STATE OF NEW HAMPSHIRE
DEPARTMENT OF CORRECTIONS
INMATE HEALTH CARE

PERFORMANCE AUDIT REPORT
JANUARY 2003

To The Fiscal Committee Of The General Court:

We have conducted an audit of the Department of Corrections division of medical and forensic services, to address the recommendation made to you by the joint Legislative Performance Audit and Oversight Committee. We conducted our audit in accordance with the standards applicable to performance audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to provide a reasonable basis for our findings and conclusions. Accordingly, we have performed such procedures as we considered necessary in the circumstances.

The purpose of our audit was to determine if the department is providing adequate health care to inmates in an economical manner. Interest in this topic was sparked by substantial increases in inmate medical expenditures. The audit period encompassed the six years from fiscal year 1997 through fiscal year 2002.

This report is our evaluation of the information noted above and is intended solely for the information of the Department of Corrections and the Fiscal Committee of the General Court. This restriction is not intended to limit the distribution of this report, which upon acceptance by the Fiscal Committee is a matter of public record.

Office Of Legislative Budget Assistant
Office Of Legislative Budget Assistant

January 2003

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF CORRECTIONS
INMATE HEALTH CARE

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ABBREVIATIONS

ACA	American Correctional Association
ARNP	Advanced Registered Nurse Practitioner
BCBS	Blue Cross And Blue Shield Of New Hampshire
CMO	Chief Medical Officer
DHHS	Department Of Health And Human Services
DOC	Department Of Corrections
HIV	Human Immunodeficiency Virus
HSC	Health Services Center (at the Men's Prison in Concord)
LRF	Lakes Region Facility
NCCHC	National Commission On Correctional Health Care
NCF	Northern Correctional Facility
QI	Quality Improvement
RN	Registered Nurse
SFY	State Fiscal Year
SOA	Statement Of Appropriation
SPU	Secure Psychiatric Unit

STATE OF NEW HAMPSHIRE
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SUMMARY

Purpose And Scope Of Audit

This audit was performed at the request of the Fiscal Committee of the General Court consistent with the recommendation of the joint Legislative Performance Audit and Oversight Committee. It was conducted in accordance with generally accepted government auditing standards. This report examines the rising costs of inmate health care and the operational context in which these increases occurred for State fiscal years (SFY) 1997 through 2002. The 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 delivery and adequacy of medical care, we engaged the services of the National Commission on Correctional Health Care (NCCHC). This report incorporates NCCHC's findings and recommendations with our own work.

Background

The Legislature created the DOC in 1983 through RSA 21-H, when it combined the Probation Department, the Parole Department, and the State Prison under one administrative structure. Two years later, further legislative action under RSA 622:41 established the secure psychiatric unit (SPU) within the department. New Hampshire is unique in placing its forensic unit administratively and physically within its prison system.

Organization

The division of medical and forensic services (division) is responsible for providing inmate health care (including dentistry and mental health services) and operating the SPU. Statutorily, an administrative director and a medical director jointly run the division, although there has not been a medical director actively involved with the health services center (HSC) since 1998. Over the last six years, there have been many changes in DOC management. These changes include five commissioners, three division medical directors, three division administrative directors, and three chief medical officers.

In January 2002, after the previous administrative director left the department, the commissioner reorganized the division. There was no longer a clear central medical or administrative authority directly responsible for health care at the men's prison, the women's prison, the lakes region facility, and the northern correctional facility. Health care personnel at each facility report to their respective wardens.

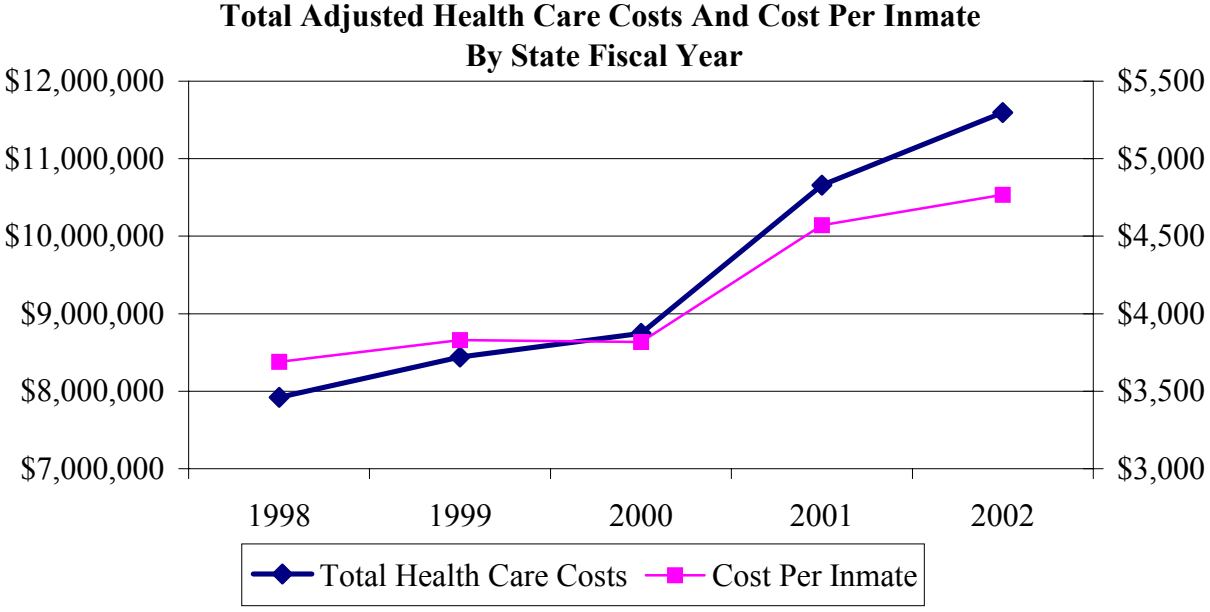
The commissioner recently filled the administrative director position, which is now located at the department's central administrative office. The medical director position has become the medical director of forensic services, responsible only for the SPU and mental health services throughout the correctional system. This director and the rest of the SPU clinical personnel work under a

contract with Dartmouth Medical School, similar to an arrangement used to provide treatment services at New Hampshire Hospital.

Increasing Health Care Costs

According to the federal Centers for Medicare and Medicaid Services data, projected national health expenditures between 1998 and 2002 increased 41 percent and per capita costs increased 27 percent. 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, as shown in Figure 1. (When expenditures related to the SPU and the Dartmouth contract are excluded, DOC medical costs increased 65 percent in the aggregate and 46 percent per inmate.) Financial data from past years and interviews with DOC health care officials point to outside medical services and pharmaceuticals as the drivers for the recent increases in total health care expenditures.

Figure 1



Note: We increased the SFY 2000 expenditures by $400,000 and decreased SFY 2001 by $400,000 to reflect the amount owed to Blue Cross and Blue Shield at June 30, 2000.

Source: LBA Analysis of Statements of Appropriation.

For further comparison, we note that monthly costs for a single State employee in the least expensive health maintenance organization plan has increased by 70 percent from approximately $183 a month in SFY 1998 to $310 in SFY 2002. If all inmates were covered by the State employee insurance, the costs in 2002 would have been $9.1 million which would be 10 percent higher than the $8.2 million total inmate health care costs exclusive of the SPU and the Dartmouth contract.

Standard Of Care

A pivotal issue in health care costs is the standard of care provided to inmates. The 1990 Laaman Consent Decree sought to improve inmate health services at the DOC, by ensuring access to health care. The decree left medical decisions to the practitioners, but required adequate care be provided. The department has failed to define its own standard of care by developing medical protocols or adopting established national standards. According to the NCCHC, inmates require, at minimum, a constitutional standard of care guaranteeing the availability of medical services and the treatment serious conditions. A "community standard of care" for the specific treatment delivered is the term generally used in health care. However, the community standard of care is not well defined.

