MICHIGAN

OFFICE OF THE AUDITOR GENERAL

AUDIT REPORT

PERFORMANCE AUDIT
OF

PRISONER MEDICAL AND DENTAL SERVICES

DEPARTMENT OF CORRECTIONS

March 2008

THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

471-0300-06

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

– Article IV, Section 53 of the Michigan Constitution

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REPORT SUMMARY

Performance Audit

Prisoner Medical and Dental Services

Department of Corrections

Report Number:
471-0300-06

Released:
March 2008

The Bureau of Health Care Services (BHCS), Department of Corrections (DOC), is responsible for coordinating medical and dental services. These services are provided through a network of outpatient clinics operated at correctional facilities and through a managed health care system for off-site specialty services.

Audit Objective:
To assess the effectiveness of DOC's efforts to comply with selected policies and procedures related to the delivery of medical and dental services.

Audit Conclusion:
We concluded that DOC's efforts to comply with selected policies and procedures related to the delivery of medical services were not effective. We also concluded that DOC's efforts to comply with selected policies and procedures related to the delivery of dental services were effective. We noted one material condition (Finding 1) and one reportable condition (Finding 2).

Material Condition:
BHCS did not conduct all required chronic condition medical evaluations, routine annual health care screenings, and clinic visits resulting from prisoner requests for health care services. Also, BHCS did not ensure that it provided these evaluations, screenings, and clinic visits within time frames established in its policies and procedures. (Finding 1)

Reportable Condition:
BHCS did not consistently charge prisoner copayments (Finding 2).

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Audit Objective:
To assess the effectiveness of DOC's utilization of the electronic prisoner medical record system.

Audit Conclusion:
We concluded that DOC's utilization of the electronic prisoner medical record system was moderately effective. We noted one material condition (Finding 3).

Material Condition:
BHCS did not ensure that its electronic medical record system (Serapis) contained complete and accurate data and provided for sufficient collection, analysis, and reporting of data (Finding 3).

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Audit Objective:
To assess the effectiveness of DOC's efforts to manage prisoner medications.

Audit Conclusion:
We concluded that DOC's efforts to manage prisoner medications were moderately effective. We noted three reportable conditions (Findings 4 through 6).

Reportable Conditions:
DOC should improve controls related to maintaining and distributing restricted medications (Finding 4).

DOC did not effectively monitor the disposal of unused or expired medications or medications returned to the pharmacy contractor (Finding 5).

BHCS did not document the justification for the use of a brand name or nonformulary drug rather than a generic or formulary drug. In addition, BHCS did not document the regional medical officer's approval for brand name and nonformulary drugs prescribed by health care professionals. (Finding 6)

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Audit Objective:
To assess the effectiveness of DOC's efforts to manage health care staffing.

Audit Conclusion:
We concluded that DOC's efforts to manage health care staffing were moderately effective. We noted one material condition related to the delivery of health care services (Finding 1), which is reported under the delivery of services objective.

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Audit Objective:
To assess the effectiveness of DOC's efforts to monitor the managed health care and pharmaceutical contracts.

Audit Conclusion:
We concluded that DOC's efforts to monitor the managed health care and pharmaceutical contracts were moderately effective. We noted one reportable condition (Finding 7).

Reportable Condition:
BHCS should improve its monitoring of the managed health care and pharmaceutical contracts.

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Agency Response:
Our audit report includes 7 findings and 9 corresponding recommendations. DOC's preliminary response indicates that it agrees with all of the recommendations and has complied or will comply with them.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: http://audgen.michigan.gov

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THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

March 25, 2008

Ms. Patricia L. Caruso, Director
Department of Corrections
Grandview Plaza Building
Lansing, Michigan

Dear Ms. Caruso:

This is our report on the performance audit of Prisoner Medical and Dental Services, Department of Corrections.

This report contains our report summary; description; audit objectives, scope, and methodology and agency responses and prior audit follow-up; comments, findings, recommendations, and agency preliminary responses; six exhibits, 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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DEPARTMENT OF CORRECTIONS

SUPPLEMENTAL INFORMATION

GLOSSARY

Description

The Bureau of Health Care Services (BHCS), Department of Corrections (DOC), is responsible for coordinating medical and dental services. These services are provided through a network of outpatient clinics operated at correctional facilities and through a managed health care system* for off-site specialty services. In-patient care is provided at local hospitals, at the Duane L. Waters Hospital, and at a DOC-operated secure unit at Foote Hospital in Jackson.

Medical and dental services are provided to prisoners using a standard of care imposed by court decisions, legislation, accepted correctional and health care standards, and DOC policies and procedures (see Exhibit 6, presented as supplemental information). Through February 5, 1999, DOC operated under a 1984 consent decree with the U.S. Department of Justice. Under this consent decree, DOC agreed to improve health care services. Federal court-appointed experts monitored DOC's compliance with the consent decree. As a result of DOC's compliance, the U.S. Department of Justice terminated the consent decree in 2002. DOC is still operating under a 1985 consent decree (the Hadix consent decree) created to resolve complaints by prisoners housed at the former Central Complex of the State Prison of Southern Michigan, including the Reception and Guidance Center. Under the Hadix consent decree, DOC also agreed to improve health care services. Federal court-appointed experts monitor DOC's compliance with the consent decree. The plaintiffs, DOC, the independent monitors, and the court are attempting to resolve issues regarding what is necessary to show compliance with the consent decree.

DOC spent $213.7 million for selected prisoner health care services* in fiscal year 2005-06, including $140.8 million for on-site health care services and central office staff and $72.9 million for off-site specialty health care services. The average prisoner population for fiscal year 2005-06 was 50,595 prisoners, resulting in an average annual cost per prisoner of $4,223 for health care services (see Exhibit 1, presented as supplemental information).

Effective April 1, 1997, BHCS entered into a contract to provide a Statewide managed health care system for off-site specialty services. DOC reimburses the contractor for

* *See glossary at end of report for definition.*

these services based on a fixed per prisoner per month rate, adjusted quarterly to reflect actual costs, plus a management fee to cover administration costs. DOC reduces the management fee as actual costs for services increase, to provide incentive for the contractor to control costs. This undertaking resulted in one managed health care contract replacing several hundred contracts with individual health care providers. Effective May 28, 2000, BHCS expanded the managed health care contract to include medical service providers*, which include physicians, physician assistants, and nurse practitioners. The cost for these services is based on a fixed hourly rate. In fiscal year 2005-06, DOC paid the managed health care contractor $84.6 million for off-site specialty services and on-site medical service providers.

Effective April 1, 2004, BHCS entered into a contract with a pharmaceutical company. Initially, 21 correctional facilities participated in the contract and DOC later added 9 more correctional facilities. As of July 1, 2006, the contract was expanded to include all correctional facilities Statewide. The cost for these services is based on a fixed per prisoner per month rate plus the cost of pharmaceuticals. In fiscal year 2005-06, DOC paid $27.1 million for pharmaceuticals, excluding psychotropic medications for mental health prisoners under the care of the Department of Community Health.

Effective November 6, 2001, DOC entered into a contract with the managed health care contractor to provide an electronic prisoner medical record system (Serapis) for $2.9 million. DOC began implementing Serapis at correctional facilities in October 2002.

Effective October 7, 2003, DOC and the Department of Information Technology entered into a contract with the managed health care contractor for $1.0 million to provide maintenance and support for Serapis. In addition, BHCS informed us that it had spent $2.0 million to equip correctional facilities for Serapis.

* *See glossary at end of report for definition.*

DOC's fiscal year 2005-06 costs for prisoner medical, dental, and vision services are summarized as follows:

	Services Provided Directly by DOC	Services Provided Under Managed Health Care Contract	Pharmacy Contracts	Total
On-site services	$ 101,921,338	$ 11,740,083	$ 27,127,051	$ 140,788,472
Off-site services		72,893,548		72,893,548
Total	$ 101,921,338	$ 84,633,631	$ 27,127,051	$ 213,682,020

Audit Objectives

Our performance audit* of Prisoner Medical and Dental Services, Department of Corrections (DOC), had the following objectives:

1. To assess the effectiveness* of DOC's efforts to comply with selected policies and procedures related to the delivery of medical and dental services.

2. To assess the effectiveness of DOC's utilization of the electronic prisoner medical record system.

3. To assess the effectiveness of DOC's efforts to manage prisoner medications.

4. To assess the effectiveness of DOC's efforts to manage health care staffing.

5. To assess the effectiveness of DOC's efforts to monitor the managed health care and pharmaceutical contracts.

Audit Scope

Our audit scope was to examine the health care and other records of the Bureau of Health Care Services (BHCS) related to the delivery of prisoner medical and dental 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 such other auditing procedures as we considered necessary in the circumstances. Our audit procedures, conducted from April through September 2006, included examining BHCS's records from October 1, 2003 through July 31, 2006.

Although BHCS is also responsible for mental health services, substance abuse services, and routine vision examinations, these were not included in the scope of this audit. In addition, DOC informed us that it is in the process of working with a consultant to revamp the delivery of health care services in a manner it believes will be more cost effective. Therefore, we did not evaluate the cost-effectiveness of the current system because our findings may not be applicable to the new system. Furthermore, the new

* *See glossary at end of report for definition.*

system was not implemented at the time of our audit fieldwork; consequently, we did not have sufficient data to evaluate its potential cost-effectiveness. Also, we did not include a review of prisoner transportation for medical reasons or the pharmacy contractor's performance in the scope of this audit because we plan to include these areas in the scope of future audits.

