

Prisons for Profit – Health Care

Private, for-profit health care companies secure contracts to provide medical, dental, mental and pharmaceutical services in prisons by promising to provide quality care for inmates and savings for taxpayers. In reality, these for-profit companies often fail to produce savings for taxpayers, while providing abysmal care to inmates, which results in unnecessary suffering and preventable deaths.

New York

In June 2015, New York City decided to end its contract with Corizon Health, the country’s largest provider of for-profit prison health care, after the city’s Department of Investigations released a report detailing “acute failures in Corizon’s hiring processes and treatment of mentally ill inmates.”^{1/2}

According to the report, Corizon “failed to do adequate background checks on employees, resulting in the employment of eight mental health staff with prior criminal convictions including second degree murder and drug possession. Even where Corizon did have evidence of criminal

“One of the cells that [Corizon staff] failed to inspect housed a diabetic, schizophrenic inmate who had tied a ligature around his genitals, smeared feces in his cell, and was in need of urgent medical attention. That inmate, Bradley Ballard, ultimately died.”

– City of New York
Department of Investigations

activity — including possession of a controlled substance, burglary and forgery — Corizon nonetheless hired these individuals.” In May 2015, the Department of Investigations arrested a Corizon employee “for smuggling a straight edge razor into a Rikers Island facility.” Upon arrest “DOI learned that he had multiple prior felony convictions and served 13 years for kidnapping.”³

Corizon’s deplorable hiring practices had deadly

- 1 http://www.nyc.gov/html/doi/downloads/pdf/2015/June%202015/pr16corizonrpt_61015.pdf.
- 2 <http://www.nytimes.com/2015/06/11/nyregion/report-details-failings-of-corizon-rikers-island-health-provider.html>.
- 3 http://www.nyc.gov/html/doi/downloads/pdf/2015/June%202015/pr16corizonrpt_61015.pdf.

“[Corizon staff] removed an inmate from a court-ordered suicide watch without consulting a psychiatrist, in violation of [supervising department] policy....the [17-year-old] inmate... was found the next morning hanging in his cell. He died 10 days later, as a result of his injuries.”

– City of New York
Department of Investigations

results for the inmates relying on the company’s employees for care. According to the report, “Corizon staff improperly removed inmates from suicide watch or otherwise failed to supervise inmates with serious mental illnesses. Two of those inmates died while unsupervised.”⁴

Florida

In 2012, Corizon and Wexford Health Services signed contracts to provide health care to inmates housed in Florida’s state prisons.⁵ Inmate deaths quickly spiked to a 10-year monthly high in January 2013, roughly 100 days after medical privatization was fully phased in.⁶ More inmates died in Florida prisons in 2014 than any previous year, even though the number of inmates had declined.^{7/8}

In May 2015, Florida fined Corizon \$67,500 for failing a series of performance audits at prison facilities across the state. According to the audits,

- 4 http://www.nyc.gov/html/doi/downloads/pdf/2015/June%202015/pr16corizonrpt_61015.pdf.
- 5 <http://www.miamiherald.com/news/special-reports/florida-prisons/article18928854.html>
- 6 <http://www.mypalmbeachpost.com/news/news/privatized-prison-health-care-in-florida-deadly-pa/nhWkX/#4366c8e4.3974883.735724>
- 7 <http://www.miamiherald.com/news/special-reports/florida-prisons/article18928854.html>
- 8 <http://www.mypalmbeachpost.com/news/news/state-hired-prison-health-firm-despite-record-of-h/nhrTM/>

“Hernando [Florida] inmate Donna Pickelsimer was taken to a state prison hospital to live out her last days. For months, medical records show, Pickelsimer’s painful, spreading lung cancer was treated with Tylenol and warm compresses by Corizon staff, even as bulges appeared on her chest, back and arm.”

– *The Palm Beach Post*

When Pickelsimer complained of pain, she was placed in an isolation cell.

Corizon staff at the Florida Department of Corrections’ only prison hospital failed to maintain industry standards for the treatment of inmate infections or adequately provide for the health care needs of inmates with physical and mental impairments.⁹ At the Columbia Correctional Institution, Corizon staff distributed psychotropic drugs without evaluations.¹⁰ Corizon staff at the Lowell Correctional Institution failed to provide autopsy reports.¹¹ At the Union Correctional Facility, Corizon staff mismanaged records and failed to provide required periodic screenings.¹²

“Months after he landed in Florida’s Manatee County Jail, Jovon Frazier’s pleas for treatment [from Corizon staff] of the intense pain that radiated from his left shoulder to his elbow were met mostly with Tylenol. ‘It really hurts! HELP!’ Frazier, then 18, wrote the second time he asked for care, in August 2009.... Four months later, after Frazier’s 13th request resulted in hospitalization and doctors quickly diagnosed bone cancer, his arm had to be amputated....But the cancer spread and Frazier died in 2011, months after his release.”

