

PERFORMANCE AUDIT
OF THE
BUREAU OF HEALTH CARE SERVICES
DEPARTMENT OF CORRECTIONS
February 2000

EXECUTIVE DIGEST

BUREAU OF HEALTH CARE SERVICES

INTRODUCTION

This report, issued in February 2000, contains the results of our performance audit* of the Bureau of Health Care Services (BHCS), Department of Corrections.

AUDIT PURPOSE

This performance audit was conducted as part of the constitutional responsibility of the Office of the Auditor General. Performance audits are conducted on a priority basis related to the potential for improving effectiveness* and efficiency*.

BACKGROUND

In 1975, the Department of Corrections established BHCS to coordinate medical, dental, and psychological services provided to prisoners.

BHCS's mission* is to provide prisoners with comprehensive health care services characterized by high quality, accessibility, and cost effectiveness. Prisoner health care services are provided through a network of outpatient clinics operated at all prisons and through a managed health care* system for off-site specialty services.

BHCS expended \$114.4 million for prisoner health care services for the fiscal year ended September 30, 1998. Of this amount, BHCS spent approximately \$81.9 million for

* See glossary at end of report for definition.

on-site health care services and central office staff and approximately \$32.5 million for off-site specialty health care services. The average prisoner population for fiscal year 1997-98 was 45,055 prisoners, resulting in an average cost per prisoner of approximately \$2,539.

BHCS employed 1,002 clinical and office staff as of March 31, 1999.

AUDIT OBJECTIVES,
CONCLUSIONS, AND
NOTEWORTHY
ACCOMPLISHMENTS

Audit Objective: To assess the effectiveness of BHCS's administration of contracts for Statewide managed health care and ambulatory health care* services for prisoners.

Conclusion: BHCS's administration of contracts provided reasonable assurance that the contractors fulfilled contract provisions in a satisfactory manner. However, we identified two reportable conditions* related to contract administration and assessment of health care initiatives (Findings 1 and 2).

Audit Objective: To assess the effectiveness of BHCS's management of health care services provided to prisoners.

Conclusion: We concluded that BHCS was generally effective in its management of health care services provided to prisoners. However, our assessment disclosed four reportable conditions related to staffing guidelines, chronic care clinics* and intake assessments, Assaultive Offender Program, and computerized medical records (Findings 3 through 6).

Noteworthy Accomplishments: After 15 years, the U.S. District Court in Kalamazoo terminated all provisions of the USA consent decree, including the medical provisions.

* See glossary at end of report for definition.

The USA consent decree, entered into on July 13, 1984, was created to resolve concerns of the U.S. Department of Justice as a result of prison riots that occurred in 1981. In presenting a motion to terminate the USA consent decree, the U.S. Department of Justice told the court that there no longer existed any current or ongoing violations of prisoners' constitutional rights in Michigan prisons. This termination illustrates BHCS's overall effectiveness in providing comprehensive health care services to prisoners.

Audit Objective: To assess the efficiency of health care services provided to prisoners.

Conclusion: BHCS generally provided prisoner health care services in an efficient manner. However, our assessment disclosed one reportable condition related to contractual personnel (Finding 7).

Noteworthy Accomplishments: In April 1997, BHCS contracted for Statewide managed health care services for prisoners. This contract provides off-site specialty care services through a managed care system based on a fixed per prisoner per month rate. Although the contract was in effect for only six months during fiscal year 1996-97, it reduced hospital/specialty expenditures by \$5,320,750 (12%). The contract contributed to an additional savings of \$5,333,160 (14%) for fiscal year 1997-98. In addition, the Department reported that, based on prior expenditures, anticipated increases in prisoner population, increases in prisoner acuity, and increases in the Consumer Price Index for Medical Goods and Services, the direct savings plus the cost avoidance realized under the managed care system totaled an estimated \$17.6 million for the first full fiscal year of operation (fiscal year 1997-98).

Also, BHCS instituted a \$3 prisoner co-pay for non-emergency, prisoner-initiated health care effective June 1997. This co-pay reduced the number of prisoner requests for health care by approximately 10,000 requests per month. This reduction in health care requests allowed clinical personnel to focus their efforts on more significant health care issues, such as the development of a proactive approach to treating chronically ill prisoners.

AUDIT SCOPE AND
METHODOLOGY

Our audit scope was to examine the health care and other records of the Bureau of Health Care Services. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and other auditing procedures as we considered necessary in the circumstances.

This audit does not include prisoner mental health care services, which we audit separately. While developing our audit objectives and scope of audit, we incorporated a legislative request for an audit of prisoner health care services and its related questions and issues. Our responses to those legislative issues were communicated in a separate document.

BHCS had not reconciled and did not have sufficient records for us to fully reconcile the amounts paid to the original managed health care contractor. Thus, we could not fully account for the \$26,555,863 paid to the contractor. We continue to communicate with the contractor's attorneys to understand the contractor's handling of funds received from BHCS. We will report separately the results of these audit procedures.

Our methodology included examining BHCS's records for the period October 1, 1995 through March 31, 1999. To

establish our audit objectives, we conducted a preliminary review of BHCS's operations. This included discussions with key central office staff and with regional and prison health care staff regarding their functions and responsibilities. Also, we reviewed BHCS health care policies and procedures. We obtained and reviewed various states' audit reports and selected national publications related to prisoner health care services.

To accomplish our audit objectives, we examined the contracts entered into by BHCS for Statewide managed health care and ambulatory health care services. We evaluated the records and procedures related to the selection of contractors and to BHCS's administration of the contracts.

We evaluated prisoner medical files for selected prisoners to determine if health care services were provided in accordance with BHCS clinical guidelines and American Correctional Association standards. We analyzed BHCS's efforts to document clinical activity, establish staffing level needs, and measure program effectiveness.

We conducted trend analyses of prisoner health care costs and evaluated BHCS's efforts to control these costs.

**AGENCY RESPONSES
AND PRIOR AUDIT
FOLLOW-UP**

Our audit report includes 7 findings and 10 recommendations. BHCS agrees with 4 recommendations, partially agrees with 4 recommendations, and disagrees with 2 recommendations.

BHCS complied with all 14 prior audit recommendations.

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Mr. Bill Martin, Director
Department of Corrections
Grandview Plaza
Lansing, Michigan

Dear Mr. Martin:

This is our report on the performance audit of the Bureau of Health Care Services, Department of Corrections.

This report contains our executive digest; description of agency; audit objectives, scope, and methodology and agency responses and prior audit follow-up; comments, findings, recommendations, and agency preliminary responses; a bibliography, presented as supplemental information; and a glossary of acronyms and terms.

Our comments, findings, and recommendations are organized by audit objective. The agency preliminary responses were taken from the agency's responses subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a formal response within 60 days after release of the audit report.

We appreciate the courtesy and cooperation extended to us during this audit.

AUDITOR GENERAL

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Description of Agency

In 1975, the Department of Corrections established the Bureau of Health Care Services (BHCS) to coordinate medical, dental, and psychological services provided to prisoners.