Results In Brief

While the quality of care provided to inmates appears to be adequate, the same cannot be said of the management of the department's health care system. We found an ineffective organizational structure, incompetent contract management, and insufficient oversight of the quality of care. We present ten observations with recommendations: three address division organization and staffing, four address fiscal management, and three address the quality of care. The NCCHC recommends the DOC assign responsibility for the health care of all inmates and the operation of the department's health care system to a physician. We recommend this physician become the director of the division. The division needs to operate as a managed care system for health care services delivery, with written treatment protocols and stronger fiscal controls.

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.

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. The NCCHC was unaware of the Board of Medicine's finding.

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.

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RECOMMENDATION SUMMARY

Observation Number	Page	Legislative Action Required	Recommendation	Agency Response
1	25	YES	Restructure the division by creating a single division director. The director should be a physician with managed care experience.	Concur In Part
2	28	NO	Develop a staffing plan for health services, which may include other types of qualified medical personnel.	Concur
3	29	NO	Assess and facilitate the performance of all normally expected RN functions.	Concur
4	31	NO	The director of administration should designate properly qualified department personnel to develop and monitor health related contracts.	Concur
5	32	NO	Seek the best prices for inmate medical services through a competitive bid process.	Concur

Observation Number	Page	Legislative Action Required	Recommendation	Agency Response
6	34	NO	Develop policies and procedures to review medical bills for errors and reasonableness.	Concur
7	35	YES	Seek legislation to receive the same price controls and options the county jails received under Chapter 255, Laws of 2002.	Concur In Part
8	37	NO	The DOC should institute treatment protocols.	Concur
9	38	NO	Fill the vacant quality improvement (QI) position, reclassify it if necessary, and form a QI committee to provide recommendations upon which the QI person may act.	Concur
10	40	YES	Request DHHS to inspect the health care facilities at all four correctional institutions. Enact legislation requiring DHHS' licensing and regulation services to regularly inspect DOC medical facilities, rather than rely on self-regulation.	Concur

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INTRODUCTORY SECTION

1.1 Overview

On December 19, 2001, the Fiscal Committee of the General Court adopted a recommendation by the joint Legislative Performance Audit and Oversight Committee for a performance audit of prison health care costs. An entrance conference with the Department of Corrections (DOC) was held the same month. We informed the DOC of our charge and briefed the commissioner and department officials on how we conduct performance audits.

1.2 Scope, Objectives, And Methodology

Scope

There is consensus within the DOC that it was providing more health services to inmates under the most recent chief medical officer than under his predecessor, as measured by appointments with internal and external providers. There was no consensus on whether the increase in health services was appropriate. The challenge for the DOC is providing adequate health care to inmates while operating in a fiscally responsible manner. Our audit sought to answer the following question: Has the division of medical and forensic services (division) provided effective and economical health care to inmates? Our audit period includes State fiscal years (SFY) 1997 through 2002.

Objectives

We developed three audit objectives to guide our work:

1. Assess the costs and standard of health care provided to inmates.
2. Assess the overall management of health care by the department, including its cost containment efforts.
3. Test the division's compliance with relevant State laws, administrative rules, and policies.

Methodology

We reviewed pertinent State laws, administrative rules, department policies and procedures, federal court decisions, annual reports, management and utilization reports, health care reports on other states' correctional departments, contracts, and news articles. We interviewed current and former officials and staff at the DOC, members of the State Legislature, and knowledgeable individuals outside of the DOC. We sought information about the department's health care delivery system, questioned medical personnel about the level of health care being provided, reviewed health care bill processing documents and financial reports, and obtained a health care claims database from the previous claims processor. In addition, we hired experts in the field of correctional health care to help us assess the DOC and address the first two audit objectives listed above.

1.3 Creation Of The Department Of Corrections

The Legislature created the Department of Corrections in 1983. RSA 21-H combined the Probation Department, the Parole Department, and the State Prison under one administrative structure to form the new department. The DOC's first commissioner had been previously in charge of the forensic unit at New Hampshire Hospital.

New Hampshire Hospital Forensic Unit Moved to State Prison

In 1985, RSA 622:41 established the secure psychiatric unit (SPU) within the DOC. This effectively moved the forensic unit at New Hampshire Hospital to the state prison and became operational in 1986. One knowledgeable source reported the legislative intent was to create "a facility within a facility." The Legislature also changed insanity statutes to conform to the new location of the unit. New Hampshire Hospital management, Department of Health and Human Services (DHHS) management, the DOC, and the Legislature agreed on this action. RSA 622:46 requires an annual meeting of the commissioners of DOC and DHHS to discuss clinical and treatment standards for the SPU. According to a department official, DOC commissioners have not maintained a consistent outlook on handling the SPU.

The principal reason for the movement of the forensic unit was inadequate security provided for forensic patients by New Hampshire Hospital. There were two murders in Concord resulting from escaped patients. Moving the unit into the state prison was a way to increase public safety. It is our understanding that this way of confining forensic patients is unique to New Hampshire.

The types of patients and conditions for confinement in the New Hampshire Hospital forensic unit remained essentially the same when the unit became the SPU at the men's prison. The SPU houses: individuals under court-ordered confinement until determined competent to stand trial; defendants waiting for a determination of insanity in relation to the criminal behavior that brought them to trial; and those judged 'Not Guilty by Reason of Insanity', whose cases are reviewed every five years. Prison administration used SPU beds for some different purposes over the years, but the SPU now functions in a manner similar to the original forensic unit.

The enabling legislation provided for a board certified psychiatrist to be medical director of the division of medical and forensic services, overseeing both the SPU and all health services for the department. According to current and former department officials, the extension of the director's authority beyond the SPU to prison health services arose from budgetary considerations and the low population of the SPU and the prison at that time. Another source reported New Hampshire Hospital provided the basis for the organizational structure.

There was also a unit administrative director for the SPU. A legislative amendment in 1993 expanded the SPU administrative director's authority to include health services, creating a dual reporting relationship from both directors to the Commissioner. This administrative structure existed from 1993 to the present. The psychiatrists filling the division's medical director position have not been involved in prison medical issues since 1998.

1.4 Personnel Changes

Although the organizational structure was constant, there have been many changes in personnel at the highest levels of the department and the division. During the past six years, the DOC and the division have experienced numerous changes in management, including:

- five commissioners,
- three division medical directors,
- three division administrative directors, and
- three chief medical officers.

This turbulent environment forms part of the background against which large increases in inmate health care costs occurred.

Commissioners

The DOC has had six commissioners since its creation in 1983, five who served during our six-year audit period. The first of these five left in August 1997 and the assistant commissioner was appointed interim commissioner. In January 1998, a new commissioner was hired from outside the State. Following his death in September 1999, the assistant commissioner became acting commissioner. The Governor and Council appointed the current commissioner in May 2000.

Medical Directors

As required by statute, a psychiatrist was the division medical director in 1996 and left the position in 1998. Another psychiatrist on staff took over on an acting basis, but did not administer the division. The medical director at New Hampshire Hospital succeeded this psychiatrist and functioned as medical director for both New Hampshire Hospital and the division. He also did not take an active role in administering the division. His role at the prison consisted of attending meetings and supervising psychiatrists at the SPU. He actually worked for New Hampshire Hospital under the mental health provider contract with Dartmouth Medical School. A psychiatrist working under the Dartmouth contract assumed part of the duties of the medical director under the new position of director of forensic services in November 2001.

Administrative Directors

The administrative director of the division also has changed. The director at the beginning of the audit period left in 1998. The director of nursing took over the position on an acting basis. The department hired a nurse practitioner from New Hampshire Hospital to oversee the mental health functions of the position. This nurse practitioner became the division's third administrative director from August 1998 through January 2002. This position remained vacant until a new administrative director was hired in November 2002.

