSD's ability to contain costs, maintain quality and manage risk.

HSD's authority is mostly advisory, limited to setting policy and providing input into a limited set of operational decisions, e.g. such as hiring and evaluation of only certain healthcare positions. With few exceptions, HSD lacks line authority over healthcare staff and resources. These exceptions include: (1) the purchase of medical equipment costing more than $5,000, which must be approved by HSD; and (2) supervision of

psychiatrists in HSD's Telepsychiatry Program (10 positions), which is intended to serve inmates in prisons providing care levels 1 through 3.[12] Most psychiatrists —28 positions[13]-- work in the seven Federal Medical Centers (FMCs) and fall under the authority of Wardens.

HSD's lack of line authority over healthcare staff and resources hinders its ability to ensure the effective and efficient management of healthcare operations in the following general ways.

- Cannot directly enforce compliance with policy guidance and thereby ensure consistent standards and practices across the system;
- Cannot allocate medical resources across institutions to address system-level needs; and
- Cannot directly address issues of staff performance and by extension, the quality of care (or data collected).

In the absence of line authority, HSD must rely on the cooperation of Wardens and staff under the correctional line of authority to ensure that appropriate medical care is provided to inmates. HSD officials emphasize that Wardens and institutional staff generally try to work cooperatively with HSD to accomplish what they all see as an important mission. However, such an arrangement is inefficient and uncertain. HSD must spend time reaching agreement on issues and marshaling support for action among Wardens and staff in the correction line of authority. Ultimately, action is contingent on the voluntary support of Wardens and staff, who change over time. Also, Wardens and staff have competing priorities and the organization of authority over healthcare staff and resources at institutions under individual Wardens hinders the management of healthcare operations as a system. This arrangement is particularly ill-suited to addressing complex system-wide issues.

[12] The Telepsychiatry Program is intended to provide a more cost-effective alternative to the practice of individual institutions using contract psychiatrists. While HSD has encouraged institutions to abandon the practice of using contract psychiatrists, it does not have the authority to make them do so. Moreover, HSD lacks ready access to data on the use of contract psychiatrists and expenditures on these contracts, so it is unable even to monitor this practice and assess its costs.

[13] Data on psychiatrist positions provided by HSD. While there are 28 total positions, 14 positions were identified as vacant.

Specific Challenges Related to HSD's Lack of Authority over Healthcare Operations

In this sub-section, we describe four specific challenges related to the current BOP structure that significantly hinders HSD's ability to contain costs, maintain quality and manage risk.

1. Ensuring Appropriate Healthcare Staffing Mix at the Institution Level
2. Planning Investment in Major Medical Equipment
3. Ensuring Standardized Collection of Healthcare Data
4. Managing medical beds

1. Ensuring Appropriate Healthcare Staffing Mix at the Institution Level

HSD sets policy on medical staffing for institutions. The level and mix of medical staffing for an institution is based on the size of the population of the institution, its care level designation, and the specialized needs of an institution's healthcare mission. HSD Central Office develops guidance on the ideal staffing mix for institutions based on population and care level, as well as several other factors such as special missions, logistical concerns, and security level of the institution. Institution HSUs are encouraged to consult with HSD on deviations from the ideal staffing mix to accommodate particular challenges, such as inability to fill certain positions. However, the institutions do not always consult with HSD Central Office. Maintaining the appropriate mix of healthcare staffing is important to ensuring the quality of care and avoiding unnecessary costs. Understaffing of Health Services Units at BOP's institutions has been directly linked to increases in outside medical services, the largest cost-driver of BOP's medical budget.[14]

HSD reports that institutions generally consult HSD on deviations from staffing plans. However, HSD does not have the ability to regularly monitor healthcare staffing at institutions due to a lack of accurate, readily accessible data on healthcare staffing at

[14] U.S. Department of Justice, Office of Inspector General, *The Impact of Aging Inmate Population on the Federal Bureau of Prisons* (May 2015), https://oig.justice.gov/reports/2015/e1505.pdf. See Also: U.S. Department of Justice, Office of Inspector General, *Review of the Federal Bureau of Prisons' Medical Staffing Challenges* (March 2016), https://oig.justice.gov/reports/2016/e1602.pdf.

institutions. This issue is addressed in more detail in Section 4 on support service challenges faced by HSD.

2. *Planning Investment in Major Medical Equipment*

In the exceptional case of major medical equipment, HSD has authority over the allocation of resources. Institutions must request funds from HSD and be approved to purchase medical equipment costing over $5,000. However, HSD makes these decisions on a reactive, case-by-case basis. HSD leaders are limited in their ability to make investments strategically from a system perspective for lack of a complete and current inventory across institutions. An electronic inventory system was implemented to address this challenge. However, participation is voluntary and institutions have not consistently provided the data needed.

3. *Ensuring Standardized Collection of Healthcare Data*

A key data limitation constraining HSD's ability to manage healthcare operations as a system is the lack of consistent utilization data on outside medical services, the single largest cost driver in the system (39 percent of total medical services costs in FY 2016).[15] This lack of consistent utilization data limits HSD's ability to contain medical costs in two ways. It precludes the move to regional or national medical services contracts that promise cost savings and it prevents Central Office analysis of utilization at system level that could identify opportunities for cost savings.

Individual institutions contract for outside medical services, but are under no requirement concerning the collection of utilization data. The resulting lack of consistent utilization data on outside medical services has hindered HSD's ability to evaluate the type and cost of care provided outside of HSD's system, thus limiting its ability to analyze such costs for the purposes of containing year–over–year spending increases in outside medical services. Additionally, the lack of utilization data hinders BOP's move from using institution-level contracts to regional contracts for outside medical services, which promises significant cost savings by means of economies of scale. The medical services industry has refused to bid on regional comprehensive care

[15] United States Government Accountability Office. 2017. "Bureau of Prisons: Better Planning and Evaluation Needed to Understand and Control Rising Inmate Health Care Costs." Report to Congressional Requesters, 18. https://www.gao.gov/assets/690/685544.pdf.

contracts without utilization data.[16] To address this challenge, HSD is seeking to implement a nation-wide medical billing adjudication contract, which would provide for the collection of standard utilization data. However, HSD does not have the authority to compel institutions to participate in this contract. BOP does in principle have the authority to compel participation in nationwide contracts, but in practice institutions can block such efforts as in the case of the prior attempt to implement a nation-wide medical billing adjudication contract.

4. Managing Medical Beds

Medical Level 4 care is defined in part by care enabled by the staff, equipment and facilities associated with a "medical bed." Medical beds fall into three categories: (1) 24-hour nursing; (2) ambulatory care; and (3) mental health. As of March 2019, BOP had a total of 3,634 medical beds, including: 468 24-hour nursing beds, 1,837 ambulatory care beds, and 1,329 mental health beds. All of BOP's medical beds are located at the seven FMCs.[17]

When the medical care level designation of an inmate is elevated to medical care level 4, that inmate must be transferred to an FMC. BOP policy prohibits medical care level 1-3 institutions from using observation beds "in lieu of transfer to a community hospital or MRC [otherwise known as an FMC]," and under no circumstances may an institution place an inmate in an observation bed who requires "medical treatment(s) normally provided in an MRC [otherwise known as an FMC] or community hospital setting."[18] So, if medical beds are not available at FMCs, BOP must pay for external medical care and the associated costs of providing security. That makes the efficient and proactive management of FMC medical beds essential to providing quality care, and containing costs by limiting the use outside medical services.

The organization of FMCs under individual Wardens hinders the efficient and proactive management of medical beds as a system-wide asset. Even though FMC Wardens and the institution healthcare staff may have the appropriate background and commitment to the healthcare mission, the tendency under such a structure is to make decisions with a focus on the implications for the individual institution, and not the healthcare system as a whole. For example, Wardens of FMCs can and do change the classification of a

[16] Ibid, 31
[17] Information obtained in a data request by the project staff to HSD
[18] U.S. Bureau of Prisons, *Program Statement: Patient Care* (June 3, 2014), https://www.bop.gov/policy/progstat/6031_004.pdf

medical bed to a custody bed to address other mission priorities. This decision's impact on the disposition of inmates on the waiting list is not necessarily a primary consideration. Likewise, institutional staff directly engaged in the management of medical beds will tend to focus on cost and workload implications for the institution rather than system-wide needs.