BHCS's mission is to provide prisoners with comprehensive health care services characterized by high quality, accessibility, and cost effectiveness. Prisoner health care services are provided through a network of outpatient clinics operated at all prisons and through a managed health care system for off-site specialty services.

In addition to providing medical and dental services, BHCS is responsible, in conjunction with the Department of Community Health, for providing prisoners with mental health care services.

BHCS expended \$114.4 million for prisoner health care services for the fiscal year ended September 30, 1998. Of this amount, BHCS spent approximately \$81.9 million for on-site health care services and central office staff and approximately \$32.5 million for off-site specialty health care services. The average prisoner population for fiscal year 1997-98 was 45,055 prisoners, resulting in an average cost per prisoner of approximately \$2,539.

BHCS employed 1,002 clinical and office staff as of March 31, 1999.

Effective April 1, 1997, BHCS entered into a contract to provide a Statewide managed health care system for off-site specialty services. The cost for these services is based on a fixed per prisoner per month rate. This undertaking resulted in one managed health care system contract replacing several hundred contracts with individual health care providers.

Through February 5, 1999 the Department of Corrections operated under a 1984 consent decree with the U.S. Department of Justice. Under this consent decree, the Department agreed to improve health care services. Compliance with the consent decree was independently monitored by federal court-appointed experts. As a result of the Department's compliance with the consent decree, the U.S. Department of Justice terminated the consent decree.

Audit Objectives, Scope, and Methodology and Agency Responses and Prior Audit Follow-Up

Audit Objectives

Our performance audit of the Bureau of Health Care Services (BHCS), Department of Corrections, had the following objectives:

1. To assess the effectiveness of BHCS's administration of contracts for Statewide managed health care and ambulatory health care services for prisoners.
2. To assess the effectiveness of BHCS's management of health care services provided to prisoners.
3. To assess the efficiency of health care services provided to prisoners.

Audit Scope

Our audit scope was to examine the health care and other records of the Bureau of Health Care Services. Our audit was conducted in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States and, accordingly, included such tests of the records and other auditing procedures as we considered necessary in the circumstances.

This audit does not include prisoner mental health care services, which we audit separately. While developing our audit objectives and scope of audit, we incorporated a legislative request for an audit of prisoner health care services and its related questions and issues. Our responses to those legislative issues were communicated in a separate document.

BHCS had not reconciled and did not have sufficient records for us to fully reconcile the amounts paid to the original managed health care contractor. Thus, we could not fully account for the \$26,555,863 paid to the contractor. We continue to communicate with the contractor's attorneys to understand the contractor's handling of funds received from BHCS. We will report separately the results of these audit procedures.

Audit Methodology

Our audit procedures were performed during the months of July 1998 through March 1999 and included examining BHCS's records from October 1, 1995 through March 31, 1999.

To establish our audit objectives, we conducted a preliminary review of BHCS's operations. This included discussions with key central office staff and on-site interviews with regional and prison health care staff regarding their functions and responsibilities. Also, we reviewed BHCS health care policies and procedures. We obtained and reviewed various states' audit reports and selected national publications related to prisoner health care services.

To accomplish our audit objectives, we examined the contracts entered into by BHCS for Statewide managed health care and ambulatory health care services. We evaluated the records and procedures related to the selection of contractors and to BHCS's administration of the contracts.

We evaluated prisoner medical files for selected prisoners to determine if health care services were provided in accordance with BHCS clinical guidelines and American Correctional Association standards. We documented the sick-call and appointment process at the prison clinics and examined the referral process for off-site specialty health care services provided through the managed care system. We analyzed BHCS's efforts to document clinical activity, establish staffing level needs, and measure program effectiveness.

We conducted trend analyses of prisoner health care costs and evaluated BHCS's efforts to control these costs.

Agency Responses and Prior Audit Follow-Up

Our audit report includes 7 findings and 10 recommendations. BHCS agrees with 4 recommendations, partially agrees with 4 recommendations, and disagrees with 2 recommendations.

The agency preliminary response which follows each recommendation in our report was taken from the agency's written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and Department of

Management and Budget Administrative Guide procedure 1280.02 require the Department of Corrections to develop a formal response to our audit findings and recommendations within 60 days after release of the audit report.

BHCS complied with all 14 prior audit recommendations.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFECTIVENESS OF CONTRACT ADMINISTRATION

COMMENT

Background: The Bureau of Health Care Services (BHCS), Department of Corrections, entered into two primary contracts for the provision of health care services to prisoners:

Statewide Managed Health Care Services for Prisoners

The purpose of this contract was to provide a Statewide managed health care system for off-site specialty services. The cost for these services was based on a fixed per prisoner per month rate. The contract period was from April 1, 1997 to April 1, 1999 with options for extensions for two additional four-year periods. The base rate for this contract was \$49.66 per prisoner per month for an estimated annual cost of \$33,089,600.

This contract was originally awarded to United Correctional Managed Care, Inc. (UCMC). Within a few months, UCMC fell significantly behind in making payments to its subcontracted medical service providers. Thus, UCMC arranged for the contract's assignment to Correctional Medical Services, Inc. (CMS), effective February 3, 1998.

The assignment was approved by the Department of Management and Budget and the State Administrative Board and was made at the original terms, conditions, and rates. However, the per prisoner per month rate increased to \$64.67 effective April 1, 1998. This rate increase was estimated to cost approximately \$3,801,350 annually.

Effective February 26, 1999, BHCS and CMS mutually agreed to extend this contract for a period of four years beginning April 1, 1999. Some modifications to the contract included: (1) an increase in the per prisoner per month rate to \$70.57, and (2) application of an annual inflation adjuster to the per prisoner per month rate for the second through the fourth extension years.

BHCS was examining the benefits of adding primary care providers (physicians, physicians' assistants, and nurse practitioners) and pharmacy services to the managed care contract with CMS. BHCS stated that it had no plans to extend privatization of staffing beyond these two areas. Such information was provided to BHCS staff.

Ambulatory Health Care Services - Baraga Maximum, Macomb, Newberry, Oaks, and Saginaw Correctional Facilities

The purpose of this contract was to provide ambulatory and limited catastrophic health care services to prisoners housed at these five prisons. This contract was awarded to Wexford Health Sources, Inc. The contract period was originally from October 1, 1995 to April 1, 1997. However, the period was extended until September 15, 1997 to allow an independent agency to perform a cost-effectiveness review. Payments to the contractor totaled \$10,329,790.

After this contract's final extension, a supplemental staffing provision included in the Statewide Managed Health Care Services for Prisoners contract allowed the contractual medical staff from these five prisons to continue working through the end of our audit fieldwork. BHCS attempted to re-bid the project throughout 1998. However, none of the vendors' proposals met the minimum cost savings requirements. As a result, BHCS decided to convert these contractual staff to civil service staff effective January 1999.

Audit Objective: To assess the effectiveness of BHCS's administration of contracts for Statewide managed health care and ambulatory health care services for prisoners.