Chief Medical Officers

There were three chief medical officers (CMOs) during the audit period. A consultant physician with ten years experience at the prison's health services center (HSC) replaced the first CMO in August 1996. Approximately four years later, this physician became a part-time consultant and the department hired another physician. The most recent physician was hired as CMO in May 2000 and left in April 2002. As of this report, the position remains vacant.

1.5 Current Administration

The division's most recent mission statement, which appears in the DOC's 2000 annual report, states it offers "offenders/patients opportunities to attain and maintain a functional level of wellness and promote staff development for the provision of health services in a safe environment while providing for the public's health and safety."

Under the guidance of the medical and administrative directors, the division performs clinical and forensic functions. Clinically, the division delivers health care and mental health services to all inmates. Health care delivery takes place through the HSC at the men's prison, as well as through clinics at the women's prison, the lakes region facility (LRF), and the northern correctional facility (NCF). Mental health programming is available at all facilities.

The division also provides forensic services to the courts, primarily through the SPU. The courts order evaluations of offenders brought before them to determine competency to stand trial or to assess insanity pleas. The SPU can house 60 residents, although only about 12 to 15 are convicted inmates. The rest are either waiting for court-ordered evaluations or are county prisoners with mental health problems the county jails cannot accommodate.

Currently, the DOC is using a contract similar to one the DHHS has with Dartmouth Medical School to meet staffing needs at New Hampshire Hospital. The DOC uses its contract to fill treatment staff positions at the SPU. The medical director of forensic services, who is in charge of the SPU and all mental health services provided by the DOC, works under the Dartmouth contract. He reports to the commissioner on broad matters, but also reports to the warden on all matters related to administration. Clinically, he reports to his department head at Dartmouth Medical School. The chief forensic examiner also works under the contract, as well as an advanced registered nurse practitioner (ARNP) who previously functioned as the division administrative director. As of September 2002, two new psychiatrists are working under the contract, bringing the total psychiatrist staff up to four.

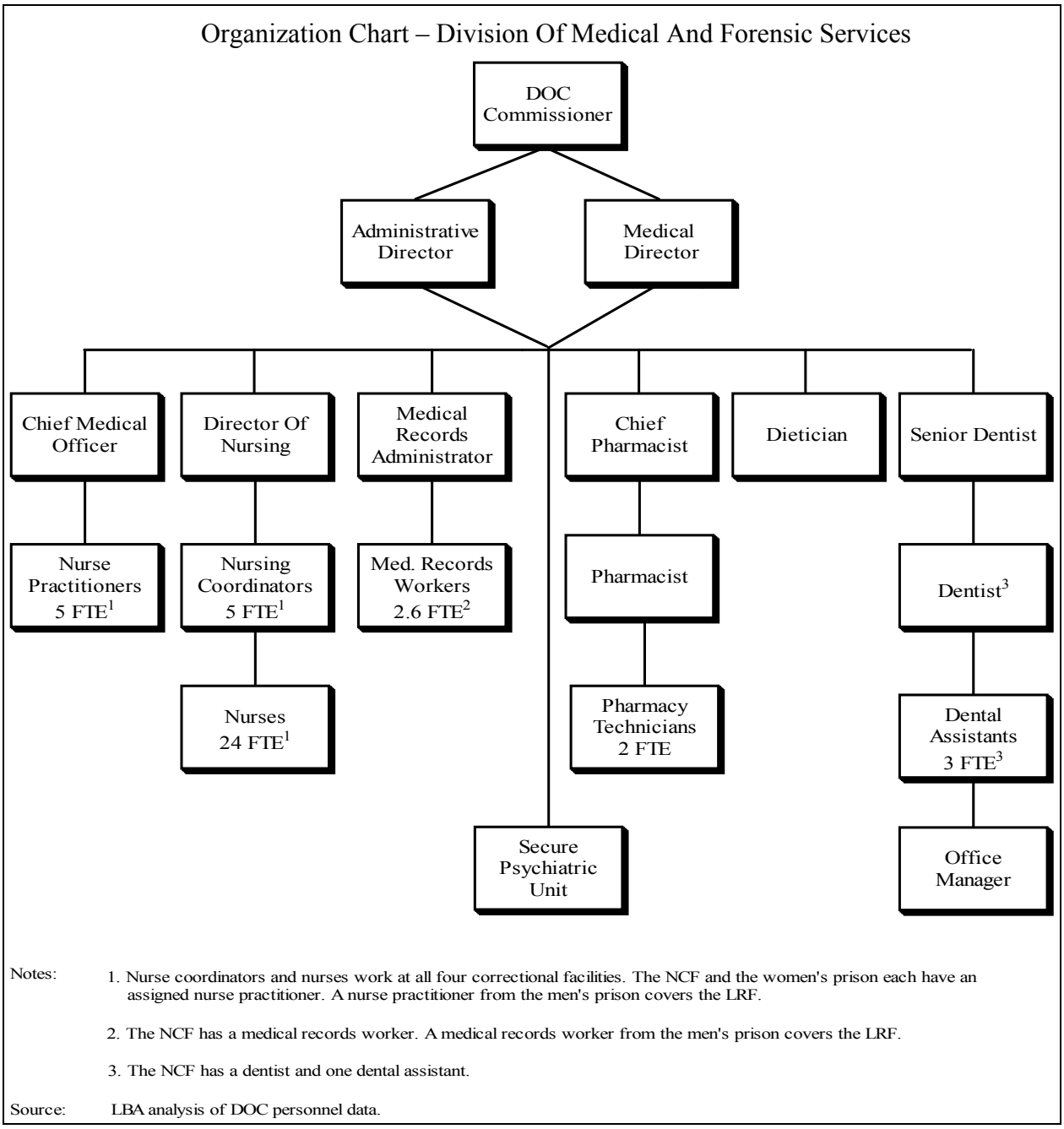
The "Ohio Report" was completed in 1999 by consultants hired under a previous DOC commissioner, and addressed issues in medical and mental health services. The current commissioner reportedly was unaware of this report until it was sent to him anonymously. Upon reviewing the report, the commissioner reported he recognized structural issues and recommendations similar to his previous correctional experiences. The commissioner thereupon requested a subsequent report from the same consultants, which was issued in November 2001. This report's contents were similar to the previous one, which indicated to the commissioner that certain changes were needed.

The commissioner is in the process of changing the administrative structure of the division consistent with recommendations made in the Ohio reports. He intends to move the administrative director position to the DOC central office and have the new director advise on system-wide issues and policy decisions only. Clinical decisions will still have to go through the medical chain of command. Operational administrative matters and budgetary issues will be the responsibility of the wardens at each facility.

1.6 Relevant Division Positions

Figure 2 (see page 12) presents the organizational structure in place during most of the audit period; it does not include contracted personnel. The CMO, contracted physicians, nurse practitioners (ARNPs), nurses, the senior dentist, and contracted dental staff provide direct inmate health care. The chief pharmacist, the medical records administrator, the director of nursing, and the dietician support their efforts. These positions are located at the men's prison in Concord. Other facilities (women's prison, LRF, and NCF) have their own nurses and nurse coordinators. They may have an ARNP on site, or schedule one to visit from the men's prison. Physicians based at the men's prison also make scheduled visits to the other facilities. The pharmacy at the men's prison supplies pharmaceuticals to all correctional facilities. Pharmacy personnel fill orders from the women's prison, the LRF, and the NCF on a daily basis and pack the prescriptions in locked bags for courier delivery to the appropriate site.

Figure 2



Notes:
1. Nurse coordinators and nurses work at all four correctional facilities. The NCF and the women's prison each have an assigned nurse practitioner. A nurse practitioner from the men's prison covers the LRF.
2. The NCF has a medical records worker. A medical records worker from the men's prison covers the LRF.
3. The NCF has a dentist and one dental assistant.

Source: LBA analysis of DOC personnel data.