–*The New York Times*

Corizon’s ongoing problems prompted the Florida Department of Corrections to announce that they

- 9 <http://www.gainesville.com/article/20150706/ARTICLES/150709810?p=3&tc=pg>
- 10 <http://www.gainesville.com/article/20150706/ARTICLES/150709810>
- 11 <http://www.gainesville.com/article/20150706/ARTICLES/150709810?p=3&tc=pg>
- 12 <http://www.gainesville.com/article/20150706/ARTICLES/150709810?p=3&tc=pg>

will consider new vendors to replace Corizon.¹³

Additionally, while the original contracts required Corizon and Wexford to deliver 7 percent cost savings for the state, both companies sought and received increases in the terms of their original agreement, undercutting the cost-savings rationale that drove the state to privatize prison health care to begin with.¹⁴ At the time the contracts were signed, the lobbyist for Wexford was a former employee of Florida Gov. Rick Scott. Corizon’s lobbyist was the head of Governor Scott’s political finance committee.¹⁵

Arizona

Arizona turned medical care for state prisoners over to Wexford Health Services in July 2012.¹⁶ Shortly afterwards, in August 2012, a Wexford nurse potentially exposed 103 prisoners to Hepatitis C by violating basic infection protocols and contaminating a prison’s insulin supply.¹⁷ In September 2012, the Arizona Department of Corrections cited Wexford for a number of serious violations. One prisoner who had not received his psychiatric medications for 23 days was found hanging in his cell.¹⁸

“He had been diagnosed with cancer for over one year, but both Wexford and Corizon denied him a referral for cancer treatment. For the last three months of his life, McCabe had been rendered completely unable to speak and was confined to a wheelchair, assisted by fellow inmates in his activities of daily living.”

– *American Friends Service Committee Report*

13 <http://www.gainesville.com/article/20150706/ARTICLES/150709810>

14 <http://www.miamiherald.com/news/special-reports/florida-prisons/article18928854.html>

15 <http://www.miamiherald.com/news/special-reports/florida-prisons/article18928854.html>

16 <https://www.afsc.org/sites/afsc.civicaactions.net/files/documents/DeathYardsFINAL.pdf>

17 <http://archive.azcentral.com/news/articles/20120904arizona-inmates-exposed-hepatitis-c-dirty-needle.html>

18 <https://www.afsc.org/sites/afsc.civicaactions.net/files/documents/DeathYardsFINAL.pdf>

At the end of January 2013, Arizona announced that it severed its contract with Wexford, and that Corizon Health would become the health care provider for state run prisons beginning in March 2013.¹⁹ However, care for inmates only deteriorated further: while 37 prisoners died in Arizona prisons in 2011 and 2012, a stunning 50 inmates died in Arizona prisons in just the first eight months of 2013.²⁰

“Medical records show there was an eight-month delay in treating Vocke, because of Corizon’s actions. ‘It was kidney cancer that could have been 95 percent survivable and now they’re saying I can’t survive it whatsoever...’ On Oct. 31, 2013, the Board of Executive Clemency commuted Vocke’s sentence. He was granted medical parole, so he can die surrounded by family.”

—NBC 12 News

According to the Arizona Department of Corrections, Corizon failed to deliver timely care at least 16,000 times during an eight-month period in 2013.²¹ Corizon delayed chemotherapy for two inmates and failed to provide another inmate with treatment for prostate cancer, medications for mentally ill inmates were not renewed, and one inmate required surgery to remove part of his skull after he fell 33 times in the infirmary.²²

In June 2015, the state Legislature considered a request from Corizon to increase payments from the state by \$5.2 million, the third time within a one year span that the company requested an increase in payments from the state.²³ At the time Corizon was awarded the Arizona contract, the company

19 <https://www.afsc.org/sites/afsc.civicaactions.net/files/documents/DeathYardsFINAL.pdf>

20 <https://www.afsc.org/sites/afsc.civicaactions.net/files/documents/DeathYardsFINAL.pdf>

21 <http://www.12news.com/story/news/arizona/2014/05/22/12news-death-sentence-prison-healthcare-costly-ineffective/9395497/>

22 <http://www.12news.com/story/news/arizona/2014/05/22/12news-death-sentence-prison-healthcare-costly-ineffective/9395497/>

23 <http://www.kpho.com/story/29366462/prison-healthcare-company-contracted-with-state-requests-another-rate-increase>

employed the former director of the Arizona Department of Corrections as a consultant.²⁴