Conclusion: BHCS's administration of contracts provided reasonable assurance that the contractors fulfilled contract provisions in a satisfactory manner. However, we identified two reportable conditions related to contract administration and assessment of health care initiatives.

FINDING

1. Contract Administration

BHCS had not fully monitored contractor compliance with the administrative provisions of its contract for Statewide Managed Health Care Services for Prisoners.

BHCS had implemented various processes for monitoring the effectiveness of health care services provided by the managed care contractor. These processes included: regular meetings between BHCS management and the contractor, regular meetings among BHCS central and regional office administrators, continuous quality improvement studies, performance reports from the contractor, and summary performance reports to Department management.

However, BHCS lacked sufficient processes to monitor selected administrative provisions within the contract and to initiate corrective action when necessary:

- a. BHCS separately paid for health care services already included within the managed care contract. The managed care concept enables BHCS to pay a fixed per prisoner per month rate to the contractor for providing specified medical services. Per the contract, the services of optometrists and dental staff at the prison camps were included in the capitated rate. However, BHCS also directly paid the salaries and wages of these employees. This duplication began with the contract's inception in April 1997.

BHCS deducted charges for the optometrist services beginning with the October 1998 billings (paid in November 1998); however, it continued to make duplicate payments for the dental services. As a result, duplicate payments for optometrist and dental services for which BHCS should seek reimbursement totaled \$90,547 as of March 18, 1999. BHCS subsequently informed us that it made arrangements with the contractor to deduct this amount from the April 16, 1999 payment.

- b. BHCS had not formalized a process to verify the accuracy of the contractor's calculations used to compute BHCS's share of the risk pool.

The contract states that BHCS shall pay the contractor a fixed per prisoner per month rate for the provision of off-site specialty health care services. However, if the provider's total costs for providing services in a contract year exceed the budgeted amount by more than 10%, BHCS and the contractor shall share equally in the costs above this 110% level. These costs represent the risk pool.

Although BHCS had not made final payment on the contract's first year risk pool, we reviewed the contractor's preliminary computation of BHCS's share. This computation included potentially voided checks totaling approximately \$186,000.

Under the risk pool sharing formula, BHCS would be responsible for paying approximately \$93,000 for these questionable items. BHCS had not formalized a process for verifying the contractor's computation of the risk pool. Such a verification process could include obtaining independent audit results from the contractor and using provider payment summaries to conduct payment confirmations with selected providers.

After our audit fieldwork, the Department provided documentation indicating that the contractor had removed the \$186,000 in voided checks from its billing.

- c. BHCS relied on inaccurate information for monitoring the current contractor's average aging of payments to medical providers. The contractor provided BHCS with a monthly report that purported to present the average aging of payments to medical providers. BHCS used this report to ensure that the contractor paid the medical providers within the 45-day average required in the contract. We determined that the payment aging data presented in this report was not accurate. As a result, BHCS could not accurately monitor the timeliness of the contractor's payments to medical providers.
- d. The contract did not contain liquidated damage* provisions. Such provisions would allow BHCS to assess charges against the contractor for failure to meet specific performance standards set forth in the contract. Specific financial penalties could be established for staff shortages, adequacy of treatment documentation, timeliness of referral processing, and compliance with BHCS policies and procedures.

BHCS management informed us that other states' contracts used as examples when developing this request for proposal did not contain liquidated damage provisions. Also, the Office of Purchasing, Department of Management and Budget, did not require such provisions. Thus, the

* See glossary at end of report for definition.

liquidated damage provisions were not included. BHCS has since re-evaluated the value of including liquidated damage provisions in its contracts. We noted that the draft contract for the privatized youthful offenders prison included such provisions.

BHCS's development of processes for monitoring compliance with the contract's administrative provisions would help ensure that contract-related problems would be detected and corrected in a timely manner. Such monitoring would also help to ensure that the contractor continues to perform in a responsible manner.

RECOMMENDATIONS

We recommend that BHCS fully monitor contractor compliance with the administrative provisions of its contract for Statewide Managed Health Care Services for Prisoners.

We also recommend that BHCS obtain reimbursement from the managed care contractor for duplicate payments made for the optometrists and dental staff at the prison camps.

AGENCY PRELIMINARY RESPONSE

BHCS disagrees that BHCS lacked sufficient processes to monitor selected administrative provisions of the contract and to initiate corrective action when necessary.

Regarding item a., BHCS had identified the problem with inappropriate payments to the contractor for optometry and dental positions through ongoing oversight activities but had not yet worked out and/or received reimbursement by the time the auditors initiated the audit. BHCS recovered the amount due from the contractor in April 1999.

Regarding item b., BHCS had not yet verified and did not need to verify the accuracy of the contractor's risk pool calculations by the time of the auditors' review. In addition, the preliminary computation was merely an estimation and was stated as such. BHCS informed us that the final bill did not include estimated future billings and voided checks. The reconciliation of the final bill was completed prior to the closing of the contract year.

Regarding item c., BHCS informed us that the problems with the contractor's aging report have been resolved. However, BHCS also monitored timeliness of payments through direct contact with vendors. All contacts with the vendors indicated that vendors were being paid in a timely manner.

Regarding item d., BHCS will pursue liquidated damage provisions in future contracts, when applicable.

FINDING

2. Assessment of Health Care Initiatives

BHCS had not developed mechanisms for fully assessing the effectiveness and efficiency of new health care initiatives. As a result, BHCS could not assure itself that selected initiatives provided effective and efficient health care services sufficient to warrant their implementation on a Statewide basis.

From October 1, 1995 to March 31, 1999, BHCS introduced several health care initiatives, including a pilot project for privatized ambulatory health care services. This pilot primarily provided privatized, on-site medical staff for selected health care clinics. These clinics were located in Baraga Maximum, Macomb, Newberry, Oaks, and Saginaw Correctional Facilities. Payments to the contractor totaled \$10,329,790. The contract for these services originally ran from October 1, 1995 to April 1, 1997. However, it was extended to September 15, 1997 to allow an independent agency to perform a cost effectiveness review which began in April 1997.

BHCS hired an independent agency to determine whether this pilot resulted in a cost savings to the State. The agency concluded:

. . . there is a savings of \$0.36 per prisoner per day for small high-security facilities, but a loss of \$0.56 per prisoner per day for large medium-security facilities. . .
. Since there are very few high-security facilities, but many medium-security facilities, the loss is more significant than the gain when considering extension of the model to other facilities.

However, the agency repeatedly qualified its conclusion by referring to the difficulty of comparing the privatized clinics with the Department clinics because of incomparable cost data. The agency stated that the Department did not have the ability to track all off-site specialty care costs for prisons because of prisoner movements. In addition, it was not possible to compare only on-site treatment costs because they were commingled with off-site and specialty care costs in the Department's payments to the contractor. Other problems cited by the agency included: health care programs offered at the Department clinics that were not offered at the privatized clinics; an additional Department employee at the privatized clinics for monitoring purposes; and the cost of health care staff charged to one clinic when staff were shared with nearby clinics.