1.7 Correctional Health Care Expenditures

The DOC experienced a dramatic increase in health care expenditures in SFY 2001. The overall medical expenditures (including the Dartmouth contract) increased by 32 percent, from $8.3 million in 2000 to $11 million in 2001. However, making a correction for $400,000 in SFY 2000 expenditures carried over to SFY 2001 for amounts owed to Blue Cross and Blue Shield of New Hampshire (BCBS), the one-year increase is actually 22 percent. Payments to outside medical providers such as hospitals and physicians drove most of this increase. The number of inmate

visits outside the prisons to specialists increased by 71 percent between SFY 2000 and 2001, and pharmaceutical expenditures increased by 42 percent. One source within the department reported the personnel responsible for higher health care costs are those who write medical orders and prescriptions. This includes physicians, psychiatrists, and ARNPs.

Costs rose again in SFY 2002, but less dramatically than the prior year. Overall, medical costs rose approximately nine percent in 2002. Outside provider costs increased seven percent. Pharmaceuticals went up 31 percent. The DOC used more of the appropriation available to pay the Dartmouth contract, increasing the expenditure for contract services 170 percent from the preceding year. The increase appeared dramatic, but the expenditure of $557,287 was substantially less than the full $1,257,287 appropriated for the services provided by Dartmouth Medical School.

Sources Of Health Care Cost Increases

Some conditions responsible for driving up health care costs are outside the control of the DOC medical staff. Factors such as increases in the inmate population, average age of the inmates, and legal mandates may increase costs over which medical management has no control. According to the U.S. Department of Justice's *Correctional Health Care: Guidelines for the Management of an Adequate Delivery System*:

> [d]rawn largely from disadvantaged segments of society for whom regular health care is often unavailable, ignored, or haphazard, inmates have health care needs more complex than their youthful demographics would suggest. In addition to such chronic diseases as diabetes, hypertension, and asthma, incarcerated patients bring to prisons and jails the ravages of substance abuse, the debilitating effects of AIDS and HIV and hepatitis infection, and the challenge of multiple-drug-resistant tuberculosis.

In addition, the overall cost of health care in the United States has significantly increased over the last few years. Table 1 shows the average annual percent increase by calendar year with projected growth as calculated by the federal Centers for Medicare and Medicaid Services, Office of the Actuary. Considering this growth trend as a baseline, one might expect correctional health care costs to increase at least by similar percentages.

Table 1

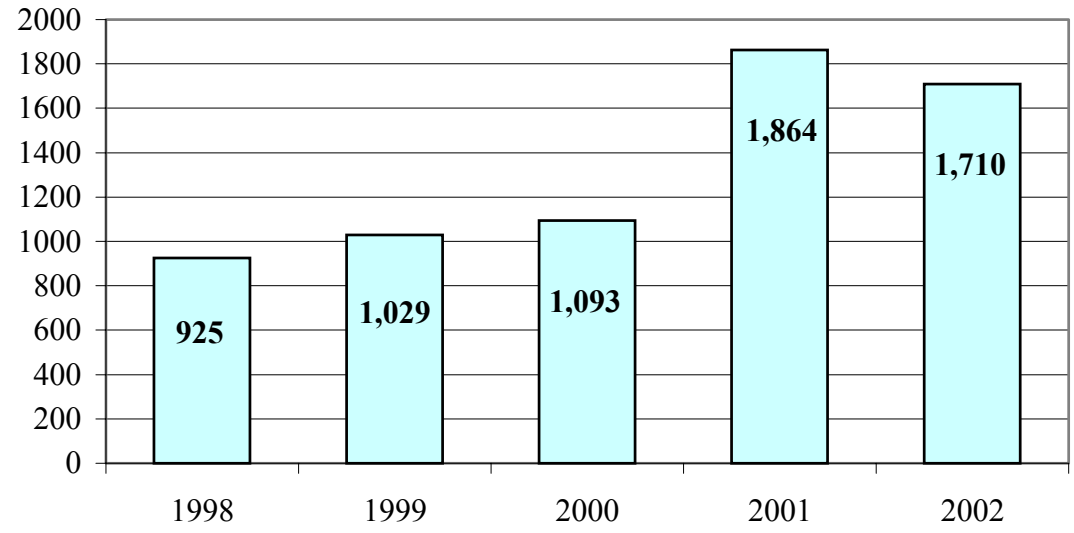
Average U.S. Annual Percent Growth Of Health Care Costs					
1998 (Actual)	**1999** (Actual)	**2000** (Actual)	**2001** (Projected)	**2002** (Projected)	**1998-2002 Growth**
5.1%	5.7%	6.9%	9.6%	8.6%	41%
Source: Centers for Medicare and Medicaid Services, Office of the Actuary.					

Outside Provider Services

Internal DOC sources and one external source expressed consistent opinions on the factors driving up the cost of inmate health care. They attribute the rising cost of health care primarily to

the rise in outside medical consultations. Figure 3 demonstrates the growth in outside consults in recent years. The change in fiscal year 2001 coincides with arrival of the new CMO. One factor reported by the new CMO and the administrative director was the level of unmet need existing when the CMO arrived; other division personnel disagreed with this assessment.

Figure 3

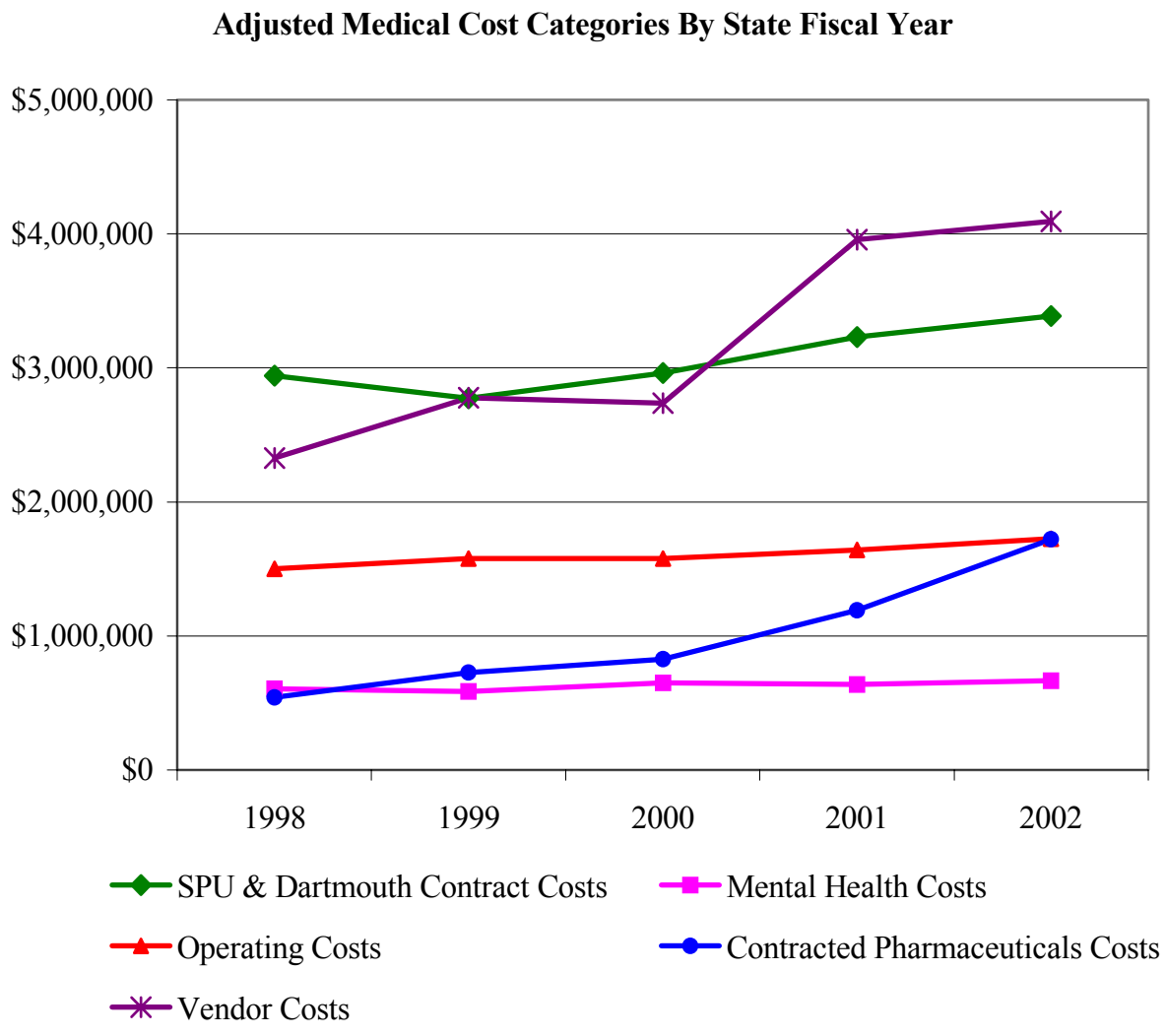


Source: LBA analysis of Department of Corrections data.

