LBA Performance Audit Report Summary:

Department of Corrections, Inmate Health Care Audit Report – January 2003

This performance audit examines the effectiveness and efficiency of the Department of Corrections' (DOC) health care management practices to determine if the DOC is delivering adequate health care to its inmates while exercising fiscal responsibility. To assist our analysis of the adequacy and delivery of medical care, we engaged the services of the National Commission on Correctional Health Care. This report incorporates the commission's findings and recommendations with our own work. The audit period includes six years from State fiscal year (SFY) 1997 through 2002.

The DOC's division of medical and forensic services (division) is responsible for providing inmate health care (including dentistry and mental health services) and operating the State's secure psychiatric unit (SPU). From SFY 1998 to 2002, the DOC total health care costs increased 46 percent and the average cost per inmate increased 29 percent, from $3,689 in 1998 to $4,766 in 2002. When expenditures related to the SPU are excluded, DOC medical costs increased 65 percent in the aggregate and 46 percent per inmate. The dramatic rise in inmate health care costs was the result of both internal and external causes, some of which the division could have more effectively controlled. We found the following factors directly or indirectly contributed to these increases:

- a fractured organizational structure,
- frequent personnel changes in departmental leadership positions,
- lack of written medical protocols,
- poor contract management,
- an insufficient quality improvement program,
- increased use of outside medical consultants, and
- the universal increases in medical and pharmaceutical costs.

Observations

Administratively, inmate medical services at the DOC are ill managed, allowing health care costs to increase without proper management controls. While care seems to have been adequate throughout the audit period, there is no assurance the care was cost effective. The report contains ten observations with recommendations: three address division organization and staffing, four address fiscal management, and three address the quality of care.

Division Leadership Needs To Be Restructured

The division needs to operate as a managed care system, with centralized clinical authority and responsibility, treatment protocols, management oversight, and continuous utilization reviews. We recommend the current medical director position be upgraded to division director, reporting to the commissioner and responsible for managing mental health and medical services

department-wide. This new division director should be responsible for all health care expenditures and health care related contracts, quality improvement initiatives, and compliance issues. The administrative director position should report to the division director. In addition, a reinstated quality improvement position should report directly to this new director to support proper management oversight.

Contract Management Needed

Unbeknownst to the DOC, its third-party health care administrator renegotiated and substantially reduced the discount the department received at Concord Hospital where a majority of inmates obtained hospital care. Poor oversight by the DOC allowed the loss of the discount to go unnoticed. The DOC did not take advantage of contract language to request its third-party administrator to negotiate special pricing with individual hospitals. The DOC responded by canceling its contract with the third-party administrator and negotiating directly with hospitals. In doing so, the DOC circumvented State contracting rules. Lastly, the department needs to address discounts with physicians used for outside consults.

Inmate Health Care Seems To Be Sufficient

The NCCHC concludes inmates are generally satisfied with current health services. There has been much debate over the medical necessity of the recent increases in outside medical consults. The NCCHC found the most recent chief medical officer (CMO) practiced within the norms of proper care, with the qualification that some outside consults might have been handled "in-house." The NCCHC was somewhat concerned with the conservative practice of the prior CMO, yet found both physicians were practicing within the normal boundaries of care. The State Board of Medicine found in July 2002 that the earlier CMO provided inadequate care to 16 State inmates with similar conditions.

Inmate Health Care May Not Be Efficient

The division lacks treatment protocols, which means that care is not standardized. This allows practitioners greater latitude in their treatment. Increased practitioner autonomy is unlikely to result in greater efficiency or effectiveness. Treatment protocols are an essential part of a cost containment program. An important part of developing and monitoring the treatment protocols would be the reestablishment of the division's quality improvement program.