The Case for HSD Line Authority over Healthcare Staff and Resources at the Institution Level

The Panel undertook effective practice research, including a review of literature on the organization of correctional healthcare and interviews with leaders of four well-regarded state correctional systems (Colorado, Minnesota, Virginia, and Wisconsin) where central health authorities have staff authority over healthcare staff and resources.[19] Based on the literature and the examples provided by these state systems, the Panel concludes that line authority over healthcare staff and resources offers the greatest potential to ensure the effective and efficient management of healthcare operations in a correctional system.

Based on this research, the Panel also concludes that line authority over healthcare staff and resources can be successfully implemented without compromising the ability of Wardens to exercise the operational control over facilities needed to maintain the safety of personnel and inmates. It is understood that in times of crisis, complete authority in an institution is retained by the Warden.

However, the Panel believes that giving HSD line authority over healthcare staff and resources at all 122 BOP institutions in the near-term would not be advisable for three reasons: (1) the large risk of negative unintended consequences attending change in large, complex systems; (2) inadequate administrative capacity in the context of

[19] While the state corrections systems are small relative of the operation at BOP, one way to conceptualize their authority is as one of BOP's six Regions. As such, HSD's line authority over the staffing and resources could be delegated to the Regional level making a centralized health services more manageable. See: Anno, Jaye B. 2001. "The Organizational Structure of Correctional Health Services." In *Guidelines for the Management of and Adequate Delivery System*, by National Institute of Corrections, 97-116. Washington D.C.: U.S. Department of Justice.; Faiver, Kenneth L. 2017. In Humane Health Care for Prisoners; Ethical and Legal Challenges. Praeger.

reportedly severe staffing constraints at HSD Central Office; and (3) likely strong resistance within BOP to such a broad realignment of authority.

Given the many interrelationships in a large complex system, many of which are informal and poorly understood, any significant organizational change is likely to have unintended consequences. In a healthcare system, this can mean disruptions that might impact healthcare delivery.

HSD's capacity to take on additional administrative responsibilities is severely constrained due to the loss of Central Office positions and the current freeze on Central Office hiring.[20] Current Central Office positions are down from 108 to 94 with only 78 filled. Many HSD Central Office staff members are already covering the responsibilities of multiple positions. While the hiring freeze was lifted in a memorandum from the Office of the Attorney General in April 2019, it was in effect for over two years.[21] It will take time for HSD to fill positions in the field and in Central Office, and for qualified candidates to make their way through the onboarding process at BOP.

A realignment of authority over healthcare staff and resources would be a major break with the BOP tradition of Wardens having authority over all institution staff and resources. It would likely be seen by many Wardens as threatening the operational control needed to ensure security and safety of inmates and staff in a dangerous correctional environment. A realignment of authority across all 122 institutions without sufficient preparation almost guarantees significant opposition.

In light of these considerations, the Panel recommends a staged approach to realigning authority over healthcare staff and resources at BOP institutions. Such an approach offers three advantages:

---

[20] BOP Central Office is under a hiring freeze issued by the Administration. Under this freeze a vacant position can only be filled by new hires after two positions have been vacated due to attrition. Trump, D. J. (2017, January 23). *Presidential Memorandum Regarding the Hiring Freeze.* Retrieved from White House Website: https://www.whitehouse.gov/presidential-actions/presidential-memorandum-regarding-hiring-freeze/ Under this freeze, only one position can be filled for every two positions left vacant by attrition. The freeze was lifted in April of 2019.

[21] United States Department of Justice. Office of the Attorney General. 2019. "Memorandum for Heads of Department Compoenents and United States Attorneys (Subject: Lifting the Hiring Freeze)." Washington, DC, April 9. https://www.justice.gov/oip/foia-library/ag_memo_lifting_the_hiring_freeze_4_9_2019/download.

1. Mitigates risk by minimizing disruption and providing time to adjust as needed to unanticipated challenges;
2. Provides time to build the needed administrative capacity; and
3. Provides an opportunity to demonstrate the value of realigning authority over healthcare staff and resources and assuages concerns, thereby lessening opposition to realignment.

The ability of HSD to demonstrate the value of realignment at each stage will depend on having a clear set of goals and metrics, and a process for assessing progress against these goals. While these goals should relate to improved system-wide performance they, must also be clearly linked to the concerns of individual institutions, such as time spent waiting to transfer inmates to institutions that can provide the designated level of care.

Recommendation 3.1: BOP leadership should commit to a long-term plan of incrementally transferring HSD line authority over healthcare staff and resources at institutions, with the decision to approve each additional transfer based on an assessment of the previous transfer's effectiveness based on established performance metrics.

Furthermore, the Panel recommends that the transfer of line authority should proceed in three stages.

1. Extend line authority over the healthcare staff and resources of the seven Federal Medical Centers (FMCs) and co-located level 3 facilities where it is determined that there are critical interdependencies (e.g., shared staffing) that would be disrupted by placing the FMC under separate administration.
2. Extend line authority over the healthcare staff and resources of the remaining care level 3 facilities.
3. Extend line authority over the healthcare staff and resources at institutions designated care level 1 and 2.

The selection of institutions for inclusion in these stages reflects the Panel's determination regarding where the extension of line authority promises the greatest opportunities for improving HSD's ability to contain costs and maintain quality. Consequently, the Panel begins with those institutions serving the most ill inmates and employing the greatest concentration of medical staff and resources. We elaborate on this logic in our discussion below arguing for the initial extension of line authority over

healthcare staff and resources at the seven Federal Medical Centers (FMCs) and selected level-3 facilities.

The Case for HSD Line Authority over Healthcare Operations at the Seven Federal Medical Centers

The Panel concludes that the transfer of line authority to HSD over healthcare staff and resources at institutions should begin with the seven FMCs. Line authority over healthcare operations at the FMCs offers the greatest opportunity for improving the capacity of HSD to contain costs and maintain quality.

The FMCs serve the inmates who are the most ill in the system and they account for the largest concentration of healthcare staff and resources. The FMCs represent 29 percent of BOP civil service healthcare staff and 37 percent of Public Health Service staff. FMCs account for all of BOP's medical beds. As discussed earlier in this section, the efficient and proactive management of these beds is critical to the ability of HSD to ensure the appropriate level of care for inmates internally and minimize the cost of external medical services.

In the absence of line authority, HSD chartered the MRC Executive Advisory Board (EAB) in 2018 to facilitate more systematic management of the FMCs on a cooperative basis. The EAB, which includes the Assistant Director, Senior Deputy Assistant Director, Medical Director, and National Health Services Administrator of Health Services and the Wardens of the seven FMCs, meets regularly to address system-level management issues. One example of success cited is the agreement by one FMC Warden to open up a floor of the facility to specialize in dementia inmates, a population that has a high demand on the finite number of medical beds across the enterprise.

While the EAB has proven useful as a voluntary effort within the existing structure of Warden authority over healthcare staff and resources, it is inherently inefficient and uncertain. HSD must go through a process of reaching agreement on issues and marshaling support for action. And, the success of the venture ultimately depends on the active engagement of Wardens, who may frequently have competing concerns and may change over time.

By contrast, line authority would allow HSD to more directly and proactively address opportunities to control costs and maintain quality at the system level, and in particular, through the more efficient management of medical beds and a strategic approach to identifying and building capacity. The more efficiently medical beds are managed, the more beds are available to take inmates who need them and avoid putting inmates in beds outside the system, which are substantially more expensive.

Moreover, with line authority over healthcare staff, HSD will be better positioned to standardize and collect a variety of important healthcare-related data (e.g., utilization, major medical equipment inventory). This will, in turn, support more effective and efficient management.

Recommendation 3.2: The BOP Director should begin by transferring line authority over healthcare staff and resources at each of the seven FMCs from the responsible Regional Directors to the Assistant Director at HSD.

Moving Regional Health Services Administrators under the National Health Services Administrator

Besides transferring to HSD line authority over healthcare staff and resources at FMCs, the Panel identifies another opportunity to enhance the ability of HSD to ensure the effective and efficient management of healthcare operations: realign Regional Health Services Administrators (RHSA) under the National Health Services Administrator (NHSA) in HSD.