There have been two categories of substantial growth in health expenditures, vendor provided goods and services, and pharmaceuticals purchased through a multi-state buying group[1]. Our analysis of medical expenditures broken down by cost category reinforces the claim that payments to external health care providers are a major medical cost driver for the department. Figure 4 (see page 15) shows various cost components of the department's medical operations for SFY 1998 through 2002. The vendor category includes: 1) payments to external health care providers such as specialists, labs, hospitals, and the third-party administrator; 2) payments to contracted health care professionals, such as physicians, dentists, and psychiatrists, who work in the prisons; and 3) other miscellaneous health related expenditures, including pharmaceuticals not available through the buying group. The SPU related category has increased by 15 percent. Starting in SFY 2001, we included Dartmouth contract costs in the SPU category. In 2002, the DOC only paid 44 percent, or $557,287 of the contracted amount to Dartmouth because of unfilled positions. Mental health services and general operating expenditures have not experienced large increases. The operating cost category includes personnel, supplies, and equipment costs for the prison medical units, dental offices, and the pharmacy.

[1] The DOC pharmacist estimates that about three percent of the prescription volume of the contracted pharmaceuticals category is for the DHHS youth development center. The center has a contract with the DOC for pharmaceuticals.

Figure 4



Note: We increased the SFY 2000 Vendor Costs total by $400,000 and decreased SFY 2001 by $400,000 to reflect the amount owed to Blue Cross and Blue Shield at June 30, 2000.

Source: LBA Analysis of Statements of Appropriation and other Department of Corrections data.

Increased Pharmaceutical Costs

Five sources, including the chief pharmacist, acknowledge the rising cost of pharmaceuticals as a factor in the overall rising cost of correctional health care. Total pharmaceutical costs are comprised of two components, the cost of the pharmaceuticals and the number of prescriptions dispensed to the inmate population. Table 2 (see page 16) illustrates the percentage change of the purchase costs and the amount of pharmaceuticals prescribed from SFY 1998 through 2002.

Table 2

Cost Of Pharmaceuticals Dispensed By State Fiscal Year						
	1998[1]	**1999**	**2000**	**2001**	**2002**	**Increase 1998-2002**
Total Costs	$523,500	$760,000	$875,600	$1,246,300	$1,634,744	$1,111,244
Percent Change	27%	45%	15%	42%	31%	212%
Prescriptions Dispensed[2]	31,881	39,190	46,977	57,508	67,170	35,289
Percent Change	18%	23%	20%	22%	17%	111%
Average Cost	$16.42	$19.39	$18.64	$21.67	$24.34	$7.92
Percent Change	8%	18%	-4%	16%	12%	48%

Notes: 1. Pharmaceuticals sold to the Division of Youth Development excluded after 1998.
2. A prescription is up to one month's supply of a medication for an inmate.
Source: LBA analysis of DOC data.

The department's formulary is a listing of drugs approved for use by division medical practitioners. A committee within the division reviews and revises the formulary by adding or subtracting drugs based on a number of factors including effectiveness, side effects, and price. Written approval is needed to use non-formulary medications. The NCCHC consultants indicated this safeguard was effective for ensuring pharmaceuticals from the formulary were being prescribed. The department purchases pharmaceuticals with a multi-state buying group, reporting a discount of 40 percent below the wholesale price.

Other Potential Cost Increasing Factors

The inmate population rose slowly over the last few years. The population was 2,147 in SFY 1998 and rose to 2,433 in SFY 2002, an increase of 13 percent. The greatest annual increase occurred between SFY 2001 and 2002, when the population went up 4.3 percent. The smallest annual increase (1.8 percent) occurred from SFY 2000 to 2001, the year of the most dramatic increases in health care cost. Inmate population increase does not seem to significantly contribute to the rapidly rising health care costs.

Due to lifestyles often including substance abuse, poor nutrition, and poor medical care, medical staff consider inmates elderly when they reach 50 years of age. Even the younger portion of the population is statistically "sicker" than the same age group outside of prison. Although an aging population may intuitively suggest higher health care costs, the most recent annual utilization report shows no utilization break down by age to demonstrate increased costs due to age. One source reported rising average age did not significantly affect costs.

Cost Comparison

NCCHC consultants examined New Hampshire's inmate health care costs and compared it to similar systems. They found New Hampshire's costs were below the average for similar systems. However, the comparison data were from 1998, prior to the significant cost increases experienced in SFY 2001. According to the consultants:

the NH DOC reported to NCCHC in its 1999 survey, an annual health care expenditure of $2,104 per inmate in 1998[2]…. In NCCHC's survey we found that the annual health cost per inmate varied significantly. In an analysis of 40 state DOCs and the Bureau of Federal Prisons, the annual health care expenditures per inmate ranged from a low of $1,007 (North Dakota) to a high of $4,258 (Massachusetts). The mean annual health care cost per inmate for the 41 correctional systems was $2,734 and the median was $2,540. To do a comparable analysis, we selected DOCs with 8.5 percent to 9.5 percent of its budget allocated to health services (New Hampshire's health services took 9.1% of the DOC budget in 1998). Table [3] provides a comparison of the New Hampshire DOC in comparison to seven state DOCs with comparable number of inmates.

Keeping in mind that these figures represent 1998 data, New Hampshire DOC was comparable to seven other DOCs in their annual health care expenditures per inmate. In comparison, New Hampshire ranked the third lowest of this group in annual health care expenditure per inmate, and was less than the average for the eight DOCs. However, this reflects 1998 data and much has changed in four years.

Table 3

Comparison Of Inmate Costs To Similar Prison Systems			
State	**Percent of Budget Devoted to Health Care**	**1998 Annual Health Care Expenditure Per Inmate**	**Average Daily Population**
Vermont	9.1%	$ 3,640	1,250
Rhode Island	9.5	3,593	3,394
Utah	8.8	2,695	5,067
Hawaii	8.7	2,613	4,086
Montana	8.7	2,581	2,706
New Hampshire	**9.1**	**2,104**	**2,147**
Idaho	8.5	1,959	3,825
South Dakota	9.5	1,889	2,266
Average	**9.0%**	**$ 2,634**	**3,093**
Source: NCCHC data as presented by the LBA.			

When New Hampshire's 1998 average expenditure per inmate, as used in this survey, is increased by 46 percent (LBA's calculated growth in per inmate medical cost between 1998 and 2002 exclusive of SPU and the Dartmouth contract), the estimated 2002 costs per inmate is $3,062, which is still below Vermont and Rhode Island 1998 costs.

[2] We assume certain costs, such as those for the SPU, were not included in the total used for the survey. The survey's per inmate cost of $2,104 ($4,517,106 divided by 2,147 inmates) is lower than our calculation of $3,689 ($7,919,806 divided by 2,147 inmates) as presented in Figure 1, found on page 2.