The Department's Finance Unit conducted comparisons among the privatized clinics and the Department clinics. However, the Finance Unit personnel informed us that they could not arrive at a definitive conclusion related to the pilot's efficiency because of the numerous variables involved.

Thus, we compared the health care costs of two privatized clinics with two Department clinics. Our results were similar to what the independent agency concluded. For maximum security prisons, we concluded that the health care services at the privatized clinics were more efficient than the Department clinics. For medium security prisons, the Department clinics were more efficient than the privatized clinics.

However, we also incurred problems when comparing the privatized clinics with the Department clinics. Each of the prisons with a privatized clinic had its own clinical complex appropriation to account for health care expenditures. This is not true for most of the prisons with Department clinics. This accounting practice significantly limited the number of prisons for which we could accurately compare health care costs.

In addition to its inability to fully analyze the efficiency of this pilot, BHCS did not have mechanisms for evaluating the quality of care provided by the privatized clinics. One regional health administrator compared three privatized clinics' policy/procedure compliance with one Department clinic's policy/procedure compliance. This comparison disclosed that the quality of care provided at the

privatized clinics was lower than at the Department clinic. The comparison tested clinics' policy/procedure compliance in several health care categories ranging from administration to crisis-intervention. Noncompliance ranged from 15% to 22% at the privatized clinics compared with only 3% noncompliance at the Department clinic.

Overall, we concluded that the privatized ambulatory health care services pilot was inefficient and provided reduced levels of care to the prisoners. However, it is imperative that BHCS be able to evaluate fully by itself the effectiveness and efficiency of new health care initiatives.

After this contractor's final extension through September 15, 1997, a supplemental staffing provision included in the managed care contract allowed the staff from these privatized clinics to continue working as temporary employees through the end of our audit fieldwork. BHCS attempted to re-bid the project throughout 1998. However, none of the vendors' proposals met the minimum cost savings requirements. As a result, BHCS decided in December 1998 to convert these clinics to Department clinics with civil service employees.

RECOMMENDATION

We recommend that BHCS develop mechanisms for fully assessing the effectiveness and efficiency of new health care initiatives.

AGENCY PRELIMINARY RESPONSE

BHCS agrees and is taking steps to comply. BHCS agrees that a more stringent evaluation of initiatives is desirable. An electronic health care event tracking system could have made the evaluation process more efficient and precise had it been in place prior to implementing the pilot. BHCS informed us that it is reviewing electronic products and is seeking funding for the products to assist in fully assessing the effectiveness and efficiency of future initiatives.

EFFECTIVENESS OF SERVICE MANAGEMENT

COMMENT

Audit Objective: To assess the effectiveness of BHCS's management of health care services provided to prisoners.

Conclusion: We concluded that BHCS was generally effective in its management of health care services provided to prisoners. However, our assessment disclosed four reportable conditions related to staffing guidelines, chronic care clinics and intake assessments, Assaultive Offender Program, and computerized medical records.

Noteworthy Accomplishment: After 15 years, the U.S. District Court in Kalamazoo terminated all provisions of the USA consent decree, including the medical provisions. The USA consent decree, entered into on July 13, 1984, was created to resolve concerns of the U.S. Department of Justice as a result of prison riots that occurred in 1981. In presenting a motion to terminate the USA consent decree, the U.S. Department of Justice told the court that there no longer existed any current or ongoing violations of prisoners' constitutional rights in Michigan prisons. This termination illustrates BHCS's overall effectiveness in providing comprehensive health care services to prisoners.

FINDING

3. Staffing Guidelines

BHCS had not staffed its ambulatory health care clinics within the prisons in accordance with its staffing guidelines. Also, BHCS had not addressed all aspects related to the delivery of prisoner health care services and had not documented its methodology when developing the staffing guidelines.

Partially in response to our prior audit, BHCS developed staffing guidelines for the ambulatory health care clinics in March 1998. The staffing guidelines address the following positions:

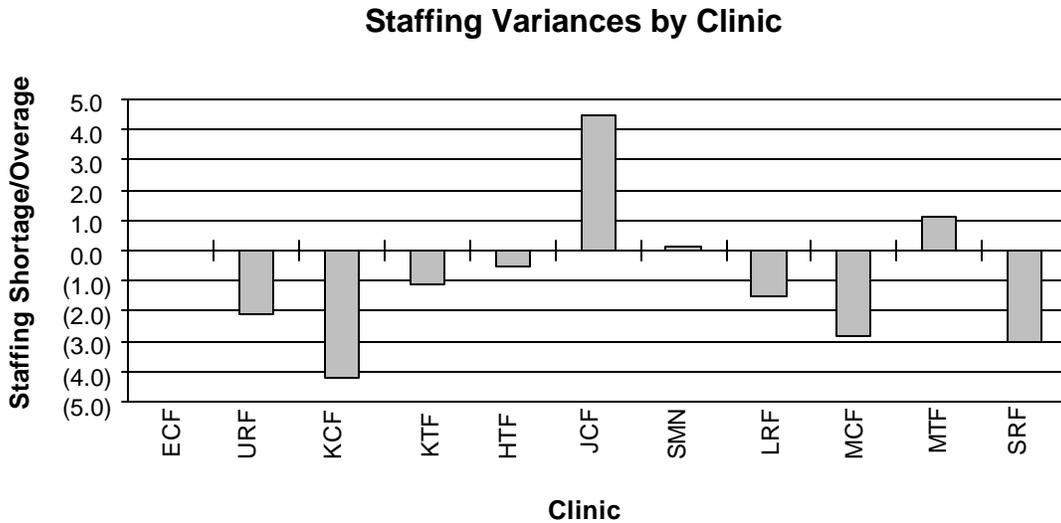
Physician/Physician Assistant	X-Ray Technician
Dentist	Administrative Support
Dental Hygienist	Pharmacist/Pharmacy Support
Dental Assistant	Staff Psychologist
Registered Nurse	Chief Psychologist
Health Unit Manager	Dietitian
Laboratory Technician	

The staffing guidelines appropriately incorporate the use of fixed factors, such as prison population and hours of nursing coverage, as well as variable factors, such as number of chronic care patients and size of treatment waiting lists.