The Panel believes that realigning the RHSA under the NHSA would provide two benefits:

1. Enable HSD to more efficiently coordinate the activities of its Regional Professional Officers and ensure alignment with healthcare mission priorities; and
2. Lay the groundwork for the transfer of line authority to HSD over healthcare staff and resources at institutions beyond the seven FMCs.

The RHSAs are a critical link between HSD and Regions in that they are responsible for deploying regional Medical Asset Support Teams (MAST) teams to address critical medical needs at institutions in the region. RHSAs are familiar with the healthcare challenges facing institutions in the region and are well positioned to direct the activities of the MAST teams.

However, the shared authority over MAST team members between the RHSA and the Chief Professional Officers at HSD (discussed in Section 2) sometimes leads to conflicts. For instance, MAST team deployments to institutions may conflict with assignments by Chief Professional Officers to Regional Professional Officers. Resolving these conflicts is complicated by the fact that RHSA in each region reports to the Regional Director (RD) and must act on the RD's priorities. In those instances, issues often must be elevated to HSD leadership for resolution. Realigning the RHSA under the National HSA would help avoid these conflicts through the improved communication under a unified authority structure.

Realigning the RHSA under the National HSA would also begin laying the groundwork for the transfer of line authority to HSD over healthcare staff and resources at institutions beyond the seven FMCs. It would establish the regional link, a future line of authority from HSD to the health services units of other institutions. Current RHSAs will gain experience in this arrangement and participate in planning for the future extension of line authority to the institution level.

Recommendation 3.3: BOP leadership should transfer the Regional Health Services Administrators and the regional staff reporting to them under the authority of the National Health Services Administrator in HSD's Central Office.

Performance Metrics Potentially a Powerful Non-Authority Tool for HSD to Align Institutions with Healthcare Mission Priorities

Line authority is the most direct way to coordinate activities within an organization. However, organizational literature identifies three other mechanisms which can enhance coordination that can serve as alternatives or complements to authority for compelling coordination. These three are common interest, exchange and the

combination of data and technology.[22] The Panel focuses on the last of these: developing pertinent data on performance and using technology to make them visible to everyone in the organization as a means of motivating action toward the desired goals. More specifically, the Panel examines the potential of HSD's efforts to induce Warden action that it seeks by making data on performance metrics for individual institutions available to everyone in the organization in real time. As such, Warden performance with respect to healthcare services can be observed across the system, and these data can even be used as a means of rating and comparing performance (when outcome-related metrics are carefully identified, commonly measured with integrity, and regularly reported).

Performance metrics and dashboards currently being developed by HSD's data analytics group have the potential to serve as powerful ***non-authority*** tools for encouraging the alignment of Warden efforts with healthcare mission priorities by providing the insights and feedback on both directions of needed changes and progress toward improvement goals. Timely, meaningful and accurate data can also stimulate both collaboration and healthy competition with their peers.

The development of these metrics and dashboards has been focused on clinical performance metrics, but could be extended over time to include financial performance metrics and applied to other institutions.

Continued progress on performance metrics and dashboards is threatened by two factors: (1) a lack of dedicated resources; and (2) uncertain cooperation by BOP support functions, such as finance and IT. Below we briefly describe issues connected to these two factors:

Lack of dedicated staff and resources

Data analytics is the responsibility of an Advisory Group, which depends on the efforts of individuals working on a collateral duty basis with little institutional basis.[23] The mining of the BOP Electronic Medical Records (BEMR) system for data and the

[22] In the case of common interest, organizations or components of an organization are motivated to cooperate by a shared interest in achieving a given goal. In the case of exchange an organization or component is motivated to cooperate by the prospect of receiving a benefit distinct from the intended outcome of the cooperative action.

[23] A memo was issued appointing staff who volunteered (and received Warden concurrence) to serve on the Data Analytics Advisory Group. However, presently there is no formal charter for the group.

development of metrics and dashboards falls primarily on one member of the data analytics working group.

The effort has reached capacity. Little can be done beyond maintaining existing dashboards. Also, sustaining this effort let alone making further progress is put at risk by a single point of failure (i.e., a single staff member with key skills).

Uncertain cooperation by BOP support functions, such as Finance and IT

The development of operational metrics will depend in part on access to financial data from the Administration Division and cooperation by the Office of Information Systems (OIS) will be needed to implement systems to enable Wardens and other decision-makers real-time access to performance metrics. However, this will require substantial investments of time and resources by Administration Division and OIS staff amid competing priorities. Therefore, the continued progress of HSD's data analytics program will require sustained support by BOP leadership both in terms of obtaining additional staff and resources and to ensure the needed cooperation by BOP headquarters support organizations.

The Panel's aim is to discuss a vision for organizing HSD's data analytics efforts as part of its combined strategic planning/change management deliverable. This is contingent on the Academy's project partners having decided on technical recommendations for building HSD's electronic medical records and data analytics capabilities. At this time, we will be in a better position to consider various organizational options. One possible set of options is suggested by the experience of the Department of Veterans' Affairs and the Evidence Based Policymaking Act, namely the establishment of an agency level position with authority to coordinate cross-agency efforts to build data analytics capabilities.[24]

[24] The Department of Veterans' Affairs created a position at the Department level to help ensure the effective implementation of an Electronic Health Records system for the Veterans Health Administration, recognizing the need to ensure the coordination of various organizational components. https://www.appropriations.senate.gov/imo/media/doc/02.05.19--Byrne%20Testimony.pdf
The Evidence Based Policymaking Act provides for the creation of a Chief Data Officer at the agency level to coordinate the development of cross-agency data analytics efforts. See: U.S. Congress. House. *Foundations for Evidence-Based Policymaking Act of 2017*. HR 4174. 115th Cong., 1st sess. Report 115-411 https://www.congress.gov/115/crpt/hrpt411/CRPT-115hrpt411.pdf

To help ensure sustained focus, the development of healthcare data analytics capabilities should be included in a BOP strategic plan. It should be one objective of a broader strategic goal to improve the capacity of BOP to deliver healthcare to inmates effectively and efficiently.

Recommendation 3.4: BOP leadership should make the improvement of healthcare data analytics capabilities as part of a BOP strategic plan under the broader strategic goal of improving the capacity of BOP to deliver healthcare to inmates effectively and efficiently.

Section 4: Challenges Related to HSD's Dependence on Other BOP Headquarters Divisions for Support Services

HSD relies on BOP Central Office Divisions for a range of support services critical to carrying out its healthcare mission. As such, HSD is just one of several customers to be served by Central Office support service organizations. This situation presents two fundamental challenges: (1) HSD's service requests are not necessarily given priority by BOP Central Office support organizations; and (2) BOP Central Office support organizations lack the specialized capabilities to adequately address the requirements of HSD's healthcare mission in certain areas.

A third challenge related to obtaining the needed support services, goes beyond the responsiveness and expertise of individual Central Office support service organizations. In some cases, such as developing an integrated healthcare staffing database and reducing the length and uncertainty of the medical hiring process, not only would multiple Central Office support divisions have to coordinate, but the coordination of support elements within the 122 institutions would be required. Like HSD, Central Office support divisions do not control staff and resources at the institution level.

The study team engaged with HSD officials to identify specific support service challenges that most greatly hinder the ability of HSD to effectively and efficiently perform its healthcare mission. In each case, our research focus aimed to identify problems where a clear path forward is apparent, but where the support of BOP leadership is needed to ensure action by responsible parties outside HSD to provide resources. We focus on those areas where the scarce resource of top leadership support is most likely to be engaged and effectively put to use. We also call out important support service challenges that need to be addressed but that are complex and do not lend themselves to a clear recommendation for action and/or fall outside the administrative expertise that the Academy was called on to provide.

The Panel focused its assessment of support service challenges on four areas that most greatly hinder HSD's ability to achieve its healthcare mission:

1. Data analytics (addressed in Section 3);
2. Attracting and hiring medical professionals, physicians in particular;
3. Lack of an integrated, reliable database on healthcare staffing at institutions; and
4. Impediments to issuing/revising policy.