Our audit was not directed toward examining medical decisions made by health care professionals, including contracted health care professionals, concerning patient treatment or expressing conclusions on those medical decisions; accordingly, we express no conclusion on those medical decisions.

We obtained information from DOC, the U.S. Department of Labor, the U.S. Department of Health and Human Services, the State of Michigan Medicaid State Plan, and the *State of Michigan Employee Benefits Summary & Enrollment Information* (see Exhibits 1, 2, and 6). We did not audit this information and, accordingly, we express no conclusion on this information.

Audit Methodology

To establish our audit objectives, we conducted a preliminary review of prisoner health care services. This included discussions with key central office staff and on-site interviews with regional and facility health care staff regarding their functions and responsibilities. Also, we reviewed prisoner health care policies and procedures.

To assess the effectiveness of DOC's efforts to comply with selected policies and procedures related to the delivery of medical and dental services, we reviewed DOC's policies, procedures, and chronic care guidelines that establish time frames for delivery of services. We then reviewed prisoner health care files to assess DOC's compliance with these time frames for chronic care visits, annual health care screenings, and clinic visits resulting from prisoner requests for medical and dental services. Also, we interviewed health care staff at the DOC central office and selected facilities and reviewed prisoner copayments. In addition, we reviewed DOC central office's procedures for conducting reviews of prisoner deaths and observed procedures for emergency runs and administration of medications at selected facilities.

To assess the effectiveness of DOC's utilization of the electronic prisoner medical record system, we interviewed personnel from BHCS and DOC's Bureau of Fiscal Management and health care staff at selected facilities, reviewed selected prisoner health care files, and reviewed reports and other information related to the system.

To assess the effectiveness of DOC's efforts to manage prisoner medications, we reviewed controls over restricted medications, disposal of medications, the use of over-the-counter medications, and approvals for the use of nonformulary drugs*.

To assess the effectiveness of DOC's efforts to manage health care staffing, we interviewed BHCS personnel, obtained and analyzed staffing data for health care positions, reviewed overtime, and researched pay rates for nursing staff.

To assess the effectiveness of DOC's efforts to monitor the managed health care and pharmaceutical contracts, we interviewed personnel from BHCS and the Bureau of Fiscal Management, reviewed the managed health care and pharmaceutical contracts, reviewed the billing process and tested a sample of billings, and tested the licensure of the health care professionals. Also, we analyzed the volume and monetary amount of health care lawsuit settlements per year and analyzed health care costs per prisoner in relation to the medical care consumer price index (see Exhibit 2). In addition, we discussed with management the reports and information that were available and used to manage selected prisoner health care services and compared basic prisoner health care services to benefits available through other programs (see Exhibit 6).

We use a risk and opportunity based approach when selecting activities or programs to be audited. Accordingly, our audit efforts are focused on activities or programs having the greatest probability for needing improvement as identified through a preliminary review. By design, our limited audit resources are used to identify where and how improvements can be made. Consequently, our performance audit reports are prepared on an exception basis.

Agency Responses and Prior Audit Follow-Up

Our audit report includes 7 findings and 9 corresponding recommendations. DOC's preliminary response indicates that it agrees with all of the recommendations and has complied or will comply with them.

The agency preliminary response that 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 the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require DOC to develop

* *See glossary at end of report for definition.*

a formal response to our audit findings and recommendations within 60 days after release of the audit report.

Within the scope of this audit, we followed up 9 of the 10 prior audit recommendations from our February 2000 performance audit of the Bureau of Health Care Services, Department of Corrections (47-300-98). BHCS complied with 4 of the prior audit recommendations, 3 recommendations were no longer applicable, and 2 were rewritten for inclusion in this report. We also followed up the 1 prior audit recommendation from our September 2002 financial related audit of Vendor Payments for the Health Care of Prisoners, Department of Corrections (47-305-00). DOC complied with the prior audit recommendation.

COMMENTS, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

EFFECTIVENESS OF EFFORTS TO COMPLY WITH SELECTED POLICIES AND PROCEDURES RELATED TO DELIVERY OF SERVICES

COMMENT

Audit Objective: To assess the effectiveness of the Department of Corrections' (DOC's) efforts to comply with selected policies and procedures related to the delivery of medical and dental services.

Audit Conclusion: We concluded that DOC's efforts to comply with selected policies and procedures related to the delivery of medical services were not effective. We also concluded that DOC's efforts to comply with selected policies and procedures related to the delivery of dental services were effective. We noted one material condition*. The Bureau of Health Care Services (BHCS) did not conduct all required chronic condition medical evaluations, routine annual health care screenings, and clinic visits resulting from prisoner requests for health care services. Also, BHCS did not ensure that it provided these evaluations, screenings, and clinic visits within time frames established in its policies and procedures. (Finding 1)

We also noted one reportable condition* related to prisoner copayments (Finding 2).

FINDING

1. Delivery of Health Care Services

   BHCS did not conduct all required chronic condition medical evaluations, routine annual health care screenings, and clinic visits resulting from prisoner requests for health care services. Also, BHCS did not ensure that it provided these evaluations, screenings, and clinic visits within time frames established in its policies and procedures. As a result, BHCS may have jeopardized its ability to identify, manage, and treat potentially serious medical conditions before they became more severe and costly to treat or before they became a threat to the prison population and staff.

* *See glossary at end of report for definition.*

We reviewed prisoners' medical files and requests for health care services and noted:

a. Of 120 prisoners identified as having chronic conditions, 61 (51%) were not seen for their chronic care visits or were not seen as often as required by DOC's chronic care guidelines (see Exhibit 3, presented as supplemental information). We reviewed 373 required visits for the 120 prisoners and determined that 44 (12%) of the visits were missed and 42 (11%) were late. The average number of days between the missed chronic care visit and the prisoner's next chronic care visit was 237 days. Also, the late chronic care visits were an average of 105 days later than the guideline requirements.

   DOC's chronic care guidelines state that, at a minimum, any prisoner enrolled in a chronic care clinic* must be seen every six months if their condition is well controlled or good, every three months if their condition is fair, and every month if their condition is poor.

   BHCS indicated that health care professional staffing vacancies at some of the facilities resulted in the untimely chronic care visits. In other cases, BHCS indicated that the prisoners were simply overlooked and had not been included in the schedule for chronic care appointments.

   We noted similar conditions in our prior audit. DOC disagreed with our prior audit recommendation and indicated that, in the cases we cited, the prisoners had been seen by medical staff in between chronic care clinics and their chronic conditions were stable. During the current audit, we considered other health care visits with medical staff in addition to chronic care clinic visits. For the 23% of visits that were missed or late, we found no documentation in the prisoners' medical records that medical staff addressed the prisoners' chronic conditions during these other visits.

b. Of 307 prisoners reviewed, 6 (2%) did not receive their most recent annual health care screening (see Exhibit 4, presented as supplemental information). The annual health care screenings for the 6 prisoners were an average of 594 days overdue. In addition, BHCS did not complete the annual health care screening for 69 (22%) of the 307 prisoners within 30 days after the prisoner's

* *See glossary at end of report for definition.*

birthday as required by policy. The annual health care screenings for the 69 prisoners were an average of 103 days late.

DOC policy directive 03.04.100 requires that prisoners have an annual health care screening within 30 days before or after their birthday.

The annual health care screening is an important health care visit as it may be the only time prisoners are seen by medical staff during the year. The annual health care screening allows BHCS to assess prisoners' disabilities and necessary accommodations, review their hepatitis B vaccination status, and provide health education and disease prevention information. In addition, the annual health care screening is the only health care visit during which prisoners are screened for tuberculosis. Both tuberculosis and hepatitis B can be contagious and, if left undetected, could be spread to other prisoners or staff.

BHCS indicated that the facility health care clinics' failure to comply with annual health care screening policy requirements was the result of nursing staff vacancies at the health care clinics. We noted that there was an 18% vacancy rate for nursing staff as of June 2006 (see background section for fourth objective). In other cases, BHCS indicated that the prisoners were simply overlooked and had not been included in the schedule for annual health care screenings.

c. Of 130 prisoners initiating requests that necessitated a visit from a health care professional, 4 (3%) prisoners initiating requests had not been seen by a health care professional for that request and 55 (42%) were not seen by a health care professional within the required time frames (see Exhibit 5, presented as supplemental information). The 4 prisoners who had requested health care visits, but had not been seen, had been waiting for an average of 128 business days. Of the 55 late appointments, we noted that prisoners who needed appointments were seen by a health care professional an average of 12 business days late.

DOC policy directive 03.04.100 requires health care staff to collect prisoners' requests for health care and nursing staff either to respond in writing to the prisoners' requests or to see the prisoners within one business day after receipt of their requests. In addition, if nursing staff believe that an

appointment is needed, the prisoner is required to be seen by an appropriate health care professional within 2 or 7 business days after the written response, depending on the type of health care professional.

BHCS indicated that health care professional staffing vacancies resulted in some of the delays in response to the prisoner health care requests.

RECOMMENDATIONS

We recommend that BHCS conduct all required chronic condition medical evaluations, routine annual health care screenings, and clinic visits resulting from prisoner requests for health care services.

We also recommend that BHCS ensure that it provides these evaluations, screenings, and clinic visits within time frames established by its policies and procedures.