However, our review of the staffing guidelines and their implementation disclosed the following concerns:

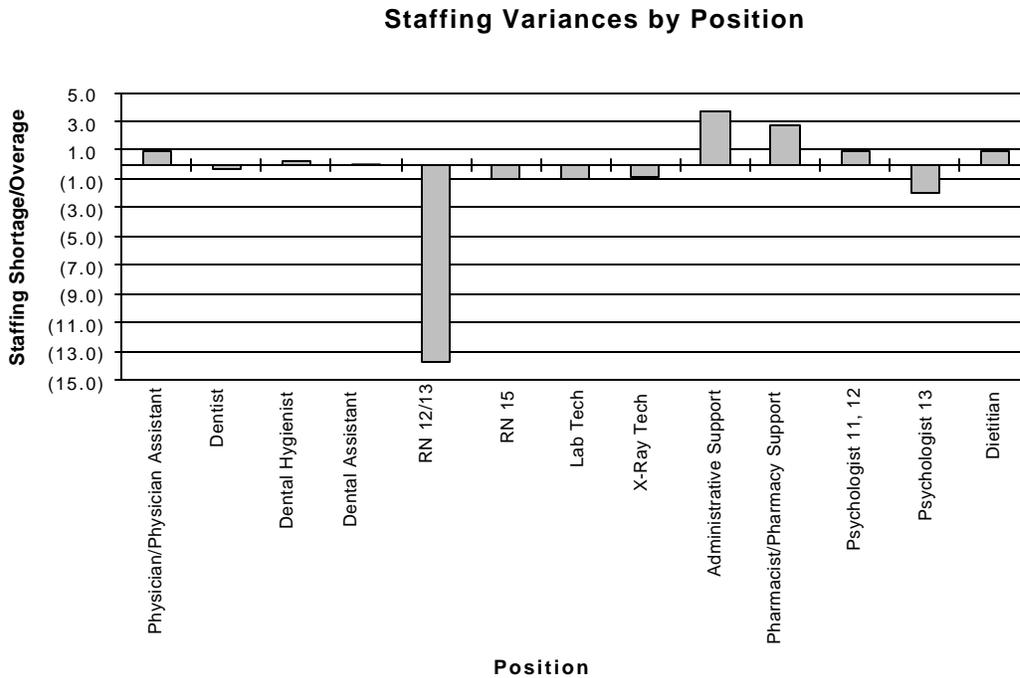
- a. Staffing at the ambulatory clinics varied significantly from the staffing guidelines. Our comparison of staffing at 11 ambulatory clinics with the

staffing guidelines disclosed that overall staffing variances by clinic ranged from a shortage of 4.2 employees to an overage of 4.5 employees:



For the 11 clinics that we evaluated, the registered nurse position was the most significantly understaffed per the staffing guidelines. For these clinics, this position was short a total of 14.8 employees. One clinic in the central health care region was short 7.9 registered nurses. Those

positions overstaffed per the staffing guidelines were administrative support and pharmacists/pharmacy technicians:



During our visits to these clinics, we selected 89 prisoners identified as having chronic diseases or disorders. Our review of prisoner medical files disclosed that 20 (22%) prisoners did not have their chronic care clinic visits scheduled within the established four-month time frame. Five prisoners waited approximately one year between their chronic care visits (Finding 4). Registered nurses and physicians are the primary medical providers who deliver treatments to the chronically ill. As shown in the preceding chart, the registered nurses position was understaffed per the staffing guidelines.

When we evaluated individual positions within each clinic, we noted 13 positions in which the position staffing variances were greater than or equal to one employee. Of these 13 positions, 5 (38%) position staffing variances were

greater than or equal to two employees. The staffing at the clinics that we evaluated ranged from 14.6 to 31.5 employees, with an average of 18.3 employees per clinic. Thus, some staffing variances were quite significant to the individual clinics. The lack of appropriate staffing within the clinics could cause additional stress among employees and affect the level of care provided to prisoners.

- b. Our review of other states' staffing guidelines indicated that BHCS did not consider all potential factors when developing its guidelines. In addition to the fixed and variable factors appropriately considered by BHCS, other factors, such as custody level, gender, age, and physical disabilities may significantly impact a clinic's staffing needs (see Bibliography). BHCS's staffing guidelines do not include these other factors.

Without considering all appropriate factors, these staffing guidelines may result in less than optimum staffing levels. For example, the preceding chart shows the staff psychologist position as slightly overstaffed per the staffing guidelines. However, as of December 1998, there were 1,026 prisoners on waiting lists for Assaultive Offender Program assessment screenings. Also, there were 400 to 450 camp prisoners awaiting assessment screenings who were not on the waiting lists. (Finding 5)

In addition, the preceding chart shows the dental positions staffed according to the staffing guidelines. However, two health care regions had waiting lists for dental services that exceeded six months.

BHCS informed us that it intends to use its current staffing guidelines for staffing new clinics. At existing clinics, it was BHCS's intent to implement these guidelines through a phase-in process as positions were vacated and refilled over time.

- c. BHCS did not have documentation to support the methodology used to develop the staffing guidelines. BHCS explained that it reviewed national standards and other states' guidelines and used them as models for its guidelines. However, BHCS could not provide us with information showing how it determined the specific factors, ratios, and calculations used to

determine the guidelines. Proper documentation of the methodology used to develop the staffing guidelines would enable BHCS to update the staffing guidelines as needed.

RECOMMENDATIONS

We recommend that BHCS staff its ambulatory health care clinics in accordance with its staffing guidelines.

We also recommend that BHCS expand its staffing guidelines to address all aspects related to the delivery of prisoner health care services.

We further recommend that BHCS document the methodology used to develop its staffing guidelines.

AGENCY PRELIMINARY RESPONSE

BHCS disagrees with the auditors' conclusion that BHCS had not staffed its ambulatory health care clinics in accordance with its staffing guidelines. BHCS staffed its clinics using data that was available at the time of the fiscal year 1998-99 budgetary process, which was 1997, and before the staffing guidelines were in place.

BHCS partially agrees with the second recommendation. BHCS will consider adding factors to the guidelines based upon how closely the guidelines have met need. BHCS informed us that it had accounted for custody level, patient acuity, and presence of special populations within facilities, which cause work load increases. Increased staffing for factors such as gender, age, and physical disability is only needed to the extent that the data (i.e., number of visits) supports it. BHCS measured supporting data for these factors through review of its monthly activity reports. BHCS disagrees with the auditors' conclusion that dental waiting lists are an indicator that dental positions are understaffed. The dental waiting lists are compiled based on assessments at intake, screenings, etc. and consist of routine dental care needs.

The BHCS agrees with the finding and recommendation related to item c. and will document its process for development of staffing guidelines when they are next reviewed.

FINDING

4. Chronic Care Clinics and Intake Assessments

BHCS did not consistently perform medical evaluations related to chronic diseases/disorders* and intake assessments in accordance with BHCS clinical guidelines and American Correctional Association (ACA) standards.

Our review of prisoner medical files disclosed:

- a. BHCS had not consistently conducted regular clinical evaluations for those prisoners identified as having chronic diseases/disorders.

BHCS clinical guidelines require that each prison establish chronic care clinics to be held on a regular basis. These chronic care clinics include: cardiovascular diseases, diabetes, gastrointestinal disorders, infectious diseases, seizure disorders, and pulmonary diseases. BHCS designed the clinics so that a clinic for each disease/disorder shall be held at least every four months resulting in a minimum of three encounters per year. This design uses a "disease of the month" system that divides the clinics into a four-month rotating schedule providing uniform coverage across the State. This scheduling uniformity was intended to reduce the chances of prisoners missing their appointed clinics even after transfer to another prison.

We selected 89 prisoners identified as having chronic diseases/disorders to assess BHCS's compliance with its clinical guidelines. Our review of prisoner medical files disclosed that 20 (22%) prisoners did not have their chronic care clinic visits scheduled within the established four-month time frame. Five prisoners waited approximately one year between their chronic care clinic visits.