1. *Data Analytics*

Building a data analytics capability is a primary focus of the Academy's project partners on the broader Medical Data Management study. The support challenges related to building a data analytics capability are addressed in Section 3 as they relate to developing performance metrics as a non-authority tool for HSD to incentivize the alignment of Wardens with healthcare mission priorities.

2. *Attracting and Hiring Medical Professionals*

Adequate and timely staffing of medical professionals at BOP institutions is critical to providing quality care and containing costs. As noted earlier, understaffing of healthcare positions at BOPs institutions has been directly linked to increases in outside medical services, the largest cost-driver of BOP's medical budget.[25]

Filling vacancies in medical professional positions is a particular challenge for BOP. First, in addition to the general government challenge of providing competitive compensation vis-à-vis the private sector, BOP has been hampered by low pay scales for civil service positions compared with its federal agency peer, the Department of Veterans Affairs (VA). (The Department of Defense has the benefit of its own more generous pay system.) Second, it is difficult for BOP to attract medical professionals to serve in correctional environments. And third, there is the additional challenge of recruiting medical professionals to work in the remote locations where many BOP institutions are located.

The VA has Title 38 pay authority for medical professionals, which allows it to pay civil service medical positions substantially more than BOP.[26] After long seeking to obtain Title 38 authority for physicians and dentists, BOP received OPM approval of Title 38 authority in January of 2019. [27] However, the period of time when BOP will implement

---

[25] U.S. Department of Justice, Office of Inspector General, *The Impact of Aging Inmate Population on the Federal Bureau of Prisons* (May 2015), https://oig.justice.gov/reports/2015/e1505.pdf. See Also: U.S. Department of Justice, Office of Inspector General, *Review of the Federal Bureau of Prisons' Medical Staffing Challenges* (March 2016), https://oig.justice.gov/reports/2016/e1602.pdf.

[26] *Veterans' Benefits, U.S. Code 38* (1958), §§ 7431

[27] HSD targets for implementing Title 38 authority for physicians and dentists are January 2020 and May 2020 respectively. HSD earlier received Title 38 authority for psychiatrists and implemented the authority. Title 38 authority was implemented for psychiatrists in 2016.

this authority reportedly could extend beyond 2020. In any case, it will take substantial time and, more importantly, the focused effort of HRMD, amidst competing demands.

Also, implementation will take substantial HSD staff time to coordinate and support HRMD. HRMD must tap the specialized expertise of HSD staff related to implementing important aspects of the authority, such as the "market pay" factors that provide for additional pay beyond the base pay.[28]

Recommendation 4.1: BOP leadership should prioritize the implementation of Title 38 pay authority for physicians and dentists and provide HSD with additional staff resources, as needed, to support the implementation of Title 38.

HSD officials have expressed the intent to seek Title 38 authority for other medical professionals including, but not limited to, advanced practice providers, physician assistants, and nurse practitioners. The Panel supports future efforts to extend Title 38 authority for other medical professionals, after the successful implementation of Title 38 authority for physicians and dentists.

While successful implementation of Title 38 will greatly aid in attracting medical professionals, BOP will still face the challenge of a lengthy and uncertain hiring process. Reportedly, the hiring process for medical professionals can take six months or more. This is a major handicap when medical professionals are often hired within weeks in the private sector.

The BOP hiring process for medical professionals was the focus of an internal BOP study commissioned in 2015 by the Health Services National Governing Board and conducted by BOP's Federal Prison Industries. The report, commonly referred to as the

[28] According to Section 7431 (C) of Title 38, "Market pay shall meet the following requirements:

a. Reflects the recruitment and retention needs for the specialty or assignment in a facility
b. Determined by the Secretary on a case-by-case basis
c. Determination of market pay shall take into account factors including:
    i. Level of expertise
    ii. The need for the position at the medical facility
    iii. The healthcare labor market in the geographic area the Secretary considers appropriate
    iv. Employee's board certifications

Lean Six Sigma report, documented a complicated process with many touch points in at least 11 different BOP organizations/locations, including various components of HSD, the Human Resources Management Division Central Office, the Human Resources Services Center/Grand Prairie, Regional offices, and BOP institutions.

The Lean Six Sigma report identified a variety of factors–inefficiencies and delays–contributing to the length and uncertainty of the BOP hiring process. These included manual processes, stove-piped information systems, a lack of information sharing, frequent errors and incomplete packages provided by institution HR staff, and the consequent need for rework. Delays were also attributed to the failure of applicants to provide a complete set of documents and information despite follow up and extensions provided by Grand Prairie.

The report makes a range of recommendations to address inefficiencies and delays. However, the improvements to be achieved by these changes are not quantified. It is not clear from a review of the report what actions might offer the greatest improvement and what would be required to achieve it, such as automating manual process within and across components. Moreover, the report identifies high turnover and inexperience of HR staff at the institutions as a source of inefficiency and delay. Neither HRMD nor HSD have authority over these staff.

Short of overhauling this complicated hiring process (which is beyond the scope of this assessment), the Panel believes that action can be taken to help applicants navigate the process, minimize delays, and avoid pitfalls. This would entail hiring personnel with HR expertise and knowledge of the hiring process who could shepherd applicants through the process from the beginning, make sure all the right information is put together and intervene as needed to move things along. It is also important to maintain continuing contact with the applicant to reduce the risk that they will give up and go elsewhere.

In the past, HSD has relied on Regional Medical Recruiters to assist applicants and institution HR staff with the hiring process of healthcare professionals. While this arrangement was not ideal in that it distracted from the main task of recruitment, it did provide for at least one professional in each region with a focus on helping applicants navigate the hiring process, minimize delays, and avoid pitfalls. However, two of the six Regional Medical Recruiter positions are vacant and HSD's National Medical Recruiter position is vacant due to retirement. At the very least, action is needed to

make sure this minimal infrastructure is fully staffed. Ideally, staff dedicated to helping applicants navigate the hiring process should be added. HSD staffing is already stretched by the loss of positions and limits on Central Office hiring imposed by the Trump Administration's 2017 hiring freeze.[29] Additional staffing resources will be needed for the facilitator role to be effective in aiding the hiring process without impeding other recruitment.

One major pitfall identified in our research is the disqualification of candidates for failure to provide the documentation needed to obtain certification from BOP's Human Resources Service Center in Grand Prairie, Texas. While Regional Medical Recruiters are able to instruct candidates on the documentation needed, only the ability to inspect the application file itself can fully safeguard against mistakes that can disqualify candidates. Currently, Regional Medical Recruiters do not have such permission. Therefore, in addition to creating/filling these positions, the positions should be given the authority to view applicant files to help ensure that all the required documentation and qualifying information are provided.

Recommendation 4.2: BOP leadership should provide HSD with adequate additional staff dedicated to the task of shepherding applicants for professional medical positions through the lengthy and complicated hiring process. These positions should have the authority to access candidate applications to help ensure that candidates are not disqualified due to inadequate documentation of qualifications.

Another source of uncertainty in the medical hiring process is connected with the Core Values Assessment (CVA) (while we speak in this section about the CVA based on our interview research, we also note that BOP has not granted access to review the CVA to project partners, as a matter of general policy). The CVA is an automated questionnaire administered to candidates for all positions at BOP. It includes questions intended to assess the willingness of candidates to carry out correctional duties. The CVA reportedly includes a question about whether the candidate would be willing to use lethal force against an inmate, if required, in the course carrying out these correctional

[29] Trump, D. J. (2017, January 23). *Presidential Memorandum Regarding the Hiring Freeze.* Retrieved from White House Website: https://www.whitehouse.gov/presidential-actions/presidential-memorandum-regarding-hiring-freeze/ Under this freeze, only one position can be filled for every two positions left vacant by attrition. This freeze was lifted in April 2019.

duties.[30] HSD officials and HSU staff members have expressed frustration about losing qualified candidates for medical positions because of such questions. They explain that such questions to medical professionals run counter to their medical training and ethical commitments. While a matter such as this may make sense in a correctional context, the study team has been unable to adequately and precisely comprehend the nature and gravity of this problem. According to HRMD officials, physicians pass the CVA 90 percent of the time, which is the highest pass rate for all categories of applicants.[31] HSD officials and HSU staff also note that the challenge presented by the CVA is compounded by the requirement that candidates who fail the CVA cannot retake it for one year.