AGENCY PRELIMINARY RESPONSE

BHCS agrees and informed us that it will comply. BHCS indicated that although this has been a problem in the past, there are several efforts underway that will improve scheduling and the timeliness of health services delivery. BHCS informed us that prisoners have been assigned an acuity index that will allow staff to better track prisoners with chronic medical conditions. DOC has appointed a Health Care Improvement Team (HCIT) which has conducted a critical assessment of the administration and management of health care operations and developed a strategic plan to guide BHCS in the redesign of the health care delivery system. BHCS indicated that in the systemic redesign of the health care delivery system, HCIT identified the following areas for improvement: BHCS management, infrastructure, health services contracts, quality assurance, communications, and independent reviews.

BHCS stated that progress steps on those HCIT activities that are aligned substantially to correct this finding include the following:

- The management infrastructure work group has developed a new management structure for the BHCS central office staff to enhance the strategic planning, quality assurance, and performance monitoring of the health care delivery system.

- A request for proposal (RFP) for an updated and robust electronic medical record (EMR) had been posted and is currently in process through collaboration with the Department of Management and Budget and the Department of Information Technology. The initiative will result in improved productivity of medical practitioner staff of all disciplines. This new EMR will also give DOC the capacity to run exception reports.

- BHCS is reviewing its medical practitioner and nursing staffing plan to ensure that sufficient human resources exist to provide timely routine health care services and to investigate and resolve exceptions. In addition, although BHCS will continue annual screenings for tuberculosis, BHCS is considering reducing the frequency of routine health care screenings for some age groups to be more consistent with the Centers for Disease Control and Prevention and correctional industry practices.

- As part of the recent extension of the Correctional Medical Services (CMS) contract, provisions were negotiated to increase accountability in the areas of provider staffing and productivity.

- An RFP for managed care health services was posted in July 2007 and subsequently withdrawn to strengthen the RFP and improve competitive bidding. Subsequently, a request for information (RFI) in advance of the second RFP was posted in November 2007. DOC hosted a successful RFI conference attended by over 50 participants from the community of potential vendors.

- In collaboration with the Department of Management and Budget, HCIT is now reviewing the RFI responses in preparation for a new RFP for managed care services that will be more responsive to DOC needs.

- The new position of an assistant chief medical officer has been added to central office staff to strengthen the clinical oversight by BHCS for performance monitoring of the health service contract providers.

- The development of a quality assurance administrator position with support staff is currently in process to monitor clinical performance by both contract providers and DOC health staff.

- The development of an independent review contract to assist in the utilization practices of the health care delivery system for implementation in fiscal year 2008-09.

FINDING

2. Prisoner Copayments

BHCS did not consistently charge prisoner copayments. Failure to charge the copayment could result in an increase in the number of requests for health care services and could result in additional work for health care staff.

Section 791.267a of the *Michigan Compiled Laws* states that a prisoner who receives nonemergency medical or dental services at his or her request is responsible for a copayment fee to DOC for those services, as determined by DOC.

DOC policy directive 03.04.101 states that the prisoner shall be charged a $5.00 copayment for each medical and dental visit, except for under certain circumstances, such as when a health care professional initiates a health care visit. The policy further states that a prisoner shall be offered necessary health care services (i.e., medical and dental services) regardless of ability to pay but shall be charged a fee for health care services.

DOC implemented prisoner copayment requirements in 1997 in an attempt to reduce frivolous health care requests and to allow health care staff to focus their efforts on more significant health care issues. BHCS claimed that the implementation of the copayment fee reduced the number of prisoner requests for health care services by approximately 10,000 per month.

BHCS provided additional information to the health care clinics in January 2005 (appended in March 2005) in an attempt to clarify the policy directive. However, health care staff misinterpreted the additional guidance. We noted that 5 of the 6 facilities we visited rarely charged copayments for medical or dental services. We also noted that, since the policy clarification was issued in January 2005, the average number of prisoner requests for health care services increased by 20%, even though the prisoner population had increased by only 2%. Although several factors could impact an increase in requests, health care staff at the facilities

attributed a significant portion of the increase in requests to reductions in copayment charges. If BHCS had charged prisoner copayments during this time period, it may have reduced the number of frivolous requests, allowing health care staff more time to provide medically necessary services in a timely manner. In addition, BHCS's collection of prisoner copayments decreased by approximately $55,000 (29.5%).

RECOMMENDATION

We recommend that BHCS consistently charge prisoner copayments in accordance with DOC policy.

AGENCY PRELIMINARY RESPONSE

BHCS agrees and informed us that it complied in 2006 by providing additional information to health care staff to clarify the DOC policy. In addition, BHCS indicated that, as a result of increased oversight by the Bureau of Fiscal Management, the new BHCS central office structure, and increased performance monitoring and quality assurance activities called for in the strategic plan, BHCS will demand better compliance with its copayment policy at the facility level.

EFFECTIVENESS OF UTILIZATION OF THE ELECTRONIC PRISONER MEDICAL RECORD SYSTEM

COMMENT

Audit Objective: To assess the effectiveness of DOC's utilization of the electronic prisoner medical record system.

Audit Conclusion: We concluded that DOC's utilization of the electronic prisoner medical record system was moderately effective. We noted one material condition. BHCS did not ensure that its electronic prisoner medical record system (Serapis) contained complete and accurate data and provided for sufficient collection, analysis, and reporting of data (Finding 3).

FINDING

3. Electronic Prisoner Medical Record System

BHCS did not ensure that its electronic prisoner medical record system (Serapis) contained complete and accurate data and provided for sufficient collection,

analysis, and reporting of data. This limited DOC's ability to efficiently analyze individual medical records; to summarize those records; and to evaluate trends and develop summary data on health care services, conditions, and costs by age group, condition, or treatment of prisoners. These types of analyses would assist BHCS in allocating resources to better manage health care services and could also be used to evaluate the success of the services in comparison with health care trends within other prisons, the State, or the nation.

DOC purchased Serapis in 2001 as the electronic health record for the prison population. Although some records such as x-rays, outside consult papers, and some diagnostic testing results are retained in a hard copy format, DOC plans to rely on Serapis as the primary record of health care services rendered to prisoners. As of May 2006, 39 of the 42 facilities had implemented Serapis. The cost for Serapis software, equipment, servers, maintenance, and support as of May 2006 was $5.9 million.

We noted:

a. BHCS's electronic prisoner medical records were not complete and accurate. For example:

   (1) BHCS did not have an accurate electronic record of prisoners enrolled in chronic care clinics. Our review of 120 prisoners enrolled in chronic care clinics disclosed that 5 (4%) should not have been labeled as chronic care patients. Furthermore, we noted that 39 (33%) of 120 chronic care patients were listed under only one chronic care clinic when the paper medical record indicated that they were enrolled in more than one clinic. Because these chronic care patients were labeled as chronic care patients when they should not be or were listed under only one chronic care clinic, BHCS could not electronically summarize the true population for any given clinic. To analyze data related to a specific clinic, BHCS would have to review individual electronic records and hard copy files of all prisoners.

   (2) BHCS did not have a complete electronic record of prisoner visits with health care staff. Our review of 187 prisoner medical files disclosed that 67 (36%) did not contain all medical information in Serapis, even though the facilities had implemented Serapis prior to the period of our testing.

For example, BHCS did not enter all health care visits in Serapis; therefore, it could not easily summarize and evaluate the number of prisoner visits with health care staff. Analysis of this type of information would assist in identifying staffing needs and monitoring the timeliness of health care visits.

We were informed that Serapis's response time was slow and that it was frequently not in operation. When Serapis was not responding, health care staff recorded medical information manually rather than electronically, preventing BHCS from creating a comprehensive electronic medical record. During our two- to three-day visits to the health care clinics at 6 facilities, Serapis was not in operation for some period of time during our visit at 3 facilities.

(3) BHCS did not have an accurate electronic record of prisoner-initiated requests for health care services processed by health care staff. The facilities we visited did not use consistent criteria when entering a prisoner request for health care on Serapis. For example, at some facilities, a prisoner inquiry regarding a prescription refill or an appointment time would not be entered as a request whereas, at other facilities, all requests, regardless of the nature of the request, would be entered into Serapis. As a result, BHCS could not analyze the number and types of requests by facility to help evaluate the medical staff work loads and the needs of the prison population.

b. BHCS did not ensure that Serapis provided sufficient collection, analysis, and reporting capabilities. For example:

(1) Serapis did not have search capabilities to summarize aggregate prisoner data by diagnosis, test, or treatment or to identify prior treatment of health care issues by individual prisoner. For individual prisoner records, health care staff had to scroll through and review every entry in the electronic file in order to find specific information. Also, BHCS could not perform other analyses of aggregate prisoner data, such as comparing condition occurrences within the prison system to occurrences outside the prison population.

(2) Serapis did not produce useful Statewide reports. Although BHCS began implementing Serapis in 2002, it informed us that it had just begun the process of developing the reports it believed would help in management of health care services. At the time of our audit, BHCS could obtain reports by prisoner or facility but could not obtain summary level Statewide reports from Serapis. Developing summary reports of Statewide data would assist BHCS in monitoring health care activities and allocating resources among facilities based on health care needs.