Without regular treatment and monitoring of their chronic diseases/disorders, these prisoners run added risk of incurring potentially severe and more costly complications.

* See glossary at end of report for definition.

- b. BHCS had not consistently completed the required intake assessments of newly arrived prisoners within the time constraints set forth in BHCS clinical guidelines and ACA accreditation standards.

For its prisoner reception centers, BHCS has incorporated ACA intake standards into its own intake health care assessment policies and procedures. These ACA standards require the reception centers to perform specific health-related tests and examinations within specific time restrictions. Such time restrictions include completing physical exams and dental screenings within 14 days of arrival and administering tuberculosis (TB) tests within 24 hours of arrival.

We reviewed the medical files for 50 prisoners who had intake dates from October 1, 1995 through December 31, 1998. We tested each medical file for seven intake attributes: (1) health histories gathered within 24 hours, (2) complete physical exams performed within 14 days, (3) psychological screenings conducted within 14 days, (4) complete dental screening conducted within 14 days, (5) TB tests administered within 24 hours, (6) blood samples collected for human immunodeficiency virus (HIV) tests within 14 days, and (7) necessary immunizations administered within 14 days. These seven attributes for each of the 50 medical files generated a total of 350 attributes tested.

Although BHCS was substantially compliant with the attributes tested, we noted 39 (11%) exceptions. Our review of BHCS's compliance with specific attributes disclosed that 54% of the physical exams were not performed or not documented as performed within 14 days. Also, 8% of TB tests were not administered or not documented as administered within 24 hours. In addition, overall noncompliance rates related to intake assessments increased from 9% in 1997 to 14% in 1998.

Without timely intake assessments of newly arriving prisoners, BHCS could fail to detect prisoners who pose a health or safety threat to themselves or others and who may require immediate medical attention.

RECOMMENDATION

We recommend that BHCS consistently perform medical evaluations related to chronic diseases/disorders and intake assessments in accordance with BHCS clinical guidelines and ACA standards.

AGENCY PRELIMINARY RESPONSE

BHCS disagrees that it did not consistently perform medical evaluations related to chronic diseases/disorders in accordance with BHCS clinical guidelines and ACA standards. The chronic care clinics' guidelines do not require that every chronically ill prisoner must attend every clinic. Rather, the goal of the guidelines is to ensure that each chronic care patient is seen at least three times per year or at least two times a year if the patient is stable and is being weaned from chronic care clinics. Physicians are permitted to forego scheduling the patient for a clinic if the patient has been recently seen and is stable. By following this procedure, BHCS makes best use of its resources. In most of the cases cited by the auditors, the chart supports that the patients had been recently seen and/or were stable. For example, one of the patients included in the auditors' exception rate was seen approximately 30 times by a physician, nurse, or registered dietician for problems related to his chronic illnesses between the last clinic visit and the next available clinic and had a physical exam 18 days prior to the next available clinic.

BHCS agrees that it did not always complete intake assessments within the time constraints set forth in its goals and will take steps to improve its compliance. BHCS is realigning work duties of medical records and clerical staff to allow monitoring of compliance with the time constraints. As intake numbers increase, BHCS will reevaluate its ability to meet the time constraints with current staff.

AUDITOR GENERAL EPILOGUE TO BHCS RESPONSE

BHCS designed the chronic care clinics to ensure that prisoners with chronic diseases/disorders are seen by physicians on a regular basis. The clinics' design incorporates a schedule in which certain disorders/diseases are treated within designated months on a Departmentwide basis. The design ensures that chronically ill prisoners receive regularly scheduled treatment even when frequently transferred among the Department's many prisons. Prisoners frequently request and receive treatment from medical staff for ailments unrelated to their

chronic care treatment regimen, such as knee and back pain, stuffy nose, eye examinations, and weight lifting injuries. Treatment for these additional ailments does not supplant the prescribed chronic care treatment. Modifications to chronic care treatment require physician orders. In the cases that we reviewed, we found no evidence that physicians allowed treatment of additional ailments to supplant the prescribed chronic care treatment.

FINDING

5. Assaultive Offender Program

BHCS did not provide all eligible prisoners an opportunity to participate in the Assaultive Offender Program (AOP).

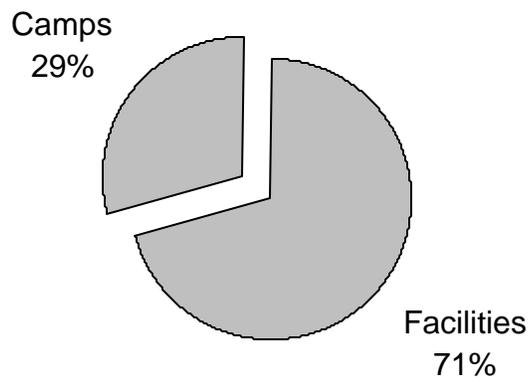
AOP is a group therapy treatment program used by BHCS to treat offenders who have a history of assaultive crimes. The primary goal of AOP is to provide an opportunity for prisoners to gain an increased understanding of their problem behaviors and to develop new skills to manage their assaultive behaviors. AOP focuses on those prisoners who demonstrate the motivation and desire to behave in a less assaultive fashion.

Incoming prisoners receive routine psychological screenings at the reception centers. These centers recommend that prisoners sentenced for assaultive offenses or who have demonstrated patterns of assaultiveness receive AOP assessment screening at their permanent housing prison. Each prison maintains a waiting list of the prisoners referred for AOP assessment screening. When these prisoners are within 24 months of their earliest release date, they are placed in the assessment phase. In this phase, a therapist interviews the prisoners to determine if they will proceed into therapy.

As of December 1998, 1,050 prisoners were enrolled in AOP. However, there were 1,026 prisoners on waiting lists for AOP assessment screenings. In addition, BHCS discontinued providing AOP to prisoners housed at prison camps during 1998 because the program was insufficiently staffed to meet demand. In January 1999, BHCS personnel estimated that 400 to 450 camp prisoners had received recommendations for AOP assessment screenings. When combined with 1,026 prisoners housed in secure prisons awaiting AOP assessment screenings,

the camp population represented 29% of all prisoners awaiting AOP assessment screenings:

AOP Waiting Lists



We reviewed studies related to social and behavioral rehabilitation in prisons, jails, and the community. These studies, published as recently as 1998, showed that effective offender treatment programs reduced recidivism (see Bibliography). Effective treatment programs included cognitive-behavioral and social learning, a highly structured program design, and a focus on criminal attitudes and behaviors. The rate at which therapy reduced recidivism varied among studies. However, most research demonstrated that offender treatment reduced recidivism by approximately 10%.

In addition, the Parole Board considers prisoners' satisfactory accomplishment of the intake center's programming recommendations when assessing prisoners' suitability for parole. These recommendations can include housing status, work programs, educational training, and/or therapy. It is difficult to assess the direct correlation among intake center recommendations, satisfactory accomplishment of these recommendations, and suitability for parole because each prisoner's parole hearing is unique.