While some CVA questions referenced above might conceivably be modified, our research indicates that removing them may not be a feasible option. As a matter of policy, all BOP employees are considered correctional officers and are expected to carry out correctional duties as required. Provision could be made for making training available to candidates in advance of completing the CVA in the process in order to minimize the number of health professionals who fail the CVA simply because of unfamiliarity with the correctional duties of the job. Indeed, this was a recommendation of the Lean Six Sigma study, discussed earlier. We agree with that study, which recommends that the required time before a candidate can retake the test be shortened so that the focus should be on minimizing failure of the test. The Panel generally agrees with these recommendations found in the Lean Six Sigma report, including the idea of developing a training video for recruitment purposes.

3. Lack of an Integrated, Reliable Database on Healthcare Staffing at Institutions

As discussed in Section 3, maintaining an appropriate mix of medical staffing is critical to ensuring quality of care and containing costs by avoiding the use of more expensive outside care. Toward these ends, HSD was given the authority to approve the medical staffing plans of institutions. However, the effectiveness of this authority is undermined by HSD's inability to regularly monitor healthcare staffing at institutions caused by a lack of ready access to accurate data.

---

[30] This has claim has been denied in interviews with HRMD officials, but as noted earlier, the study team has been unable to confirm this because the Panel's access to the questionnaire is not allowed.

[31] The study team was told that this pass rate is documented in annual reports. The study team has requested these reports from HRMD but has not yet received them.

Currently, the determination of healthcare staffing is a time-consuming, one-shot effort that entails cleaning, validating, and reconciling data from three data bases maintained by two other Divisions. This is not practical for regular and timely monitoring.

The three databases are:

1. **PZ Report** – This report provides information on actual positions existing and the quantity. This is an accurate report. This is the controlling document. It comes in every month. This database is maintained by the Administration Division (ADMN).
2. **Pay Data Report** – This database provides reliable pay data on civil service positions, but pay data on Public Health Service officers is less reliable because of the movement of these personnel and how they are tracked. This database is maintained by ADMN.
3. **Staffing Report** – This report, which comes out twice monthly, provides information on vacancies in positions by job series, grade, and position name. It is generally agreed that the data provided in this report are highly inaccurate. This database is maintained by HRMD.

Addressing the data integration issue would require coordinated action by two separate Central Office Divisions and resources for developing an integrated database. More difficult still, it would require coordinated action at the institution level. The staffing report, while maintained by HRMD, depends on data entered by staff at the institutions over which neither HRMD nor HSD has direct authority.

The recently enacted First Step Act mandates regular reporting on vacancies in medical positions, but does not require reporting at a frequency that would enable regular monitoring.[32]

Action is needed to ensure that HSD has ready access to complete and accurate data on healthcare staffing at the institutions. However, a recommendation on how to address the current situation falls outside the administrative expertise the Academy was called upon to provide in this project. The Academy partners may choose to address this issue in their recommendations.

[32] The First Step Act requires the Director of the Bureau of Justice Statistics, with information that provided by the Director of BOP, to submit annually a number of statistics including "the vacancy rate for medical and healthcare staff positions, and average length of such vacancy," and "the number of facilities that operated, at any time during the previous year, without at least one clinical nurse, certified paramedic, or licensed physician on-site."

4. *Lengthy and Uncertain Policy Process*

Clear and current policy is essential to ensuring consistent standards and practices across the system. Effective policy helps to maintain consistent quality of care and the collection of standard clinical and operational data needed to monitor and manage healthcare operations as a system.

Because it lacks line authority over medical staff, HSD must rely on the program review process to enforce policy. Part of the policy process at BOP is the establishment of criteria to be used in program reviews. These reviews, undertaken by the Program Review Division, are taken seriously by the institution Wardens. Performance on program reviews is understood to be a key factor in the career advancement of Wardens.

Unfortunately, the BOP policy process is lengthy and uncertain, making it difficult for HSD and other Divisions to issue and revise policy in a timely way. For example, HSD has not been able to update a number of policies since 2005.

Difficulties in updating policy are attributed variously to union opposition and BOP's approach to the policy process. BOP's labor union, the Council of Prison Locals, gained the right to negotiate with BOP on matters of Agency policy in 1995. Under the Master Agreement with the Council of Prison Locals, draft policies are subject to formal negotiation.[33] Negotiations, which are to occur at least four times a year for two days each time, are bound by elaborate protocols for scheduling and deadlines for the provision of draft policy documents and response. This formal approach to negotiating policy has resulted in very limited action on policy.

Between the years 2013 and 2016, BOP's approach to negotiations, which was different than before or after, allowed for exceptional progress in updating policies. An Executive Order was issued allowing for a more frequent, less formal supplementary process for considering changes in policy.[34] Under this approach, ten Joint Policy Committees

[33] Federal Bureau of Prisons, Council of Prison Locals. 2014. "Master Agreement." Washington, DC: American Federation of Gvoernment Employees. https://www.afgelocal1034.org/ewExternalFiles/2014%20New%20Master%20Agreement.pdf.

[34] Executive Order 13522 of December 9, 2009, Creating Labor-Management Forums to Improve Delivery of Government Services," *Federal Register, 74* (2009): 66201-66206, https://www.federalregister.gov/documents/2009/12/14/E9-29781/creating-labor-management-forums-to-improve-delivery-of-government-services

organized around different technical areas were created. The Joint Policy Committees provided multiple venues for informal discussions about possible policy changes. Under this approach, BOP was able to successfully negotiate changes in a larger number of policies, including six of the twenty in the health services series.[35] With the reversal of the Executive Order, this less formal approach has been discontinued and progress on updating policies has stalled.

HSD does provide documents separate from policy in the form of clinical guidance. The advantage of issuing clinical guidance is that it allows HSD to communicate changes in clinical standards of care to the field. The disadvantage of guidance is that it is not mandatory and cannot be enforced through the program review process.

While action through the policy process is preferred, the Panel concludes that this is not a viable path under the current circumstances. The current approach to policy negotiations is a matter of general Administration policy and is beyond the authority of BOP leadership to change.

[35] https://www.bop.gov/PublicInfo/execute/policysearch?todo=query

THIS PAGE INTENTIONALLY LEFT BLANK

Section 5: Opportunities for Improved Coordination of Mental Health Services

Responsibility for mental healthcare programs at BOP is divided between HSD and the Reentry Services Division (RSD). HSD oversees psychiatric mental health services to inmates at BOP institutions, delivered via HSD's Telepsychiatry Program and staff psychiatrists working in the five FMCs with mental health missions and at Secure Mental Health Units.[36] RSD includes the Psychology Services Branch, which oversees approximately 600 psychologists providing mental health services and Reentry Services mission related services such as drug abuse and sex offender treatment programs.[37] These roles must be coordinated to ensure the integration of mental healthcare services to inmates.

Discussion in this section is organized as follows:

- Mental health coordination issues identified;
- Option for improving voluntary inter-Divisional coordination of mental healthcare; and

Mental Health Coordination Challenges

HSD and RSD officials interviewed expressed different views of the challenges to coordinating mental healthcare and of how serious the challenges are. Three issues were identified:

1. Conflicts between psychologists and psychiatrists regarding diagnosis and drug treatment;
2. Consultations by psychologists with psychiatrists on diagnosis and drug treatment creating an unsustainable workload on psychiatrists; and
3. Conflicts between physicians and psychologists regarding diagnosis and drug treatment.

Only psychiatrists, physicians, and advanced practice providers (e.g., Nurse Practitioners and Certified Physicians Assistants) and Clinical Pharmacists have authority to prescribe.[38] Therefore, BOP psychologists must consult psychiatrists or a

[36] BOP operates two Secure Mental Health Units at its Allenwood and Atlanta institutions.
[37] RSD officials provided this estimate of psychologist positions in interview on February 15, 2019.
[38] The prescribing authority of advanced practice providers and Clinical Pharmacists is provided through collaborative practice agreements.

physician on drug treatment decisions. Conflicts reportedly have arisen where psychiatrists have disagreed on whether and what course of drug treatment is needed. When disagreements cannot be resolved by the psychiatrist and psychologist involved, the issues in conflict may be referred up the professionals' respective chains of command making their way ultimately to the Chief Psychiatrist and Chief Psychologist at HSD and RSD for discussion and resolution.