(3) Serapis did not include templates or data collection methods to collect medical information related to hepatitis C. In addition, Serapis did not have an effective means of gathering information for prisoners enrolled in multiple chronic care clinics. As a result, health care staff did not fully utilize Serapis to maintain prisoner health care records. Documenting this information electronically would assist BHCS in monitoring prisoners enrolled in the hepatitis C chronic care clinic and the needs of prisoners with multiple chronic conditions.

RECOMMENDATION

We recommend that BHCS ensure that its electronic prisoner medical record system (Serapis) contains complete and accurate data and provides for sufficient collection, analysis, and reporting of data.

AGENCY PRELIMINARY RESPONSE

BHCS agrees and informed us that it is taking steps to comply. BHCS indicated that progress steps to date on those HCIT activities related to EMR include the following:

- BHCS has established a form to record medical information when the system is nonoperational. Staff have been instructed to enter information recorded on the form when the system returns to operation. In addition, staff have been instructed to record all prisoner-initiated requests and all health care encounters into the EMR system.

- In the recently negotiated extension of the CMS contract, provisions were added to allow for penalties if the medical practitioners fail to use EMR.

- DOC has conducted an exhaustive review of several national software products for correctional health electronic medical records. This included a weeklong series of product presentations as part of DOC's RFI process. As a result of this process, the Department of Management and Budget has posted an RFP to replace the Serapis EMR.

- The Joint Evaluation Committee is currently in the RFP evaluation process for a new EMR. The improvement of the fully integrated EMR will greatly enhance the efficiency of staff and provide additional reporting capabilities. The new EMR will also incorporate the dental and mental health records.

BHCS will also address enrollment of prisoners in multiple chronic care clinics in the EMR system. The new EMR will also enhance the retrieval of information already in the record.

EFFECTIVENESS OF EFFORTS TO MANAGE PRISONER MEDICATIONS

COMMENT

Audit Objective: To assess the effectiveness of DOC's efforts to manage prisoner medications.

Audit Conclusion: We concluded that DOC's efforts to manage prisoner medications were moderately effective. We noted three reportable conditions related to restricted medications, disposal of medications, and brand name and nonformulary prescriptions (Findings 4 through 6).

FINDING

4. Restricted Medications

DOC should improve controls related to maintaining and distributing restricted medications. Failure to ensure that medications are properly controlled and distributed increases the cost of restricted medications and the risk that restricted medications could be subject to loss, theft, or abuse.

Restricted medications are defined in the BHCS formulary* and include psychotropic medications, scheduled medications, injectable medications, and medications that health care staff identify as having a potential for abuse. Nursing staff keep restricted medications in the health care clinic and distribute the medications to prisoners.

Our review of restricted medications disclosed:

a. BHCS did not periodically inventory restricted medications with the most potential for theft or abuse. As a result, BHCS increased its risk that these medications could be lost or stolen without being detected in a timely manner. BHCS only requires restricted medications to be inventoried if they are located in the physician's dispensing box or classified as a controlled substance. BHCS should consider expanding its procedures to periodically inventory additional restricted medications with the most potential for theft or abuse.

b. Nursing staff did not always ensure that prisoners had swallowed their restricted medications as required by operating procedures. As a result, staff were not assured that the prisoners had taken the prescribed medications, thereby increasing the risk that prisoners could introduce the medications as contraband in the facility.

   DOC operating procedure 03.04.100C requires that nurses observe each prisoner taking restricted medication, ask the prisoner to repeat his or her name and number to ensure that the medication was swallowed, and perform a mouth check, if necessary.

   We observed the distribution of medications at four facilities and noted that nurses at two facilities did not perform mouth checks to ensure that the prisoners had swallowed their medications prior to leaving the health care area. Health care staff and corrections officers from one facility where staff had not performed mouth checks informed us that they had found medications in the prison yard. Both staff and officers thought that prisoners were discarding medications after leaving the health care area.

* *See glossary at end of report for definition.*

RECOMMENDATION

We recommend that DOC improve controls related to maintaining and distributing restricted medications.

AGENCY PRELIMINARY RESPONSE

BHCS agrees and informed us that it will comply. BHCS indicated that the HCIT Strategic Plan for health care has several initiatives that will address this issue, including:

- The pharmaceutical RFP will include an electronic medication administration record that will electronically record the receiving, dispensing, and disposing of medications. This will make reconciliation of inventories of restricted medications with the potential for theft or abuse more feasible.

- BHCS has reminded staff to ensure that prisoners have swallowed their restricted medication as required by policy.

- The development of a quality assurance administrator position with support staff will increase clinical performance monitoring and lead to continuous quality improvement activity in this area as appropriate.

- The new RFPs for managed care service and pharmacy service will allow DOC to incorporate further controls over restricted medications.

FINDING

5. Disposal of Medications

DOC did not effectively monitor the disposal of unused or expired medications or medications returned to the pharmacy contractor. As a result, BHCS was unable to control the cost and quantity of disposed medications. In addition, this increased the risk of loss, theft, or abuse of medications.

Health care clinics disposed of medications if they were expired, they were discontinued by the physician, the prisoner was paroled or discharged, or the

medication was prepared in advance but not taken by the prisoner. During our review, we noted:

a. DOC operating procedures did not address the standard information that should be documented when medications are destroyed or returned to the pharmacy contractor. As a result, facilities did not use a standardized log to document destroyed and returned medications. We reviewed logs of destroyed and returned medication from 12 facilities and noted that some of the logs did not include the prisoner's name, the name of the medication, or whether the medication was destroyed or returned. Only 3 (25%) of 12 logs included the standard information to document what medications had been destroyed or returned to the pharmacy contractor. Without detailed information, BHCS cannot ensure that medications were properly disposed of and that the facility received the proper credit for returned medications.

b. Destroyed medication logs at 3 (25%) of 12 facilities did not contain two required signatures. We noted:

   (1) Of 100 log sheets we reviewed at the first facility, 55 (55%) did not contain any signatures and 45 (45%) contained only one signature.

   (2) Of 3 log sheets we reviewed at the second facility, 2 (67%) did not contain any signatures.

   (3) Of 41 log sheets we reviewed at the third facility, 2 (5%) contained only one signature.

   DOC operating procedure 03.04.100C requires that two nurses dispose of unused medications and that both must sign the destroyed medication log.

c. DOC operating procedures did not address the return of medications to the pharmacy contractor for credit and/or disposal. As a result, health care clinics were not aware that DOC could receive credit for the return of some medications to the pharmacy contractor. Without policies and procedures on when and how to return medications to the pharmacy contractor, BHCS cannot ensure that it has properly received credit for returned medications and has controls in place to reduce the risk of loss, theft, or abuse.

d. DOC operating procedures did not address what to do with a prisoner's excess medications when the prisoner is paroled or discharged. As a result, the health care facilities were handling these medications inconsistently and medications purchased by DOC may have been destroyed unnecessarily.

DOC operating procedure 03.04.100C requires that the health care clinic provide a 30-day supply of prescribed medications in safety containers for prisoners being paroled or discharged upon the prisoners' departure. To comply with this procedure, health care staff order a new 30-day supply of all medications just prior to discharge even if the prisoner has a supply of medications available.

Health care staff from 4 of 6 facilities informed us that they allowed prisoners to take any unused nonrestricted medications in addition to the 30-day supply. Staff from the 2 other facilities informed us that they did not allow prisoners to take nonrestricted medications already in the prisoners' possession. Instead, nonrestricted medications were returned to the health care clinic for disposal and prisoners were provided a new 30-day supply of the same medication. Standardizing procedures for handling prisoner medications upon parole or discharge of prisoners may help BHCS control the cost of medication.

RECOMMENDATION

We recommend that DOC effectively monitor the disposal of unused or expired medications or medications returned to the pharmacy contractor.

AGENCY PRELIMINARY RESPONSE

BHCS agrees and informed us that it is taking steps to comply. BHCS indicated that the following are initiatives in the HCIT Strategic Plan for health care that address this issue:

- The pharmaceutical RFP will include an electronic medication administration record that will electronically record the receiving, dispensing, and disposal of medications. This will improve BHCS's ability to monitor the disposal of medications and returns to the pharmacy vendor for credit.

- The development of a quality assurance administrator position with support staff will increase performance monitoring and lead to continuous quality improvement activity in this area as appropriate.

- The Bureau of Fiscal Management is assisting BHCS with monitoring the contractor's credits for returned medications.

- BHCS will also strengthen future pharmacy contracts to ensure that contractors are required to disclose the reason when credits are not issued for returns.

In addition, BHCS indicated that it has sent direction to staff and is in the process of updating the operating procedure to allow prisoners to take unused nonrestricted medications with them upon parole or discharge in addition to a 30-day supply when it is not cost effective to have the pharmacy contractor fill prescriptions for less than 30 days.

FINDING

6. Brand Name and Nonformulary Prescriptions

BHCS did not document the justification for the use of a brand name or nonformulary drug rather than a generic or formulary drug. In addition, BHCS did not document the regional medical officer's approval for brand name and nonformulary drugs prescribed by health care professionals. As a result, BHCS was unable to ensure that medications were being prescribed at the lowest cost to the State while maintaining prisoner health care. BHCS purchased approximately $641,000 in brand name drugs that had generic equivalents between October 2003 and April 2006.

DOC operating procedure 03.04.100C states that generic drugs are to be substituted for brand name drugs whenever a generic equivalent is available. When a brand name or nonformulary drug must be used because of medical necessity, the regional medical officer is required to approve the request. Typically, generic drugs are less expensive than brand name drugs; therefore, requiring the use of generic drugs whenever possible provides a cost savings to DOC.