The NCCHC addressed the recent increase in costs by comparing it to other states and identifying potential causes.

> On average, state DOCs are reporting between 5 to 7 percent increases in their health services budgets for 2001. Florida, for example, in its 2000-2001 FY budget had a 6.7% increase over its 1998-1999 health services budget…. The [NH DOC] health system lacks customary managed care cost controls such as risk management, utilization review, and [continuous quality improvement]. Cost savings and effectiveness are found as a result of good [continuous quality improvement] methods. For example, high-risk, high-volume, or problem-prone aspects of health care provided to patients should be continuously reviewed so that policies/procedures can be revised and incorporated into daily activities. Cost savings will be found when health staff are reviewing elements of a health care system to determine if there is a need for either a process or outcome study. The previous CMO began these programs but without any success or thoroughness. In addition, [this increase] could be accounted for the increase in outside consultants by a new CMO and to the loss of the discounts at the local hospital.

1.8 Claims Processing Contract

By the end of SFY 2001, the department realized it was not receiving discounts on over half of its external health care expenditures being paid through Blue Cross and Blue Shield of New Hampshire (BCBS). The department was unaware of the loss of the discount partly because of its poor oversight of the third party administrator contract. The contract language emphasized the savings the department would enjoy, however, the discount with the department's largest health care provider was lost.

Spirit Of Contract Not Upheld By Blue Cross And Blue Shield Of New Hampshire

Starting in the early 1990s, the DOC contracted for claims and utilization management for the department's external health care delivery system with BCBS. Since SFY 1994 the administrative fee based on payments to providers ranged from 11.5 percent to 14 percent in SFY 2001. The vendor acted as a third party payer and provided the department with BCBS negotiated discounts when using its network of hospitals and physicians. According to the last contract:

> **The Department of Corrections will benefit from significant savings through our negotiated hospital rates** and physician discounts for our network providers. **Our network includes over 98% of all New Hampshire physicians and all New Hampshire hospitals**…. **The Department of Corrections will enjoy the effect of substantial discounts off of hospital charges through our competitive hospital contracts**. Cost savings are also achieved through our [diagnosis-related groups] and per diem reimbursement arrangements. Hospital contracts within our service area are reviewed annually. Because of our large market share in New Hampshire, we are able to negotiate and achieve economical contracts that are among the most competitive in the market place…. The average percent of all

> discounts is 18%. To provide more detail to the DOC, we are providing the **effective rates of discounts for various provider groups: Hospital Inpatient 13%, Hospital Outpatient 12%**, Physician Services 23%, Lab 39%, [and] X-ray 20%. (emphasis added)

According to a BCBS representative, there was a loss of discount on indemnity (fee for service) plans with Concord Hospital occurring after rate negotiations in 1995 or 1996. These negotiations focused on getting larger discounts on the BCBS managed care plans, which comprised most of the insurer's business with the hospital. An indemnity plan covered costs incurred by the DOC. It is likely the loss of discount on the indemnity plan occurred in 1997, however, the BCBS representative stated the department did not realize the loss of discount until it began looking at high cost cases in 2000.

Contrary to the contract language, the department was not receiving "substantial discounts off of hospital charges" with the one hospital receiving 58 percent of the department's external health care payments through BCBS for the last three and a half years of the contract.[3] According to the BCBS representative, the loss of discount at Concord Hospital was not targeted at the department, but for all of BCBS's indemnity coverage.[4] In addition, the department was still receiving discounts at other hospitals and with other providers, such as physicians.

Department Oversight Of Contract Lacking

According to a senior department official, the department was not doing a good job reviewing the BCBS contract. Because no one monitored the contract and reports generated by BCBS, the reduction in Concord Hospital's discount escaped notice. It does not appear the department ever had a true contract manager. A former division administrative director was in charge of the contract. After the director left in April 1998, neither his replacement nor anyone else monitored the contract. This, and changes in commissioners, may have been factors in the poor oversight of this contract.

We estimate in SFY 2000 the DOC paid $225,921 in administration fees to BCBS for claims processing, reports, and the ability to receive "substantial discounts off of hospital charges." However, according to department officials, they discovered BCBS was not providing them with a discount at Concord Hospital. Ironically, when asked what improvement the department was looking for at the March 1999 bidder conference for the last contract, the department answered it wanted the successful vendor to negotiate a new pricing structure with Concord Hospital. There was a clause in the final contract stating BCBS was responsible for negotiating rates with providers. This clause further stipulated the department could request BCBS to "negotiate special pricing with identified hospitals." The director of administration said the department never made

[3] The 58 percent figure is based on LBA analysis of claims information provided by BCBS.

[4] According to the New Hampshire Insurance Department report *New Hampshire's Individual and Small Group Health Insurance Markets*, "Among Americans with job-based coverage, the percentage of employees with indemnity insurance coverage declined from 95% in 1978… to 14% in 1998."

a request to negotiate with Concord Hospital after signing the contract. The department did not renew the contract with BCBS for SFY 2002.

1.9 Standard Of Care

Inherent in the problem of containing rising health care costs is the question of what level and quality of care should be provided. Precisely what the level and quality should be is not easily determined. The department has to balance the need to provide quality health care with its responsibility to taxpayers. In fact, private health plans and government programs have their own standards and limits on coverage. According to the division's mission statement, the division offers inmates "opportunities to attain and maintain a functional level of wellness." In our analysis, the department's standard of care is ill-defined and not being adequately assessed. We also note that in July 2002, the New Hampshire State Board of Medicine found a former chief medical officer provided inadequate care to 16 State inmates.

According to the NCCHC:

> [t]he phrase "standard of care" is a term of art that means "to do all that needs to be done." Who and what determines a standard of care? A standard of care is determined through a consensus of national experts who validate their opinions on evidence-based information and science which has demonstrated a particular method to improve outcome and/or be cost effective…. Each situation is unique and how clinicians and administrators implement the standards of care is the art of medicine and its administration.

Laaman Decree

A 1976 lawsuit filed in Federal court against the State of New Hampshire for deficiencies in the correctional system contained a number of items related to medical and dental care. The Laaman Decree is the subsequent consent agreement. The medical and dental aspects of the decree covered minimum staffing and coverage, mandated intake and periodic procedures, inmate health care tracking, and required system support (i.e. quality assurance and medical records standards). The decree called for adequate medical and dental care. It left actual clinical decisions in the hands of the physicians. In 1993, after three annual reviews by an independent auditor, the auditor reported the DOC had met the terms of the decree. New Hampshire Legal Assistance, the legal representative for the inmates, did not contest the auditor's finding. This addressed the one medically-related observation from our 1992 Prison Expansion Performance Audit (see Appendix D, Current Status Of Prior Audit Findings). However, we note the department has entered into a settlement agreement to further address problems with its mental health services.

Constitutionally Required Care

Inmates are the only class of people constitutionally given the right to health care. According to the U.S. Supreme Court in *Estelle v. Gamble*, the government has an:

> obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical "torture or a lingering death,"….

According to the U.S. Department of Justice's *Correctional Health Care: Guidelines for the Management of an Adequate Delivery System*:

> In the 25 years since *Estelle v. Gamble*, the notion of deliberate indifference has been articulated in various ways by the courts, but at least three categories have emerged: denied or unreasonable delayed access to a physician for diagnosis and treatment, failure to administer treatment prescribed by a physician, and the denial of professional medical judgment.

The U.S. Supreme Court said "deliberate indifference" by prison workers, including medical personnel, to an inmate's serious illness or injury violates the Eighth Amendment of the Constitution. By "intentionally denying or delaying access to medical care or intentionally interfering with treatment once prescribed" prison workers are violating inmate rights. What constitutes "serious illness or injury" is not clear, leaving open a possibility that treatments for non-serious illness or injuries are not constitutionally guaranteed. According to Wisconsin State auditors, "Inmates in all states have a constitutional right to health care that meets minimum adequate standards. However, the Supreme Court has found that inmates are not guaranteed the right to the best heath care available in a community." A NCCHC publication states, "that courts have defined only constitutional *minima*. Therefore legal authority provides only the barest of foundations for a quality system of care." According to a national expert on correctional health care, while the constitutional level requires prisons to provide medical services and inmates must have access to the care, it does not truly address the quality of the care.