HSD officials have noted such cases of conflict and described the inefficiency of the process for resolving them. However, they characterize these conflicts as isolated cases that were ultimately resolved without adversely affecting healthcare outcomes. RSD officials suggest that such cases are more frequent even if the complaints do not reach Central Office. They take issue with what they see as a lack of respect for the professional judgment of psychologists. They emphasize that psychologists are more familiar with inmates' conditions and behavior as they do the initial intake and deal with inmates on regular basis. For example, a psychologist on the ground is better able to determine whether an inmate is drug seeking than a telepsychiatrist, who is doing an evaluation remotely.

Even in the absence of conflict, the practice of psychologists consulting with psychiatrists has presented a workload issue given the very small number of psychiatrists at institutions. The 115 lower care level institutions are served by ten psychiatrists employed by HSD's Telepsychiatry Program.[39] The five FMCs with mental health missions and Secure Mental Health Units have 28 staff psychiatrist positions with a vacancy rate of 50 percent.[40] The Telepsychiatry Program is being tapped to fill gaps. To address this workload issue, HSD has encouraged psychologists to first consult physicians at institutions on drug treatment.[41]

Both HSD and RSD officials report some cases of difficult interactions between psychologists and physicians at institutions. This is attributed in part to some physicians not being knowledgeable or comfortable addressing mental health issues. There is disagreement on how serious an issue this is.

[39] Telepsychiatry Program has a total of twelve positions including the Chief of Telepsychiatry, but only ten positions, including the Chief position are filled.
[40] Data on psychiatrist positions provided by HSD.
[41] See discussion of "triage" on page 3 of BOP Telepsychiatry Program Guidelines, January, 14, 2016.

However, an external expert interview indicates that this issue is not specific to BOP. Rather, it is an issue even for many well-run healthcare systems outside the correctional universe.

What is clear is that there is concern among psychologists about maintaining their professional autonomy and apprehension about the prospect of coming under the authority of psychiatrists in a potential BOP reorganization. Also, there is resentment at not being treated as equal partners in dealings with HSD physicians and psychiatrists. One example offered is that psychologists were compelled to give up their patient record system in favor of BEMR. Another is that HSD leads the cross-Divisional Mental Health Clinical Care Committee (MHCC).

Given the lack of a clear, consistent definition of the coordination challenge and the apparent distrust and resentment, it seems prudent to focus on rudimentary efforts to build trust and improve cooperation. Such an effort might be aided by the creation of a neutral forum for identifying and addressing cross-Divisional mental health coordination issues.

Opportunity to Improve Voluntary Inter-Divisional Coordination of Mental Healthcare

The Panel concludes that the prudent course would be to focus initially on rudimentary efforts to understand the coordination challenge and identify possible solutions. Also, it concludes that a working-level group is best suited to enabling the frank and open discussions needed to explore issues, consider options, and build support for possible solutions. To help engender support for collaboration on both sides, the new group should be co-chaired by the Chief Psychiatrist at HSD and his/her counterpart at RSD.

With a co-chaired entity there is always the challenge of ensuring effective leadership. To help ensure action while respecting the joint nature of the effort, leadership of the Committee should be designed to shift back and forth between RSD and HSD on a regular basis. Another effective practice to help ensure action on issues would be to set clear goals and measures of progress accompanied by a requirement to report on progress against these goals to BOP leadership.

Recommendation 5.1: RSD and HSD should create a new, working-level mental healthcare group to further explore clinical coordination issues, consider options, and build support for possible solutions. The Committee should be co-chaired by the Chief Psychiatrist at HSD and his/her counterpart at RSD. To help ensure action on

issues, leadership of the Committee should shift between HSD and RSD on a regular basis and the Committee's work should be guided by clear goals and measures of progress accompanied by a requirement to report on progress against these goals to BOP leadership.

This recommendation should be considered as an initial, incremental step and should be revisited after the other recommendations have been implemented. This will provide time to better define issues and build support for action and enable greater leadership focus.

Appendix A: Panel and Study Team

Study Panel

Kristine Marcy,* ***Chair,*** Former President and Chief Executive Officer, National Academy of Public Administration; Consultant, McConnell International; Chief Operating Officer, Small Business Administration; Senior Counsel, Detention and Deportation, Immigration and Naturalization Service; Former positions with U.S. Department of Justice: Assistant Director for Prisoner Services, U.S. Marshals Service; Associate Deputy Attorney General, Office of the Deputy Attorney General. Acting Director, Deputy Director, Office of Construction Management and Deputy Budget Director, U.S. Department of the Interior; Deputy Assistant Secretary, Office of Civil Rights, U.S. Department of Education; Assistant Director, Human Resources, Veterans and Labor Group, U.S. Office of Personnel Management.

Harold Clarke,* Director, Virginia Department of Corrections. Former Commissioner, Massachusetts Department of Corrections; Secretary, Washington State Department of Corrections; Director, Nebraska Department of Correctional Services; Former Positions with Lincoln Correctional Center: Unit Administrator, Unit Manager; Former Positions with Nebraska State Penitentiary: Warden, Deputy Warden, Associate Warden/Custody, Assistant Superintendent, Rehabilitation Counselor/Supervisor, Institutional Counselor and Parole Advisor.

Thomas Garthwaite,* Former Vice President, Diabetes Care & Medical Director for Employee Health, Hospital Corporation of America, Nashville, TN. Vice President and Chief Operating Officer, Clinical Services Group, Hospital Corporation of America, Nashville, TN; Former Executive Vice President and Chief Medical Officer, Catholic Health East, Newtown Square, Pennsylvania; Former Director and Chief Medical Officer, Department of Health Services, County of Los Angeles, Los Angeles, California; Undersecretary for Health, Department of Veterans Affairs; Deputy Undersecretary for Health, Department of Veterans Affairs; Chief of Staff and Associate Dean, the Medical College of Wisconsin, Milwaukee, Wisconsin; Internal Medicine Residency, Medical College of Wisconsin Affiliated Hospitals; Endocrinology and Metabolism Fellowship, Medical College of Wisconsin, Veterans Medical Center.

Gary Glickman,* Former Managing Director, Health & Public Service Innovation, Accenture. Senior Policy Advisor, US Department of Treasury; Coordinator,

Partnership Fund for Program Integrity Innovation, Office of Management and Budget (OMB), Executive Office of the President; President and CEO, Imadgen LLC; President and CEO, Giesecke and Devrient Cardtech; President and Chief Marketing Officer, Maximus; President, Phoenix Planning & Evaluation, Ltd.; Principal/ National Director, Federal Consulting, Laventhol & Horwath; Practice leader, Financial Institutions Division, Orkand Corporation; Senior Consultant, Deloitte Consulting, LLP.; Team Member, Office of the Secretary, US Department of the Treasury; Chief, Financial Management Division, Office of the Comptroller of the City of New York.

Barton Wechsler,* Dean, Harry S. Truman School of Public Affairs, University of Missouri-Columbia. Former positions with Harry S Truman School of Public Affairs and Institute of Public Policy, University of Missouri: Director; Professor. Positions with Edmund S. Muskie School of Public Service, University of Southern Maine: Professor; Dean. Positions with Institute of Government and Public Affairs, College of Urban Planning and Public Affairs, University of Illinois-Chicago: Professor; Director of the Public Management Program. Positions with Florida State University: Director of Graduate Studies, Reubin O'D. Askew School of Public Administration and Policy; Associate Professor, Reubin O'D. Director, Florida Center for Productivity Improvement; Faculty Associate, Florida Center for Productivity Improvement.

Project Staff

Brenna Isman, *Director of Academy Studies:* Ms. Isman joined the Academy in 2008 and oversees the Academy studies and provides strategic leadership, project oversight, and subject matter expertise to all of the project study teams, providing guidance for the teams in developing work plans, research methodology, and comprehensive analysis and recommendations. She has also served as Project Director for Academy projects including assisting a national regulatory and oversight board in developing and implementing its strategic plan, directing a statutorily required assessment of the National Aeronautics and Space Administration's (NASA) use of its Advisory Council, and analyzing the Environmental Protection Agency's (EPA) practices for determining the affordability of regulatory mandates. Her prior consulting experience includes both public and private sector clients in the areas of communication strategy, performance management, and organizational development. Prior to joining the Academy, Ms. Isman held several consulting positions with a focus on facilitating effective organizational change and process improvement. She holds an MBA from American

University and a Bachelor of Science in Human Resource Management from the University of Delaware.