We reviewed 30 prescriptions written for brand name or nonformulary drugs prescribed between January 2004 and April 2006 and noted:

a. BHCS did not document the justification for 19 (63%) prescriptions written for a brand name or nonformulary drug rather than a generic or formulary drug.

b. BHCS did not document the regional medical officer's approval for 26 (87%) prescriptions.

RECOMMENDATIONS

We recommend that BHCS document the justification for the use of a brand name or nonformulary drug rather than a generic or formulary drug.

We also recommend that BHCS document the regional medical officer's approval for brand name and nonformulary drugs prescribed by health care professionals.

AGENCY PRELIMINARY RESPONSE

BHCS agrees and informed us that it has complied. BHCS indicated that the pharmacy contractor and State pharmacists have been instructed to ensure that brand name and nonformulary drugs are only provided when the prescription for such has been approved by the regional medical officer or when the prescription is for a 10-day supply or less. The regional medical officers have been instructed to ensure that justification for prescriptions for brand name and nonformulary drugs are documented prior to their approval. In addition, the HCIT Strategic Plan calls for additional initiatives that will address this issue, including:

- Redesign of the health care infrastructure at both central office and regional office levels will result in increased administrative control and monitoring of pharmaceutical usage.

- The new pharmacy RFP will contain more control over acquisition and dispensing of pharmaceuticals.

- The new RFP for managed care services will contain more control over the prescriptive practices and patterns of prescribing medical practitioners.

- The development of a quality assurance administrator position with support staff will increase performance monitoring and lead to continuous quality improvement activity in this area as appropriate.

EFFECTIVENESS OF EFFORTS TO MANAGE HEALTH CARE STAFFING

COMMENT

Background: BHCS had a vacancy rate for nurses in health care clinics of 18% as of June 2006. This rate included the following vacancies by position:

Position	Total Full-Time Equated Positions	Vacant Full-Time Equated Positions	Rate
Licensed practical nurse	92.0	21	23%
Registered nurse	411.5	70	17%
Registered nurse manager	110.0	21	19%
Total	613.5	112	18%

BHCS informed us that it had worked with the Office of the State Employer to obtain rate increases and signing bonuses for nursing staff and had attended several recruitment fairs in an attempt to attract nurses. Our review of the Department of Labor and Economic Growth's Labor Market Initiative related to nursing salaries Statewide compared with the Civil Service Commission Compensation Plan disclosed that registered nurses and licensed practical nurses Statewide annually earned about $55,380 and $36,920, respectively. DOC's registered nurses annually earned from $37,481 to $51,480 and DOC's licensed practical nurses annually earned from $32,656 to $43,867. It should be noted that DOC's nurses have additional custody type responsibilities and are required to work in an inherently dangerous environment.

Audit Objective: To assess the effectiveness of DOC's efforts to manage health care staffing.

Audit Conclusion: We concluded that DOC's efforts to manage health care staffing were moderately effective. We noted one material condition related to the delivery of health care services (Finding 1), which is reported under the delivery of services objective.

EFFECTIVENESS OF EFFORTS TO MONITOR CONTRACTS

COMMENT

Audit Objective: To assess the effectiveness of DOC's efforts to monitor the managed health care and pharmaceutical contracts.

Audit Conclusion: We concluded that DOC's efforts to monitor the managed health care and pharmaceutical contracts were moderately effective. We noted one reportable condition related to contract monitoring (Finding 7).

FINDING

7. Contract Monitoring

BHCS should improve its monitoring of the managed health care and pharmaceutical contracts. Monitoring this type of information could assist BHCS in controlling costs, delivering health care services, and identifying future health care needs. DOC expended $180.5 million and $213.7 million on selected prisoner health care services, which included $57.7 million and $72.9 million for contracted specialty services and $29.1 million and $27.1 million for pharmaceuticals in fiscal years 2004-05 and 2005-06, respectively.

DOC is required by the United States Constitution, federal court cases, and its policies and procedures to provide health care services to prisoners. Although DOC contracts for health care and pharmaceutical services, contracting does not relieve DOC of its responsibilities to ensure that it meets its legal mandate.

DOC has assigned the responsibility for monitoring the financial aspects of the contracts to the Bureau of Fiscal Management and the responsibility for monitoring the service delivery aspects to BHCS. We noted that the Bureau of Fiscal Management has implemented controls to monitor and reconcile billings, to monitor cost fluctuations, and to ensure timely payments to the contractor. We also noted that BHCS could improve its monitoring of the health care and pharmaceutical services. For example:

a. BHCS did not obtain data on the number and types of off-site specialty services provided under the managed health care contract in a format that could be easily summarized and used for analytical purposes. As a result,

BHCS could not determine whether off-site specialty services were being provided in the most efficient manner. Also, analyzing this data could help to facilitate an understanding of current prisoner health care status and help to project future contract costs. For example, contract costs for the contract year covering April 1, 2005 through March 31, 2006 unexpectedly increased by $10.4 million, or more than three times the rate of the consumer price index annual increase for health care costs for the Midwest region. BHCS was unable to determine specific reasons for the increase in costs because it did not obtain useful data to analyze fluctuations in services provided from its contractor.

b. BHCS did not work with the Bureau of Fiscal Management or the contractor to identify the cause of inaccuracies in quarterly pharmacy reports. As a result, the reports were not useful in monitoring prescription activity. Analysis of prescription activity could be used to control costs and better manage health care services.

The Bureau of Fiscal Management obtained data from the contractor on the volume and type of prescriptions written by health care professionals and compiled quarterly reports for BHCS's use in managing the contract. BHCS informed us that the reports were cumbersome and inaccurate and, therefore, BHCS did not utilize the reports. Based on our review of the report for the period June 1, 2006 through June 15, 2006, we identified items that BHCS should have followed up with the contractor. For example:

(1) The report showed that prescriptions were written by one health care professional who was no longer assigned in a capacity to write prescriptions and one health care professional who had retired. After pursuing these issues with the contractor, it was determined that these items were errors on the report and that the actual prescriptions were written by authorized individuals. Although we found that these prescriptions were proper, BHCS should review the report and follow up these types of discrepancies to reduce the risk that a prescription could be written by an unauthorized individual and not be detected in a timely manner.

(2) The names of several health care professionals who wrote prescriptions could not be located on the Licensing Database of the Bureau of Health

Professions, Department of Community Health. After follow-up with the contractor, we determined that these names were incorrectly spelled in the contractor's database or that the names had changed because of a change in marital status. Although we were able to verify licensure for all the health care professionals, BHCS should be reviewing the report and bringing these types of discrepancies to the contractor's attention so that they can be corrected.

(3) Medications were ordered by a health care professional identified as "practitioner" on the report. Through follow-up with the contractor, we determined that these orders were used to fill a physician's box that health care professionals could access to fill prescriptions for urgent medical care. BHCS should review this practice and ensure that controls are in place over the ordering of this medication.

c. BHCS did not obtain the information necessary to identify and monitor the use of nonformulary drugs from one of the pharmacy contractors it used during our audit period. As a result, BHCS could not determine the cost and volume of nonformulary drugs purchased from this contractor. BHCS attempted to obtain the information; however, the contractor did not identify whether DOC purchased the generic or brand name drug.

RECOMMENDATION

We recommend that BHCS improve its monitoring of the managed health care and pharmaceutical contracts.

AGENCY PRELIMINARY RESPONSE

BHCS agrees and informed us that it has taken steps to comply. BHCS indicated that it continues to work with the present off-site specialty services contractor to obtain reports and information to assist in monitoring prisoner health care services under the present contract.

BHCS also indicated that the recently negotiated contract extension with CMS added several provisions that allow DOC to hold CMS more accountable in several areas.

BHCS informed us that the HCIT Strategic Plan for health care calls for the following initiatives in this area, which will improve contract monitoring:

- A new improved robust EMR will allow for additional electronic monitoring capabilities.

- A new managed care contract will greatly improve accountability, employ global managed care principles, and provide incentives for greater fiscal responsibility.

- A new management structure will enhance contract performance monitoring, including:

    - A health services administrator who is accountable together with the Bureau of Fiscal Management for developing new business processes that will require enhanced accountability and oversight of the managed care vendor.

    - The new position of an assistant chief medical officer to strengthen the clinical oversight by BHCS for performance monitoring of the health service contract providers.

    - The development of a quality assurance administrator position with support staff to monitor clinical performance by both contract providers and DOC health care staff.

- The development and implementation of a comprehensive continuous quality improvement program within a "Culture of Quality."

- The development of an independent review contract to assist in the utilization practices of the health care delivery system for implementation in fiscal year 2008-09.

SUPPLEMENTAL INFORMATION

Exhibit 1 - Average Annual Health Care Expenditures Per Prisoner

This exhibit shows the trend in health care expenditures per prisoner for fiscal years 1996-97 through 2005-06.

Exhibit 2 - Cumulative Percentage Change in Health Care Expenditures Per Prisoner and Medical Care Consumer Price Index

This exhibit shows the cumulative percentage increase or decrease in the Department of Corrections' health care expenditures per prisoner compared to the percentage increase in the consumer price index for medical care from fiscal year 1996-97 through fiscal year 2005-06.