There does seem to be a difference between what is constitutional and what might be considered adequate. In 1999, a Federal District Court concluded "large numbers of inmates throughout the [Texas Department of Corrections] system are not receiving adequate health care." However, the Texas Department of Corrections' "medical and psychiatric care systems, while at times plagued by negligent and inadequate treatment of [inmates], are not so deliberately indifferent to inmates' physical and mental health needs as to be unconstitutional."

The court wrote:

> A medical accident cannot alone be characterized as wanton infliction of unnecessary pain. Nor can the inadvertent failure to provide adequate medical care constitute an unnecessary and wanton infliction of pain. "Medical malpractice does not become a constitutional violation merely because the victim is a prisoner." Moreover, "[p]risoners do not have a constitutional right to any particular type of treatment." Rather, prisoners' medical rights have been pared down to treatment that is not "deliberately indifferent" to their "serious" medical needs. (citations omitted)

> The standard for evaluating the constitutionality of medical care in prisons is… unduly low. That is, the plaintiffs' [i.e. inmates'] burden in this area is inordinately high. Plaintiffs must show not that defendants are merely negligent in their provision of health care, but that defendants have shown "deliberate indifference" to inmates' medical needs…. The court was deeply disconcerted by the inadequate and negligence medical and psychiatric treatment exposed by the plaintiffs and their experts. Plaintiffs demonstrated time and again fact patterns that would likely make winning malpractice suits in civil court. Regrettably, the Supreme Court has stated in no uncertain terms that for an inmate, this is not enough. The inmates must show a systemic pattern of intentional indifference to known medical needs…. As the law stands today, the standards permit inhumane treatment of inmates."

According to the U.S. Department of Justice's *Correctional Health Care: Guidelines for the Management of an Adequate Delivery System*:

> [a] condition need not be life-threatening to be deemed serious, and many treatment plans that are labeled "elective" nevertheless are deemed serious within the meaning of *Estelle v. Gamble*…. In *Delker v. Maass* (1994), a chief medical officer was found to be deliberately indifferent when he adopted a blanket policy of denying surgery for "routine, nonincarcerated, simple small to moderate sized hernia[s]."… Where surgery is elective, prison officials may properly consider the costs and benefits of treatment in determining whether to authorize that surgery, but the words "elective surgery" are not a talisman insulating prison officials from the reach of the eighth amendment. Each case must be evaluated on its own merits…. The length of the prison sentence is also a valid consideration. In some cases, prison officials may be justified in deferring "elective" treatment for an inmate serving a very brief sentence because the inmate will be able to obtain proper treatment following his release.

Community Standard Of Care

The philosophy of the most recent management of the division has been that inmates are entitled to the *community standard of care*, which is supposedly the level of care someone in the community should be receiving. Anything less than the *community standard of care* could increase the possibility of inmate lawsuits against the department over inadequate care. When asked to explain the *community standard of care*, knowledgeable individuals gave a variety of responses. Some see it as a national standard because medical experts used in lawsuits can come from any part of the country to testify as to what proper care should be in an individual case. An expert on prison health care said, "There is no single reference that clearly states what the required treatments are for every medical condition. The *community standard of care* is what you learn to practice at medical school." One physician defined the *community standard of care* as treatment prudent practitioners would deliver to their patients: give patients what they need, not what they want.

For some, *community standard of care* is ill defined and not a helpful concept in determining what care inmates are required to receive. One division official said the standard of care would vary with who provides it. Another knowledgeable person said the *community standard of care* is what insurance would cover or what the patient can afford. In fact, providing a "national" standard of care would increase costs for the department. Likewise, a national expert on prison health care called this standard a "soft" subject, because care in the community is affected by the type of coverage (government program, insurance, or health maintenance organization) a patient has.

Standard Of Care In A Correctional Setting

While the Federal Bureau of Prisons lists procedures it will and will not perform, it places the determination of what is medically necessary with the clinical judgment of health care professionals. According to the Federal Bureau of Prisons *Health Services Manual*:

> The health care mission of the Federal Bureau of Prisons is to provide necessary medical, dental, and mental health services[5] to inmates by professional staff, consistent with acceptable community standards…. Levels of care <u>not</u> provided are designated as care that is <u>medically acceptable but not medically necessary</u> and is for the convenience of the inmate. Examples include routine hernia repair, noncancerous skin lesion and tattoo removal, and cosmetic surgery. Exceptions can be made per policy (e.g., plastic surgery) on a case-by-case basis by the Medical Director.

According to an article for the National Institute of Justice, *Controlling the Use of Prison Health Care Services*:

> the definition of "medically necessary" is probably elastic enough for one physician to deliver procedures to some prisoners that other physicians might term "unnecessary." Ambiguity is probably most pronounced with respect to conditions for which new diagnostic and treatment technologies have been developed…. Consumers in the free community do not have an unrestricted legal right to any type of service from a health care provider… In prison, however, where prisoners do not typically pay for their health care services, the availability of "exotic" treatments raises questions for state policymakers. Should prison systems provide treatment that prisoners would not have received if the prisoners were free because they could not afford to pay for the medical service?… Because of the legal obligation to meet the standards of good medical practice within the organized legal community, the ground is not firm for limiting expensive or exotic diagnostic tests, or treatments, that may arguably be medically necessary.

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[5] According to the Federal Bureau of Prisons *Health Services Manual*, medically mandatory is defined as immediate, urgent or emergency care required to maintain or treat life threatening illness or injury. Presently, medically necessary is defined as routine care or treatment that cannot be reasonably delayed without the risk of further complication, serious deterioration, significant pain or discomfort, provided to maintain a chronic or non life threatening condition.

According to an official of the Massachusetts Department of Correction, their standard of care is based on what citizens on public assistance (i.e. Medicaid) receive. Another knowledgeable person said this is a common approach, but some states find this standard as being too generous. One division staff member mentioned a *correctional standard of care*, as opposed to the *community standard of care*, referring to the more conservative approach to care practiced by the former CMO. For example, as long as there was no pain or discomfort, surgical treatment of a hernia is not necessary. However, a higher standard might provide surgical treatment, even if the condition presented no discomfort or impairment. This *correctional standard of care* seemed to be more of a philosophical approach to inmate care rather than a written policy.

One DOC official said it is necessary to have written standards in place. Policies and procedures derived from a quality improvement program and utilization review can establish a cost effective, adequate standard of care to serve the institution. However, health providers have to use their judgment based on their own experiences and knowledge; a treatment given to one patient may not be appropriate for another suffering from the same illness. An expert on correctional health stated even written policies will contain the statement "upon the recommendation of the medical director." The Federal Bureau of Prisons has clinical guidelines for the treatment of a number of conditions. In addition, an official at the NCCHC reported the commission is coming out with six clinical guidelines dealing with conditions such as asthma, human immunodeficiency virus (HIV), and diabetes. The department has few written standards implemented and followed.

1.10 Significant Achievements

It is important to recognize performance auditing is by its nature a critical process; designed to identify weaknesses in past and existing practices. With that in mind, we mention here a successful and positive practice we have observed and for which sufficient documentation is available.

Accreditation By The American Correctional Association

The American Correctional Association (ACA) audits and accredits correctional programs and facilities. It is a 20,000 member organization founded in 1870 and is active in 44 states and more than 40 countries. According to the U.S. Department of Justice's *Correctional Health Care: Guidelines for the Management of an Adequate Delivery System*, "compliance with national standards and accreditation frequently are regarded favorably by the courts."