Roger Kodat, *Senior Project Director* – Mr. Kodat has directed more than 24 Academy projects, several focusing on organizational assessment, strategic planning, and change management. He brings 20 years of commercial and investment banking experience with JPMorganChase, and six years of senior level federal government experience at the Department of the Treasury. He was appointed by President George W. Bush in 2001 to serve as Deputy Assistant Secretary of Treasury, responsible for Federal Financial Policy. Some of his tasks at Treasury included: policy formulation for the 2006 Postal Accountability and Enhancement Act; rule-making and oversight of Federal loan and loan guarantee programs; and managing the Federal Financing Bank (a $32 billion bank at that time). Mr. Kodat holds a BS in Education from Northwestern University and both an MBA in Finance and MA in Political Science from Indiana University.

Jonathan Tucker, *Senior Research Analyst* — Dr. Tucker is a senior analyst and project director at the Academy. His areas of expertise include: strategic planning/foresight, organizational design, change management, and S&T/innovation policy. His public management consulting experience includes projects with twenty federal agencies. Recent projects include: assessment of research coordination function at the U.S. Department of Transportation; developing a strategic plan for the Office of Urban Indian Health Programs (U.S. Indian Health Service); developing options for the establishment of a new Under Secretary at USDA focused on international trade; developing a white paper for the Project Management Institute on institutionalizing project and program management in the federal government; assessing Census transformation initiatives; developing a long-term strategic plan for operational transformation at the Social Security Administration. In addition to his consulting activities, Jon contributes to the work of the Academy's Strategic Foresight Panel (part of the broader Academy Transition 2016 initiative). Dr. Tucker also has experience assessing science and technology policies and programs, with a focus on supporting innovation. He has worked for organizations including Battelle; the National Research Council; the National Institute of Standards and Technology; and the New York State Department of Economic Development. He holds a Ph.D. in Public Policy (with a concentration in Science and Technology Policy) from George Mason University, an M.S. in Science and Technology Studies from Rensselaer Polytechnic Institute, and a B.A. from New College of Florida.

Adam Darr, *Research Analyst*—Mr. Darr joined the Academy in 2015 as a Research Associate having previously interned in the summer of 2013. He has served on numerous Academy projects, including work for the National Science Foundation, Farm Service Agency, US Secret Service, Federal Aviation Administration, and National Nuclear Security Administration. His areas of emphasis have been governance and management reform, organizational change, human capital, project and acquisition management, customer service best practices, and strategic planning. Mr. Darr graduated from Virginia Commonwealth University (VCU) with a B.A. in Political Science and Homeland Security/Emergency Management.

Kyle Romano, *Research Associate* **–** Kyle recently graduated from the School of Public and Environmental Affairs at Indiana University where he earned a Master of Public Affairs. He attended the University of Central Florida for his undergraduate studies where he earned a BA in Political Science and a BS in Legal Studies. Kyle's internships and academic studies provided him the opportunity to work on economic development projects. As a research assistant with the Sanibel Re-Analysis Team, he worked with a team to identify the Everglades restoration project that would have the most significant economic impact on the Sanibel and Captiva Islands. Most recently, Kyle worked with the Hebrew Immigrant Aid Society where he reviewed documentation for refugee resettlement and researched opportunities for the self-sufficiency of refugees and asylum-seekers.

Appendix B: Acronym List

ACA – American Correctional Association

AD – Assistant Director

Admin – Administration Division

BOP, the Bureau, the Agency – Federal Bureau of Prisons

CD – Clinical Director

CDCR – California Department of Corrections

CPD – Correctional Programs Division

CSU – Consolidated Staffing Unit

DOC – Department of Corrections

DOJ – Department of Justice

FLRA – Federal Labor Relations Authority

FMC/MRC – Federal Medical Center/Medical Referral Center

FPI – Federal Prison Industries

GAO – Government Accountability Office

HRMD – Human Resources Management Division

HRSC – Human Resources Services Center

HSA – Health Services Administrator

HSD – Health Services Division

IPPA – Information, Policy, & Public Affairs Division

LSS – Lien Six Sigma

MAST – Medical Asset Support Team

MD – Medical Director

MXR – Mid-Atlantic Region

NCCHC – National Commission on Correctional Healthcare

NCR – North Central Region

NER – Northeast Region

NHSA – National Health Services Administrator

NIC – National Institute of Corrections

OGC – Office of General Counsel

OIG – Office of the Inspector General

ORE – Office of Research and Evaluation

PHS – Public Health Service

PRD – Program Review Division

RHSA – Regional Health Services Administrator

RMD – Regional Medical Director

RRC – Residential Reentry Center

RSD – Reentry Services Division

SCR – South Central Region

SDAD – Senior Deputy Assistant Director

SER – Southeast Region

UR – Utilization Review

WXR – Western Region

Appendix C: Participating Individuals and Organizations

Federal Bureau of Prisons

Health Services Division (HSD)

- Abrahims, Scott – Food Service Administrator
- Allen, Jeffrey, M.D. – Medical Director
- Ballom, Tecora, M.D. – Medical Director, South-Central Region (SCR)
- Bina, Chris – Senior Deputy Assistant Director
- Bingham, Ty, PharmD – Chief, Clinical Pharmacy
- Bingham, Ty, PharmD – Chief, Clinical Pharmacy
- Bur, Sarah – Infection Prevention & Control Officer
- Burkett, Jeffrey – Acting National Health Services Administrator
- Bush, Cecilia – Health Services Administrator
- Campbell, Eric – Director of Nursing
- Cohen, Sylvie, M.D. – Director, Occupational and Employee Health
- Conrad, Tami – Management Analyst
- Crockett, Michael, RPh – Chief, Pharmacy Logistics
- Day, Ron – Chief, National Environmental & Safety Compliance
- Dougan, Jeremy – Mid-Level Practitioner
- Duchesne, Carlos, M.D. – Staff Physician
- Dunwoody, Michelle – Chief Nurse
- Dusseau, Charles - SCR Quality Improvement/Infection Prevention & Control Coordinator; Data Analytics Work Group Leadership
- Edinger, Andrew, M.D. – Clinical Director
- Garcia, Alfredo – Assistant Health Services Administrator
- Griffith, Scott – National Health Technology Administrator
- Haskins, Torrey – Health Services Administrator
- Hogan, Lisa – Utilization Review Nurse
- Hogan, Lisa – Utilization Review Nurse Consultant
- Johnston, A. Martin – Chief Pharmacist
- Jones, Curtis – IT Specialist/Program Manager
- King, Julie – Infection Prevention & Control Officer
- Kynard, Melanie – Medical Contract Consultant
- Langor, Charles, M.D. – Clinical Director
- Lewis, Don, M.D. – Chief of Psychiatry

- Lockhart, Anita, DDS – Central Office Dentist
- Long, Mike – Southeastern Region (SER) Chief Pharmacist; Data Analytics Work Group Leadership
- Lopez de LaSalle, Abigail, M.D. – Medical Officer
- Manenti, John, M.D. – Medical Director, Northeastern Region (NER)
- McManus, Wendy – Health Services Administrator
- Ocampo, Jeanne – Chief, Health Informatics
- Patel, Tushar – Chief, Quality Management
- Pelton, James, M.D. – Medical Director, Western Region (WXR)
- Ramos, Rhodelynn, M.D. – Chief National Telepsychiatry Coordinator
- Seligman, Jay – Chief Social Worker
- Shult, Deborah G., PhD – Assistant Director
- Smith, Spencer – Regional Health Systems Administrator
- Sutcliffe, Judith – National Health Services Administrator
- Wilson, Eric – Clinical Director
- Zach, Theresa – Staffing and Recruitment Officer

Correctional Programs Division (CPD)