Exhibit 3 - Results of Timeliness of Health Care Services Testing - Chronic Care Visits

This exhibit displays two tables. The top table summarizes, by facility, the number of prisoner medical files reviewed for chronic care treatment, the number of prisoners with late or missed chronic care visits, the number of required chronic care visits reviewed, the number of late or missed chronic care visits, the average number of days that late chronic care visits were late, and the average number of days between the missed chronic care visit and the subsequent chronic care visit. The bottom table summarizes, by control status, the number of required chronic care visits reviewed, the number of late or missed chronic care visits, the average number of days that late chronic care visits were late, and the average number of days between the missed chronic care visit and the subsequent chronic care visit.

Exhibit 4 - Results of Timeliness of Health Care Services Testing - Annual Health Care Screenings

This exhibit summarizes, by facility, the number of prisoner medical files reviewed for annual health care screenings, the number of prisoners with late annual health care screenings, the average number of days that late annual health care screenings were late, the number of prisoners whose most recent annual health care screening was more than one year late, and the average number of days that annual health care screenings were overdue for prisoners whose most recent annual health care screening was more than one year late.

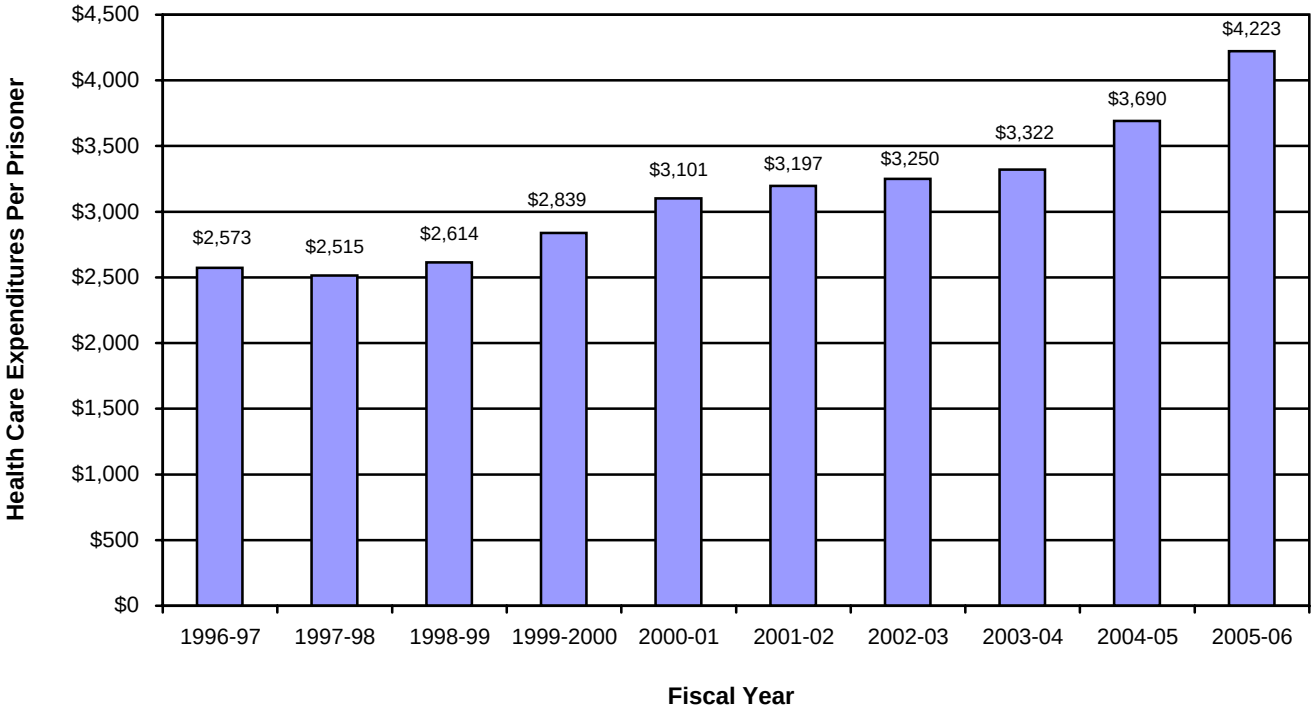
Exhibit 5 - Results of Timeliness of Health Care Services Testing - Prisoner-Initiated Health Care Visits

This exhibit summarizes, by facility, the number of health care requests reviewed, the number of health care requests requiring a visit with a health care professional, the number of late visits with health care professionals, the average number of business days late when policy required a visit within 2 days, the average number of business days late when the policy required a visit within 7 days, the number of health care requests requiring a visit for which the prisoner had not been seen at the time of our testing, and the average number of business days late for requests requiring visits for which the prisoner had not been seen at the time of our testing.

Exhibit 6 - Comparison of Prisoner Health Care Services and Benefits Available Through Other Programs

This exhibit shows a comparison of basic prisoner health care services and benefits available through other programs. This is not an all-inclusive list of services provided to prisoners or of benefits available through the other programs.

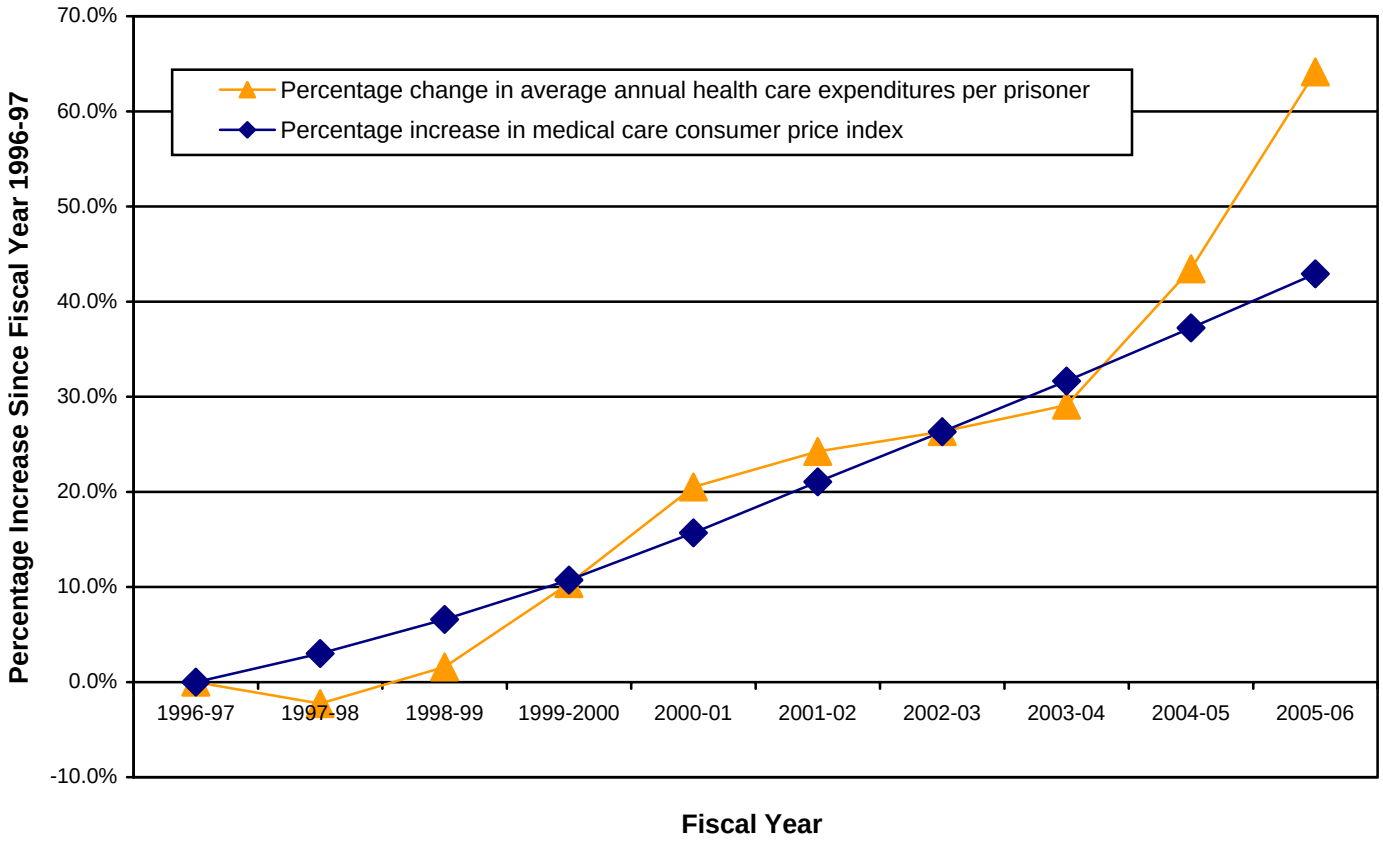
PRISONER MEDICAL AND DENTAL SERVICES
Department of Corrections
Average Annual Health Care Expenditures Per Prisoner
For Fiscal Years 1996-97 Through 2005-06



This graph shows that the Department of Corrections' health care expenditures per prisoner have steadily increased since fiscal year 1997-98.

Source: Bureau of Fiscal Management, Department of Corrections.

PRISONER MEDICAL AND DENTAL SERVICES
Department of Corrections
Cumulative Percentage Change in Health Care Expenditures Per Prisoner
and Medical Care Consumer Price Index
For Fiscal Years 1997-98 Through 2005-06



This graph shows the cumulative percentage change in the Department of Corrections' health care expenditures per prisoner and the medical care consumer price index from fiscal year 1996-97 through fiscal year 2005-06.