Parole is significantly more efficient than incarceration. The Department of Corrections has determined that it annually costs \$1,600 to parole one prisoner

while incarceration annually costs \$24,350 per prisoner. An increase in the number of prisoners suitable for parole could result in significant savings for the Department. Also, the Department's statement of purpose states that it will provide ". . . meaningful opportunities for offenders to help themselves to improve their behavior and become law abiding and productive citizens. . . ." Without the availability of AOP to all eligible prisoners, the Department is not fully providing all opportunities to carry out its purpose.

RECOMMENDATION

We recommend that BHCS review the feasibility of providing all eligible prisoners an opportunity to participate in AOP.

AGENCY PRELIMINARY RESPONSE

BHCS partially agrees. BHCS agrees that all prisoners eligible for AOP should be provided with the opportunity to participate in the program. BHCS also agrees that it should extend the program to prisoners in camps and informed us that it has already implemented the program in camps. However, BHCS disagrees with the auditors' implication that waiting lists for screening to get into the program are indicative that prisoners were not given the opportunity to participate in the program. A list of 1,000 prisoners waiting to be assessed for the program indicates that DOC must assess them within the next 12 months to determine who is appropriate to enter the program. The program, by design, is provided in the last 12 months before the earliest release date. To manage or reduce the AOP waiting list, BHCS monitors group therapy caseloads to ensure that maximum groups and capacities are maintained and also initiates transfers for prisoners in need of program services to those sites and groups that can accommodate larger numbers. In addition, between 25% - 50% of prisoners on the waiting list prove not to be appropriate candidates.

Although all current sources of information indicate that few prisoners get to the point of potential parole and are prevented from doing so only due to the absence of AOP completion, BHCS agrees that closer monitoring of those in immediate need is warranted. BHCS will systematically identify prisoners who are within 12 months of their earliest release date and have not been assessed and/or entered the program. BHCS will then take immediate action to prioritize intake of any identified prisoners into AOP. BHCS will also determine if there is any gap

between demand and resources so that additional resources can be requested if needed.

FINDING

6. Computerized Medical Records

BHCS had not instituted a computerized medical records system. Such a system could have helped BHCS avoid numerous exceptions noted during our review of prisoner medical files.

Current medical literature supports computerized medical records systems as they offer multiple advantages over the traditional paper system (see Bibliography). The identified advantages include:

- Standardized and legible progress notes.
- Multi-user capabilities.
- Meaningful data collection.
- Extensive utilization reports.
- Integrated patient scheduling.
- Lab ordering and results tracking.
- Prescription ordering, tracking, and automatic refilling.
- Correctional environment customization.

We examined prisoner medical records at nine prisons located throughout the State. We readily noticed that computerized medical records may have negated or reduced the occurrence of numerous exceptions:

- a. We reviewed 309 prisoner medical files for attributes related to medical care, dental care, transfer documentation, and licensing and noted 72 exceptions. Our review of medical care produced 11 exceptions related to illegible handwriting and 7 exceptions related to progress notes not prepared in the

standardized SOAP* format. These are basic exceptions that a computerized medical records system could have remedied completely.

Our review of prisoner transfers produced 17 exceptions resulting from incomplete medical documentation for prisoners transferred among prisons. A computerized medical records system could have minimized these exceptions by automatically generating the applicable forms and by impeding medical clearance until health care personnel completed the forms.

- b. We reviewed an additional group of prisoner medical files for treatment of chronic diseases/disorders. Of these 89 prisoners, 20 (22%) prisoners did not have their chronic care clinic visits scheduled within the established four-month time frame (Finding 4). An integrated patient scheduling system could help to ensure that chronically ill prisoners were seen at the required interim.
- c. Medical personnel at the prisons occasionally requested us to search our sample of medical files to assist with locating a particular file. Frequently, the file requested was not in our sample. Tracking down files consumes personnel time that could be more effectively used for treating patients. An on-line, multi-user records system would eliminate the problems associated with not having records readily available.

In addition, a computerized medical records system would assist BHCS with effective data collection. Recently, BHCS has initiated the standardized collection of data related to each clinic's activities. However, BHCS still receives inconsistently collected and incomparable data from various clinics. For example, nursing shortages at one clinic delayed the collection of activity data and another clinic did not consistently report various activity data. A computerized medical records system could automatically collect and compile data for effective analysis without detaining medical personnel from their clinical duties.

* See glossary at end of report for definition.

RECOMMENDATION

We recommend that BHCS and the Department review the feasibility of instituting a computerized medical records system.

AGENCY PRELIMINARY RESPONSE

BHCS and the Department agree. BHCS and the Department believe that a computerized medical records system is vital to continuous improvement of quality and cost effectiveness. The Department has contracted the Department of Management and Budget to oversee the development of specifications and a request for proposal for a pilot project. Statewide implementation will depend upon executive and legislative approval of funding.

EFFICIENCY OF SERVICE

COMMENT

Audit Objective: To assess the efficiency of health care services provided to prisoners.

Conclusion: BHCS generally provided prisoner health care services in an efficient manner. However, our assessment disclosed one reportable condition related to contractual personnel.

Noteworthy Accomplishments: In April 1997, BHCS contracted for Statewide managed health care services for prisoners. This contract provides off-site specialty care services through a managed care system based on a fixed per prisoner per month rate. Although the contract was in effect for only six months during fiscal year 1996-97, it reduced hospital/specialty expenditures by \$5,320,750 (12%). The contract contributed to an additional savings of \$5,333,160 (14%) for fiscal year 1997-98. In addition, the Department reported that, based on prior expenditures, anticipated increases in prisoner population, increases in prisoner acuity, and increases in the Consumer Price Index for Medical Goods and Services, the direct savings plus the cost avoidance realized under the managed care system totaled an estimated \$17.6 million for the first full fiscal year of operation (fiscal year 1997-98).

Also, BHCS instituted a \$3 prisoner co-pay for non-emergency, prisoner-initiated health care effective June 1997. This co-pay reduced the number of prisoner requests for health care by approximately 10,000 requests per month. This reduction in health care requests allowed clinical personnel to focus their efforts on more significant health care issues, such as the development of a proactive approach to treating chronically ill prisoners.

FINDING

7. Contractual Health Care Personnel

BHCS filled vacant health care positions with contractual health care personnel at significantly higher costs than comparable civil service pay rates.

The managed care contract for Statewide off-site specialty care (the contract) contains provisions for temporarily filling vacant health care positions with contractual personnel. The direct cost of these individuals is BHCS's responsibility and is not included in the contract's cost-of-care capitated rate. Staffing service companies are subcontracted through the contract and provide supplemental health care personnel as needed. Prior to the contract, BHCS recruited and entered into separate contracts with individual health care providers to fill vacancies until civil service replacements were recruited.

We obtained a listing of contractual personnel working for BHCS as of December 26, 1998. There were 62 contractual personnel filling positions throughout the State's four health care regions: 30 in the central, 19 in the northern, 9 in the western, and 4 in the eastern. We compared the hourly rates that BHCS paid for the contractual personnel with those paid to civil service personnel in the same positions. The hourly rates paid by BHCS for the contractual personnel significantly exceeded the maximum hourly rates, including fringe benefits, available to civil service employees.