- Bell, Jesse – Warden
- Langford, Jason – Associate Warden
- Luna, Richard – Warden
- Ormond, J. Ray – Regional Director, Northeast Region
- Quintana, Francisco – Warden
- Smith, Michael – Warden
- Sproul, Dan – Senior Deputy Regional Director
- Sullivan, Barbara – Warden

Reentry Services Division (RSD)

- Gustin, Jon – Administrator, Residential Reentry Management Branch
- Leukefeld, Allison – Chief of Mental Health Services, Psychology Services Branch
- Litsey, Cherryl – Administrator, National Reentry Affairs Management Branch
- McLearen, Alix – Acting Senior Deputy Assistant Director
- Spencer, Latoya – Program Management Officer, Residential Services Branch
- Wentzel, Steve – Executive Assistant

BOP Support Services

- Allison, Susan – Chief, Policy Information Management Branch - IPPA
- Betchelder, Jennifer, PhD – Social Science Research Analyst – IPPA
- Cole, Kathy – Purchasing Contact; U.S. Penitentiary – ADMN
- Doggett, Darren – Chief, Procurement & Property Management; Field Acquisitions Office (FAO) Chief – ADMN
- Durkee, Carol – Chief, Budget Execution - ADMN
- Jacobs, Paul – Chief, Finance Branch – ADMN
- Kiernan, Sheila – Senior Deputy Assistant Director – HRMD
- Mangold, Matt – Chief, Human Resources Services Center (HRSC) – HRMD
- Proietta, Matthew – Library Technician, Federal Bureau of Prisons Library - IPPA

External Experts

- Clarke, Harold – Director, Department of Corrections – Virginia Department of Corrections
- Garthwaite, Thomas, M.D. - Vice President and Chief Operating Officer, Clinical Services Group, Hospital Corporation of America
- Gibson, Brent, M.D. – Chief Health Officer – National Commission on Correctional Healthcare
- Gondles, Elizabeth, PhD – Director, Office of Correctional Health - American Correctional Association
- Goodwin, Gretta, PhD – Director, Homeland Security and Justice Team - Government Accountability Office
- Greer, James – Health Services Bureau Director – Wisconsin Department of Corrections
- Kane, Thomas, PhD – Former Acting Director, BOP
- Kasindi, Valerie – Senior Analyst - Government Accountability Office
- Kendig, Newton, M.D. – Clinical Professor of Medicine, George Washington University. Former Assistant Director, HSD; Former Medical Director, HSD
- Larson, Nannette – Director, Health Services – Minnesota Department of Corrections
- O'Toole, Laurence, PhD – Distinguished Research Professor emeritus of Public Administration of Policy, University of Georgia
- Wasko, Kellie – Deputy Executive Director – Colorado Department of Corrections

THIS PAGE INTENTIONALLY LEFT BLANK

Appendix D: References

American Correctional Association. 2017. *Public Correctional Policies: Correctional Healthcare.* https://bit.ly/2gbSHYg.

Anno, Jaye B. 2001. "The Organizational Structure of Correctional Health Services." In *Guidelines for the Management of and Adequate Delivery System*, by National Institute of Corrections, 97-116. Washington D.C.: U.S. Department of Justice.

Congressional Research Service. 2018. "Appropriations for the Bureau of Prisons (BOP): In Brief." CRS Report for Members and Committees of Congress.

Council of Prison Locals; Federal Bureau of Prisons. 2014. "Master Agreement." Washington D.C.

Damberg, Cheryl L., Rebecca Shaw, S. Stephanie Teleki, Liisa Hiatt, and Steven M. Asch. 2011. "A Review of quality Measures Used by State and Federal Prisons." (Sage) 17 (2): 122-137. doi:10.1177/1078345810397605.

David, Redemske. 2018. *Providing Healthcare in the Prison Evironment.* HDR.

Deloitte, Partnership for Public Service. 2014. "Helping Government Deliver: Transforming Mission and Support Services."

Faiver, Kenneth L. 2017. "Corrections and Healthcare Working Together." In *Humane Healthcare for Prisoners: Ethical and Legal Challenges*. Praeger.

Faiver, Kenneth L. 2017. "Organizing Correctional Healthcare." In *Humane Healthcare for Prisoners; Ethical and Legal Challenges*. Praeger.

Federal Bureau of Prisons, Council of Prison Locals. 2014. "Master Agreement." Washington, DC: American Federation of Gvoernment Employees. https://www.afgelocal1034.org/ewExternalFiles/2014%20New%20Master%20Agreement.pdf.

Fernandez, Sergio, and Hal G. Rainey. 2006. "Managing Successful Organizational Change in the Public Sector." *Public Administration Review* 66 (2): 168-176. doi:10.1111/j.1540-6210.2006.00570.x.

Hall, Jeremy L., and Edward T. Jennings. 2008. "Taking Chances: Evaluating Risk as a Guide to Better Use of Best Practices." *Public Administration Review* 68 (4): 695-708. doi:10.1111/j.1540-6210.2008.00908.x.

Kim, KiDeuk, and Bryce Peterson. 2014. *Aging Behind Bars: Trends and Implications of Graying Prisoners in the Federal Prison System.* Urban Institute.

Lukas, Carol Vandeusen, Sally K. Holmes, Alan B. Cohen, Joseph Restuccia, Irene E. Cramer, Michael Shwartz, and Martin P. Charns. 2007. "Transformational Change in Healthcare Systems." *Healthcare Management Review* 32 (4): 309-320. doi:10.1097/01.hmr.0000296785.29718.5d.

National Commission on Correctional Healthcare. 2018. "Standards for Health Services in Prisons."

Plata v. Brown. 2015. C01-1351 TEH (United States District Court for the Northern District of California, March 10).

Rainey, Hal G. 2014. *Understanding and Managing Public Organizations.* San Francisco, California: Jossey-Bass.

The PEW Charitable Trusts. 2017. "Prison Healthcare: Costs and Quality - How and why states strive for high-performing systems."

Tip, Fallon. n.d. "To Centralize or Decentralize? Key Considerations." *Evan's Incorporated.* Accessed 2018. http://www.evansincorporated.com/centralizing-and-decentralizing/ .

U.S. Department of Justice. Federal Bureau of Prisons. 2014. "Health Services Administration; 6010.05."

U.S. Department of Justice. Federal Bureau of Prisons. 1998. "Directives Management Manual; 1221.66."

U.S. Department of Justice. Office of the Inspector General. 2015. "The Impact of Aging Inmate Population on the Federal Bureau of Prisons." https://oig.justice.gov/reports/2015/e1505.pdf.

United States Department of Justice. 2018. "Federal Prison System: FY 2019 Performance Budget: Salaries and Expenses." Congressional Submission.

United States Department of Justice. Office of the Inspector General. 2010. "Follow-up Audit of the Federal Bureau of Prison's Efforts to Manage Inmate Healthcare." Audit Report.

United States Department of Justice. Office of the Inspector General. 2017. "Procedural Reform Recommendation for the Federal Bureau of Prisons."

United States Department of Justice. Office of the Inspector General. 2016. "Review of the Federal Bureau of Prisons' Medical Staffing Challenges."

United States Department of Justice. Office of the Inspector General. 2008. "The Federal Bureau of Prison's Efforts to Manage Inmate Healthcare." Audit Report.

United States General Accounting Office. 2000. "Federal Prisons: Containing Healthcare Costs for an Increasing Inmate Population." Testimony Before the Subcommitte on Criminal Justice Oversight.

United States Government Accountability Office. 2018. "2018 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits." Report to Congressional Addressees.

United States Government Accountability Office. 2017. "Bureau of Prisons: Better Planning and Evaluation Needed to Understand and Control Rising Inmate Healthcare Costs." Report to Congressional Requesters. https://www.gao.gov/assets/690/685544.pdf.

United States Government Accountability Office. 2014. "Bureau of Prisons: Information on Efforts and Potential Options to Save Costs." Report to Congressional Requesters.

United States Government Accountability Office: Comptroller General of the United States. 2014. "Standards for Internal Control in the Federal Government." Green Book and Internal Control.

World Health Organization. 2015. *WHO Accountability Framework.* March. https://www.who.int/about/finances-accountability/accountability/accountability-framework.pdf?ua=1.

1600 K Street NW
Suite 400
Washington, D.C. 20006
Phone: (202) 347-3190
Website: www.napawash.org