Source: Bureau of Fiscal Management, Department of Corrections, and Bureau of Labor Statistics, U.S. Department of Labor.

PRISONER MEDICAL AND DENTAL SERVICES
Department of Corrections
Results of Timeliness of Health Care Services Testing - Chronic Care Visits

By Facility

Facility	Number of Prisoner Medical Files Reviewed for Chronic Care Treatment	Number of Prisoners With Late or Missed Chronic Care Visits	Percentage of Prisoners with Late or Missed Chronic Care Visits	Number of Required Chronic Care Visits Reviewed	Number of Late or Missed Chronic Care Visits Included in Review	Late or Missed Visits as a Percentage of Chronic Care Visits Reviewed
Facility A	20	10	50%	79	17	22%
Facility B	20	14	70%	53	19	36%
Facility C	20	10	50%	66	13	20%
Facility D	20	7	35%	53	8	15%
Facility E	20	5	25%	73	8	11%
Facility F	20	15	75%	49	21	43%
Total	120	61	51%	373	86	23%

This table summarizes the results of our review of the timeliness of chronic care visits by facility. We used DOC's chronic care guidelines that establish requirements for chronic care visits to assess timeliness.

The percentage of prisoners with late or missed chronic care visits ranged from 25% (Facility E) to 75% (Facility F).

The average number of days that the prisoners' chronic care visits were late ranged from 84 (Facility A) to 130 (Facility E). For missed visits, the average number of days between the missed chronic care visit and the subsequent chronic care visit ranged from 179 (Facility E) to 328 (Facility D). See Finding 1.a.

By Control Status

Control Status for Chronic Care Condition	Number of Months Between Chronic Care Visits	Number of Required Chronic Care Visits Reviewed	Number of Late or Missed Chronic Care Visits	Number of Late or Missed Visits as a Percentage of Chronic Care Visits Reviewed
Good	6	271	53	20%
Fair	3	82	27	33%
Poor	1	20	6	30%
Total		373	86	23%

This table summarizes the results of our review of the timeliness of chronic care visits by control status for the chronic care condition.

For chronic care conditions in "Good" status, 35 of the visits reviewed were late an average of 112 days and 18 visits had been missed.

For chronic care conditions in "Fair" status, 7 of the visits reviewed were late an average of 71 days and 20 visits had been missed.

For chronic care conditions in "Poor" status, 6 visits had been missed.

Number of Late Chronic Care Visits	Late Visits as a Percentage of All Late or Missed Chronic Care Visits	For Late Chronic Care Visits, Average Number of Days Late	Number of Missed Chronic Care Visits	Missed Visits as a Percentage of All Late or Missed Chronic Care Visits	For Missed Chronic Care Visits, Average Number of Days Between Missed Visit and Subsequent Visit
7	41%	84	10	59%	234
14	74%	113	5	26%	192
7	54%	86	6	46%	187
5	63%	110	3	38%	328
2	25%	130	6	75%	179
7	33%	120	14	67%	283
42	49%	105	44	51%	237

Number of Late Chronic Care Visits	Late Visits as a Percentage of All Late or Missed Chronic Care Visits	For Late Chronic Care Visits, Average Number of Days Late	Number of Missed Chronic Care Visits	Missed Visits as a Percentage of All Late or Missed Chronic Care Visits	For Missed Chronic Care Visits, Average Number of Days Between Missed Visit and Subsequent Visit
35	66%	112	18	34%	283
7	26%	71	20	74%	224
0	0%	0	6	100%	145
42	49%	105	44	51%	237

Exhibit 4

PRISONER MEDICAL AND DENTAL SERVICES
Department of Corrections
Results of Timeliness of Health Care Services Testing - Annual Health Care Screenings

Facility	Number of Prisoner Medical Files Reviewed for Annual Health Care Screenings	Number of Prisoners With Late Annual Health Care Screenings	Percentage of Prisoners With Late Annual Health Care Screenings	Average Number of Days That Late Annual Health Care Screenings Were Late	Number of Prisoners Whose Most Recent Annual Health Care Screening Was More Than One Year Late	Average Number of Days That Annual Health Care Screenings Were Overdue for Prisoners Whose Most Recent Annual Health Care Screening Was More Than One Year Late
Facility A	50	2	4%	187	0	0
Facility B	52	0	0%	0	0	0
Facility C	50	28	56%	136	3	620
Facility D	54	14	26%	75	1	513
Facility E	50	4	8%	64	0	0
Facility F	51	21	41%	77	2	594
Total	307	69	22%	103	6	594

This table summarizes the results of our review of the timeliness of annual health care screenings by facility. We used DOC's policies and procedures that establish requirements for annual health care screenings to assess timeliness.

The number of late screenings ranged from 0 (Facility B) to 28 (Facility C).

The average number of days that the visits were late ranged from 0 (Facility B) to 187 (Facility A). In addition, 6 prisoners at three facilities (Facilities C, D, and F) had missed their annual health care screenings. See Finding 1.b.

Exhibit 5

PRISONER MEDICAL AND DENTAL SERVICES
Department of Corrections
Results of Timeliness of Health Care Services Testing - Prisoner-Initiated Health Care Visits

Facility	Number of Health Care Requests Reviewed	Number of Health Care Requests Requiring Visit With Health Care Professional	Number of Late Visits With Health Care Professional	Percentage of Late Visits With Health Care Professional	For Late Visits, Average Number of Business Days Late When Policy Required Visit Within 2 Days	For Late Visits, Average Number of Business Days Late When Policy Required Visit Within 7 Days	Number of Health Care Requests Requiring a Visit for Which Prisoner Had Not Been Seen at Time of Testing	Average Number of Business Days Late for Requests Requiring Visits for Which Prisoner Had Not Been Seen at Time of Testing
Facility A	25	14	12	86%	18	10	0	0
Facility B	24	16	6	38%	3	22	0	0
Facility C	25	24	13	54%	9	0	1	162
Facility D	29	29	4	14%	3	13	0	0
Facility E	25	23	9	39%	7	5	0	0
Facility F	26	24	11	46%	30	13	3	116
Total	154	130	55	42%	12	12	4	128

This exhibit summarizes the results of our review of the timeliness of prisoner-initiated health care visits by facility. We used DOC's policies and procedures that establish requirements for prisoner-initiated health care visits to assess timeliness.

The percentage of late visits ranged from 14% (Facility D) to 86% (Facility A).

The average number of business days late when policy required a visit within 2 days ranged from 3 (Facilities B and D) to 30 (Facility F). The average number of business days late when policy required a visit within 7 days ranged from 0 (Facility C) to 22 (Facility B). In addition, 4 prisoners were not seen by a health care professional at two facilities (Facilities C and F). See Finding 1.c.

PRISONER MEDICAL AND DENTAL SERVICES
Department of Corrections (DOC)
Comparison of Prisoner Health Care Services and Benefits Available Through Other Programs
As of August 2006

Service	Prisoner Health Care Services	Medicare	Medicaid	State Health Maintenance Organization (HMO) and Dental Maintenance Organization (DMO)	State Health, Preferred Provider Organization (PPO), Dental, and Vision Plans
PREVENTIVE CARE:					
Health maintenance examination	Covered for comprehensive history and physical examination upon intake and annual health care screening	Covered once	Covered	Covered after $10 office visit copayment	Covered once per year
Annual gynecological examination	Covered (included in annual health care screening)	Covered, one every 24 months or one every 12 months for high risk	Potentially covered as part of annual health maintenance examination	Covered after $10 office visit copayment	Covered once per year
Pap smear	Covered (included in annual health care screening)	Covered	Covered	Covered after $10 office visit copayment	Covered once per year
Immunizations	Covered	Pneumococcal vaccine and hepatitis B vaccine for those at high or medium risk	Recommended preventative immunizations are covered	Covered after $10 office visit copayment	Covered
Annual flu shot	Covered for prisoners at risk for influenza-related complications	Covered	Not specifically addressed	Covered after $10 office visit copayment	Covered
Dietary services	Covered	Covered for diabetics, kidney disease	Not specifically addressed	Not specifically addressed	Not specifically addressed
Health education	Covered	Not covered	Not specifically addressed	Not specifically addressed	Not specifically addressed
MAMMOGRAPHY:					
Annual standard film mammography	Covered (included in annual health care screening)	Covered	Covered	Covered	Covered, not subject to preventative maximum
PHYSICIAN OFFICE SERVICES:					
Office visits/consultations	Covered, with $5 copayment if not emergent	Covered	Covered if to diagnose or treat a disease or serious medical condition	Covered, with $10 copayment	Covered, with $10 copayment, deductible not applicable
Urgent care visits	Covered, with $5 copayment if not emergent	Covered	Not specifically addressed	Covered, with $10 copayment	Covered, with $10 copayment, deductible not applicable
EMERGENCY MEDICAL CARE:					
Hospital emergency room for medical emergency or accidental injury	Covered	Covered	Covered	Covered, with $50 copayment if not admitted	Covered
Ambulance services - medically necessary	Covered	Covered	Covered	Covered	Covered after deductible

This comparison continued on next page.