The contractual rates paid in excess of maximum civil services rates ranged from \$1.79 to \$39.79 per hour with an average excess of \$19.40 per hour. There were 6 contractual personnel whose hourly rates represented a savings. These savings averaged \$8.99 per hour.

BHCS employed many of these contractual personnel through the contract for substantial periods of time. Our analysis noted that 37% of the contractual personnel worked for BHCS for over one year. Based on full-time employment, BHCS could have paid up to an additional \$350,000 during 1998 for six physicians by contracting rather than hiring them through civil service at the civil service maximum pay rate, including benefits.

BHCS regional staff informed us that BHCS's policy to restrict offers of employment to civil service's minimum hourly rate hindered its ability to attract competent personnel through the civil service system. Therefore, BHCS established an hourly rate structure for contractual personnel that significantly exceeded the maximum civil service hourly rates for the same positions:

Comparison of Hourly Pay Rate Structures*

Position	Contractual Personnel**		Civil Service + 35% Benefits	
	Base	Maximum	Base	Maximum
Physician	\$95.00	\$115.00	\$56.82	\$75.21
Dentist	\$57.23	\$ 67.63	\$42.42	\$54.43
Dental Hygienist	\$28.64	\$ 34.09	\$18.24	\$24.34
Dental Assistant	\$24.68	\$ 29.17	\$17.24	\$20.30
Registered Nurse	\$31.93	\$ 37.73	\$21.84	\$27.72
Licensed Practical Nurse	\$26.09	\$ 30.83	\$17.58	\$21.72
Laboratory Technician	\$27.92	\$ 33.00	\$17.71	\$23.45
X-Ray Technician	\$27.92	\$ 33.00	\$19.01	\$25.76
Pharmacist	\$36.07	\$ 42.63	\$23.94	\$31.35

* Rates effective August 1997 through November 1998.

** Amounts paid by BHCS to staffing service company.

As shown in the accompanying chart, BHCS's contractual personnel rate structure set a physician's hourly rate between \$95 and \$115. However, we identified that the contractual service companies paid three medical services providers an average of \$41.50 per hour less than BHCS paid these staffing companies. In

contrast, a physician seeking employment within civil service would be offered the minimum hourly rate of \$56.82, including fringe benefits. Even civil service's maximum hourly rate of \$75.21, including fringe benefits, is significantly less than the range of rates approved for contractual physicians.

In November 1998, BHCS adjusted the rate structure for contractual personnel to more closely reflect civil service pay rates. However, BHCS personnel informed us that the staffing companies had successfully recruited few, if any, personnel since these rates became effective. Also, the new rates were not retroactive for contractual personnel hired under the previous rate structure.

The Civil Service Commission has approved a pilot compensation program that authorizes signing bonuses to enhance the recruitment of information technology employees. The Commission has approved a one-time amount of up to \$5,000. Such a bonus could be used to enhance BHCS's recruitment of medical personnel.

RECOMMENDATION

We recommend that BHCS and the Department of Corrections review the feasibility of hiring health care personnel at the civil service maximum hourly rates and offering a signing bonus to fill vacant positions within BHCS prior to hiring more costly contractual health care personnel.

AGENCY PRELIMINARY RESPONSE

BHCS agrees in part.

During the audit, BHCS clarified its policy regarding starting salaries and offering employment above the minimum starting civil service rate in accordance with civil service rules when it was necessary to attract individuals. Contractors were only used when civil service candidates were not available.

Regarding signing bonuses, BHCS agrees and will comply by pursuing signing bonuses with the Department of Civil Service.

In addition, it is important to note that premium prices are paid for contractual employees because of the temporary "at will" nature of the position. Prices for professional positions of this nature in the community are based on a sliding scale

and subject to the market forces of competition and scarcity. Care is taken to fill positions with the lowest cost suitable contract professional and only when overtime cannot meet the critical need.

In addition, the auditors did not capture all of the costs of hiring civil service employees by only identifying salaries, wages, and benefits. The auditors did not consider that costs such as malpractice litigation costs, other litigation costs, workers compensation, hiring and recruitment costs, and indirect personnel costs are absorbed by the prime contractors and passed through to the Department through the rates charged by the contractors.

SUPPLEMENTAL INFORMATION

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Glossary of Acronyms and Terms

ACA	American Correctional Association.
ambulatory health care	Outpatient health care services available to prisoners at each prison.
AOP	Assaultive Offender Program.
BHCS	Bureau of Health Care Services.
chronic care clinics	Regularly scheduled health care treatments for prisoners diagnosed with chronic diseases/disorders.
chronic diseases/disorders	Include cardiovascular diseases, including hypertension; diabetes mellitus; gastrointestinal disorders; infectious diseases; seizure disorders; and pulmonary diseases.
CMS	Correctional Medical Services, Inc.
DMB	Department of Management and Budget.
ECF	Oaks Correctional Facility.
effectiveness	Program success in achieving mission and goals.
efficiency	Achieving the most outputs and outcomes practical for the amount of resources applied or minimizing the amount of resources required to attain a certain level of outputs or outcomes.
goals	The agency's intended outcomes or impacts for a program to accomplish its mission.
HIV	human immunodeficiency virus.

HTF	Hiawatha Temporary Correctional Facility.
inputs	Resources (e.g., staff hours or expenditures) that a program consumes in producing outputs.
JCF	G. Robert Cotton Correctional Facility.
KCF	Kinross Correctional Facility.
KTF	Chippewa Temporary Correctional Facility.
liquidated damages	Charges assessed against and paid by the contractor for failure to meet specific standards set forth in the request for proposal.
LRF	Earnest C. Brooks Correctional Facility.
managed health care	Systems that combine the financing and delivery of health care services to patients by arranging with providers to provide patient services.
MCF	Muskegon Correctional Facility.
mission	The agency's main purpose or the reason the agency was established.
MTF	Muskegon Temporary Correctional Facility.
outcomes	The actual impacts of the program. Outcomes should positively impact the purpose for which the program was established.
outputs	The products or services produced by the program. The program assumes that producing its outputs will result in favorable program outcomes.

performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve public accountability and to facilitate decision making by parties responsible for overseeing or initiating corrective action.
performance indicators	Information of a quantitative or qualitative nature indicating program outcomes, outputs, or inputs. Performance indicators are typically used to assess achievement of goals and/or objectives.
performance standards	A desired level of output or outcome as identified in statutes, regulations, contracts, management goals, industry practices, peer groups, or historical performance.
reportable condition	A matter coming to the auditor's attention that, in his/her judgment, should be communicated because it represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.
RFP	request for proposal.
SOAP	A standardized format for writing medical progress notes. S : Subjective Data O : Objective Data A : Assessment P : Plan.
SMN	Charles Egeler Correctional Facility.
SRF	Saginaw Correctional Facility.
UCMC	United Correctional Managed Care, Inc.
URF	Chippewa Correctional Facility.