Illinois

In 2011, Wexford Health Services was awarded a 10-year, \$1.36 billion contract to provide health care to state inmates in Illinois.²⁵ In 2012, the John Howard Association — an independent, non-partisan prison oversight organization — released a report based on the organization’s in-depth monitoring of the health care provided at 12 Illinois correction facilities and found widespread problems.²⁶

The John Howard Association found that “health care resources and staffing are inadequate to meet minimum standards of care...lack of adequate medical staffing and resources in all areas — medical, mental health, dental, vision — threaten serious harm by delaying diagnosis and treatment and inviting medical error.”²⁷

“Patient presented with classic signs and symptoms of lung cancer from the time he arrived in IDOC, yet these were ignored by [Wexford] health care staff for three months. By the time he was finally diagnosed, the only treatment he was eligible for was palliative radiation, which he declined. He died nine days later.”

—Final Report of the Court Appointed Expert, *Lippert v. Godinez*

In 2013, a federal court appointed an independent expert to “investigate all relevant components of the health care system.”²⁸ The results of the investigation were documented in a December 2014 report that concluded “that the state of Illinois has been unable to meet minimal constitutional standards with regards

24 <http://www.kpho.com/story/21875586/az-doc-contract-questions>

25 <http://www.wpsdlocal6.com/story/29117680/expert-panel-criticizes-medical-care-at-illinois-prisons>

26 <http://www.thejha.org/unaskedquestions>

27 <http://thejha.org/sites/default/files/Unasked%20Questions-Unintended%20Consequences.pdf>

28 <http://www.aclu-il.org/wp-content/uploads/2015/05/Final-Report-of-Court-Appointed-Expert-With-All-Appendices-REDACTED.pdf>

to the adequacy of its health care program for the population it serves.” The report contains extensive documentation of instances where Wexford failed to provide inmates with adequate care — leading to severe health consequences and even the deaths of inmates.

“At Illinois River, a 26-year-old man repeatedly informed [Wexford] health care staff that he had atrial fibrillation, a fact that was confirmed by his jail records, but this history was discounted until he suffered a stroke. Had clinical staff listened to the patient and reviewed his jail record, they would have learned that he should have been on blood thinners to reduce the chances of this devastating event.”

*—Final Report of
the Court Appointed Expert, Lippert v. Godinez*

For many inmates, care from Wexford is inadequate and disorganized from the moment they enter the Illinois corrections system. According to the report, the medical records system at the Northern Reception Center, which handles the bulk of newly admitted inmates, is “dysfunctional.”²⁹ Experts examining the facility found that new inmates diagnosed with tuberculosis, hypertension, HIV and Hepatitis C never received necessary follow-up care.³⁰

Patient had a history of cirrhosis and was admitted to the infirmary with recurrent active GI bleeding. Despite evidence of substantial blood loss, the patient was not sent to the hospital [by Wexford staff] until the following day; he died at the hospital two days later.”

*—Final Report of
the Court Appointed Expert, Lippert v. Godinez*

29 <http://www.aclu-il.org/wp-content/uploads/2015/05/Final-Report-of-Court-Appointed-Expert-With-All-Appendices-REDACTED.pdf>

30 <http://www.aclu-il.org/wp-content/uploads/2015/05/Final-Report-of-Court-Appointed-Expert-With-All-Appendices-REDACTED.pdf>

Unfortunately for inmates, being transferred to another facility after intake is unlikely to improve their chances of receiving adequate care. The experts noted in their report that “at every facility we visited, we encountered cases of patients with poorly controlled chronic disease going months without any active management of their disease process.”³¹

At one facility, none of the Wexford physicians had any formal training in a primary care field, leading to “several examples of avoidable harm to patients resulting from inappropriate management of common primary care conditions.”³² At another facility, 23 of the 66 budgeted positions were vacant, including half of the registered nurse positions.³³

“At Illinois River, patient was admitted to the infirmary with rapidly progressive paralysis of the lower half of his body. Despite his requests to be sent to the hospital because he could not move his legs, he was kept in the infirmary for two weeks, until finally a nurse intervened on his behalf and appealed to the doctor for transfer to the emergency department. He was found to have leukemia involving his spine and is now permanently wheelchair bound.”

*—Final Report of
the Court Appointed Expert, Lippert v. Godinez*

31 <http://www.aclu-il.org/wp-content/uploads/2015/05/Final-Report-of-Court-Appointed-Expert-With-All-Appendices-REDACTED.pdf>

32 <http://www.aclu-il.org/wp-content/uploads/2015/05/Final-Report-of-Court-Appointed-Expert-With-All-Appendices-REDACTED.pdf>

33 <http://www.aclu-il.org/wp-content/uploads/2015/05/Final-Report-of-Court-Appointed-Expert-With-All-Appendices-REDACTED.pdf>