PRISONER MEDICAL AND DENTAL SERVICES
Department of Corrections (DOC)
Comparison of Prisoner Health Care Services and Benefits Available Through Other Programs
As of August 2006
Continued

Service	Prisoner Health Care Services	Medicare	Medicaid	State Health Maintenance Organization (HMO) and Dental Maintenance Organization (DMO)	State Health, Preferred Provider Organization (PPO), Dental, and Vision Plans
DIAGNOSTIC SERVICES:					
Laboratory and pathology tests	Covered if ordered by a medical service provider	Covered if medically necessary	Covered when ordered by a physician	Covered	Covered after deductible
Diagnostic tests and x-rays	Covered if ordered by a medical service provider	Covered if medically necessary	Covered when ordered by a physician	Covered	Covered 100% after deductible
HOSPITAL CARE:					
Semi-private room, inpatient care, general nursing care, hospital services, and supplies	Covered when medically appropriate	Covered	Covered	Covered for unlimited days	Covered after deductible for unlimited days
Inpatient consultations	Covered when medically appropriate	Covered	Covered	Covered	Covered 100% after deductible
SURGICAL SERVICES:					
Surgery (including related surgical services)	Covered if ordered by a medical service provider	Covered	Covered	Covered	Covered 100% after deductible
ORGAN AND TISSUE TRANSPLANTS:					
Liver, heart, lung, pancreas, and other specified organ transplants	Covered when medically appropriate	Covered	Reviewed on a case-by-case basis for coverage	Covered in designated facilities	Covered in designated facilities only; up to $1 million lifetime maximum for each organ transplant
Bone marrow - specific criteria apply	Covered when medically appropriate	Covered	Reviewed on a case-by-case basis for coverage	Covered in designated facilities	Covered after deductible in designated facilities
Kidney, cornea, and skin	Covered when medically appropriate	Covered	Not specifically addressed	Covered subject to medical criteria	Covered after deductible in designated facilities
OTHER MEDICAL SERVICES:					
Durable medical equipment	Covered	Covered	Covered	Covered	Covered
Prosthetic and orthotic appliances	Covered	Covered	Covered if directed by physician	Covered	Covered
Hearing care (hearing tests, hearing aids, etc.)	Covered, as needed	Not covered	Covered	Varies by HMO	Covered after medical clearance examination by physician

This comparison continued on next page.

PRISONER MEDICAL AND DENTAL SERVICES
Department of Corrections (DOC)
Comparison of Prisoner Health Care Services and Benefits Available Through Other Programs
As of August 2006
Continued

Service	Prisoner Health Care Services	Medicare	Medicaid	State Health Maintenance Organization (HMO) and Dental Maintenance Organization (DMO)	State Health, Preferred Provider Organization (PPO), Dental, and Vision Plans
PRESCRIPTION DRUGS:					
Generic	Covered	Other Medicare programs available for prescription coverage.	Covered, with limitations	Varies by HMO	Covered after $7 copayment
Brand-name (preferred)	Covered if approved by a medical service provider and a regional medical officer	Other Medicare programs available for prescription coverage.	Covered, with limitations	Varies by HMO	Covered after $15 copayment
Brand-name (nonpreferred)	Covered if approved by a medical service provider and a regional medical officer	Other Medicare programs available for prescription coverage.	Covered, with limitations	Varies by HMO	Covered after $30 copayment
OUTPATIENT PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY:					
Outpatient physical, speech, and occupational therapy - facility and clinic services	Covered if ordered by a medical service provider	Covered	Not covered	Covered, with $10 copayment	Covered after deductible
Outpatient physical therapy - physician's office	Covered if ordered by a medical service provider	Covered	Not covered	Covered, with $10 copayment	Covered after deductible
DENTAL CARE OPTIONS:					
Diagnostic examinations and consultations	Covered once a year and on intake	Not covered	Covered if to diagnose and treat conditions related to a specific medical problem	Covered, two per year	Covered, two per year
Preventive services (teeth cleaning)	Covered when determined necessary by the examining dentist	Not covered	Not specifically addressed	Covered	Covered
Radiographs	Covered	Not covered	Not specifically addressed	Covered	Covered 90%
Oral surgery	Covered	Not covered	Covered if to diagnose and treat conditions related to a specific medical problem	Covered	Covered 90%
Extractions	Covered	Not covered	Covered if to diagnose and treat conditions related to a specific medical problem	Covered	Covered 90%
Restoratives	Covered	Not covered	Not specifically addressed	Covered	Covered 90%
Endodontics	Covered	Not covered	Not specifically addressed	Covered	Covered 90%

This comparison continued on next page.

PRISONER MEDICAL AND DENTAL SERVICES
Department of Corrections (DOC)
Comparison of Prisoner Health Care Services and Benefits Available Through Other Programs
As of August 2006
Continued

Service	Prisoner Health Care Services	Medicare	Medicaid	State Health Maintenance Organization (HMO) and Dental Maintenance Organization (DMO)	State Health, Preferred Provider Organization (PPO), Dental, and Vision Plans
Periodontics	Not covered	Not covered	Not specifically addressed	Covered	Covered 90%
Prosthodontics	Covered if recommended by dentist	Not covered	Covered if to correct deficiencies likely to impair general health	Covered	Covered 50%
Prosthodontics repair	Covered if recommended by dentist	Not covered	Not specifically addressed	Covered	Covered 50%
Orthodontics	Not covered	Not covered	Not specifically addressed	Covered 100% up to age 19; $1,250 copayment for age 19 and over	Covered 60%
VISION CARE:					
Routine vision examinations and glaucoma testing	Covered once every two years with potential $5 copayment.	Covered for glaucoma testing	Covered once every two years if medically necessary	Not applicable - covered under State Vision Plan	Covered, once per year
Corrective lenses and frames	Covered unless prisoner has adequate glasses; replacements covered no more than once every two years.	One pair of eyeglasses after cataract surgery	Covered once every year if determined that it is medically necessary	Not applicable - covered under State Vision Plan	Copayment applies and plan covers only once in 24-month period

This comparison identifies most health care services available to prisoners and compares those services to the services available to individuals enrolled in Medicare, Medicaid, the State's health maintenance and dental maintenance plans, and the State's health and dental plans. The analysis shows that services available to prisoners are similar to that of individuals enrolled in the State's health maintenance and dental maintenance plans and the State's health and dental plans. The analysis also shows that services available to prisoners either meet or exceed services available to individuals enrolled in Medicare and Medicaid.

DOC informed us that based on the Eighth and Fourteenth Amendments to the United States Constitution, it is required to provide health care necessary to treat serious medical needs. The basic rights of prisoners and the responsibilities of states have also been defined by federal case law, which establishes that prisoners must be provided a right to access, a right to care that is ordered, and a right to professional medical judgment.

DOC indicated that serious medical needs of prisoners are needs that are diagnosed by a physician as mandatory treatment or that are obvious to a lay person, needs that require a doctor's attention, and/or needs that cause pain, discomfort, or a threat to good health. Federal courts have also upheld the prisoner's right to receive care consistent with the community standard of care. Prisoners, by virtue of their incarceration, are the only individuals who have a constitutionally mandated right to health care.

These legal bases were used by DOC in developing its policies and procedures for prisoner health care services.

Sources for:
Prisoner Health Care Services - DOC policies and discussions with Bureau of Health Care Services as of August 30, 2006.
Medicare - *Medicare & You* 2006, issued by the U.S. Department of Health and Human Services.
Medicaid - State of Michigan Medicaid State Plan under Title XIX of the Social Security Act as of August 30, 2006.
State HMO and DMO - *State of Michigan Employee Benefits Summary & Enrollment Information* as of August 14, 2006.
State Health, PPO, Dental, and Vision Plans - *State of Michigan Employee Benefits Summary & Enrollment Information* as of August 14, 2006.

GLOSSARY

BHCS	Bureau of Health Care Services.
chronic care clinics	Regularly scheduled health care treatments for prisoners diagnosed with chronic conditions. Chronic care clinics are established for pulmonary, cardiovascular, neurologic, endocrine, gastrointestinal, and infectious conditions.
CMS	Correctional Medical Services.
DMO	dental maintenance organization.
DOC	Department of Corrections.
effectiveness	Program success in achieving mission and goals.
EMR	electronic medical record.
formulary	The book of prescription drugs and their uses. The book includes generic prescription drugs approved for use and the brand name equivalents, as applicable, with instructions on the process for approving the use of brand name equivalents or nonformulary prescription drugs.
HCIT	Health Care Improvement Team.
HMO	health maintenance organization.
managed health care system	A system that combines the financing and delivery of health care services to patients by arranging with providers to provide patient services.
material condition	A reportable condition that could impair the ability of management to operate a program in an effective and efficient manner and/or could adversely affect the judgment

	of an interested person concerning the effectiveness and efficiency of the program.
medical service provider	A physician, physician assistant, or nurse practitioner licensed by the State of Michigan or certified to practice within the scope of his/her training.
nonformulary drug	A prescription drug that is not included in the listing of prescription drugs approved for use unless approved by a regional medical officer.
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.
PPO	preferred provider organization.
reportable condition	A matter that, in the auditor's judgment, represents either an opportunity for improvement or a significant deficiency in management's ability to operate a program in an effective and efficient manner.
RFI	request for information.
RFP	request for proposal.
selected prisoner health care services	Medical, dental, and vision services required to be provided to prisoners. The Bureau of Health Care Services, Department of Corrections, is also responsible for providing mental health and substance abuse services; however, these services, as well as routine vision examinations, were not included in the scope of this audit.
Serapis	The electronic medical record system used by the Department of Corrections.

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