The ACA has accredited the men's prison, the SPU, the LRF, the NCF, all three halfway houses, the administrative offices, and the division of field services. If the ACA reaccredits the women's prison in Goffstown, New Hampshire will be in the company of New York, Ohio, Florida, and Louisiana, the only other states to have all their correctional programs and facilities accredited. New Hampshire will then be eligible to receive ACA's Golden Eagle Award.

OBSERVATIONS AND RECOMMENDATIONS

Over the past six years, the division of medical and forensic services (division) has been ill managed, which, in our analysis, has contributed to the substantial jump in health care costs. We have grouped our ten observations into three general categories: organizational structure and staffing, fiscal management, and quality assurance.

2.1 Organizational Structure And Staffing

The structure of an organization plays an important part in its ability to accomplish its goals. The structure establishes managerial, administrative, and operational relationships by arranging authority, responsibility, and accountability. Our review of division operations identified a serious weakness in its management structure based on statute, agency evolution, and leadership. We also found the division should reassess its staffing needs, especially its use of registered nurses (RNs).

Observation No. 1

Reorganize Division To Improve Management

The organizational structure of the division and personnel changes in Department of Corrections (DOC) leadership positions have contributed to the poor oversight of the division and health care costs. Management of medical services has been inadequate; poor oversight of the third-party administrator, lack of written treatment protocols, and an insufficient quality improvement program produced an environment in which costs dramatically increased. The DOC needs to have an organizational structure and positions that provide division managers clear responsibilities and authority to effectively manage inmate medical services. Along with responsibility and authority comes accountability for inmates' health and related costs to the DOC and ultimately the State.

The division is poorly organized to effectively provide leadership and management oversight of medical services. According to RSA 622:43, the division's leadership consists of two positions: a medical director who must be a psychiatrist and a division administrator. Since the creation of the department and the addition of the secure psychiatric unit (SPU), medical services may not have received adequate management attention. The management of the division has been dominated by professionals with mental health backgrounds.

- The DOC commissioner at the time of creation of the division was formerly the head of the forensic unit at New Hampshire Hospital.
- The division's first administrator started at New Hampshire Hospital before transferring to the DOC.
- The previous division administrator also came from New Hampshire Hospital, and when first hired admittedly focused on mental health services.
- The former director of nursing was the director of nursing for the Laconia School for the Developmentally Disabled and assistant director of nursing at the SPU before becoming the director of nursing for the department.

While nothing precludes individuals with mental health backgrounds from being successful at managing medically related operations, taken as a group, their predilection for mental health may have had a negative affect on the management of medical services.

While the administrative director position has recently been filled, the division is still without adequate clinical leadership. A psychiatrist under contract with Dartmouth Medical School has taken over all the responsibilities related to mental health services and holds the new title of medical director of forensic services. This leaves vacant the medical director and chief medical officer positions, which hamper the department's efforts to set and monitor clinical policy. This also means there is no single clinical person ultimately responsible for the quality and costs of inmate health care within the division.

The most recent actions by the commissioner to reorganize the division have had little impact on improving the management and oversight of medical services. The commissioner seeks to make wardens more responsible for medical services in their facilities and to decentralize medical services. The chief medical officer's duties were limited to the men's prison in Concord. The commissioner is familiar with this model from his many years of experience in another state. Prison health units operate within the walls of prisons where security is essential. In our analysis, while increasing wardens' involvement in the medical activities taking place within their facilities offers some benefits, it does not directly address controls over clinical decisions and the resulting costs of outside medical services.

The National Commission on Correctional Health Care (NCCHC) has recommended the DOC centralize medical leadership, responsibility, authority, and accountability. A head physician would become responsible for directing all aspects of medical care, including oversight of contract physicians, nurse practitioners, nurses, dentistry, medical records, and the pharmacy. In addition, this physician would be responsible for developing treatment protocols for clinicians and approving nursing guidelines developed by the director of nursing. NCCHC also recommends replacing the division administrator with this head physician, thus becoming the "responsible health authority." We translate this to creating a single division director who is a physician. This division director would be responsible for the administrative aspects of both health care and mental health services, including oversight of the Dartmouth contract for mental health services. This position should be responsible for developing the department's health care policies, advising the commissioner, managing the division, and overseeing related contracts.

According to NCCHC, this position should be the first position filled and the DOC should seek candidates with managed care backgrounds. An NCCHC study found the average salary for physicians in correctional institutions was $110,403 in 1999. NCCHC estimated a medical director salary should be 10 to 15 percent above that base, or $121,443 to $126,963, respectively. The division director would spend a majority of the time dealing with administrative and policy matters, and overseeing the work of division and contract staff. We believe there may still be a need for some type of administrative position to support this new division director, such as a business administrator or health care analyst, in addition to a quality improvement position (see Observation No. 9).

Recommendation

The DOC should restructure the division leadership positions and lines of authority to improve the management of inmate medical care by creating a division director position, which should be filled by a physician with managed care experience. This type of reorganization will require the DOC to seek legislative action to change statutory positions and organization. (See Appendix B for our recommended organizational chart.)

Auditee Response

We concur in part. The department recognizes that a more centralized approach is necessary to enforce policies, procedures, and directives system-wide. The department further recognizes that certain key positions are currently vacant and need to be addressed, such as Chief Medical Officer, Nursing Director, and Quality Assurance Coordinator to accomplish a more comprehensive approach to health services system-wide.

The Commissioner issued a directive in December 2001 that decentralized many of the daily functions of health services and shifted responsibility to the wardens. This action was taken due to the environment that confronted NHDOC and health services at that time. Since then, the department has become better able to centralize and manage those functions that must be consistent throughout a correctional health service system. Line authority for routine health service functions will remain with the warden of each prison. This offers the best mechanism for the day-to-day operations to be handled expeditiously, efficiently, and consistent with the practices of each facility. For health services to be effectively coordinated within total prison operation, the warden must bear responsibility for daily management decisions in all areas.

The department does not agree that in order to properly restructure the Division of Medical and Forensic Services, a physician should be responsible for the overall management of the division and oversight of related contracts. In as much as the department recognizes the importance of the Chief Medical Officer, such a position should be responsible for the management of physicians and nurse practitioners and provide assistance in medical oversight of all clinical practices. Such assistance may be, but is not limited to, the involvement in a number of multi-disciplinary initiatives such as the establishment of clinical protocols (please refer to Observation No. 8 and Observation No. 9). Observation No. 1 observes that the management of the division has heretofore been dominated by professionals with mental health backgrounds. Similarly, the department believes that if the division is led by a medical doctor, there will be a predilection for medical services that may have a negative effect on the management of mental health services.

Instead, the department believes that an organizational model that encourages collaboration between disciplines will be more effective. The department has established an organizational model that gives central oversight of all services within the Division of Medical and Forensic Services to the Administrative Director reporting directly to the Assistant Commissioner. The Chief Medical Officer, Chief Psychiatric Officer, and Supervising Dentist will have responsibility for practitioners within their own discipline and serve as clinical liaisons to the administrative director of medical and forensic services. The Nursing Director, Quality

Assurance Coordinator, Chief Pharmacist, Medical Records Administrator, rehabilitation services, and consulting dietician will be reporting directly to the Administrative Director. (See organizational chart in Appendix C.)

This structure is contrary to the recommendation made by the audit team who strongly recommend a physician be the division director. The audit team states in Section 1.11 of the report that the NCCHC has recommended "replacing the division administrator with this head physician, thus becoming the 'responsible health authority.' We translate this to creating a single division director who is a physician."

The 2003 edition Standards for Health Services in Prisons compiled by the National Commission on Correctional Health Care (NCCHC) states:

> *P-A-02: Standard*
> *The facility has a designated health care authority responsible for health care services. (Subset 5) The health authority may be a physician,* ***health administrator****, or agency."*

They further define a health administrator as:

> *"….a person who by virtue of education, experience or certification…..is capable of assuming responsibility for arranging all levels of health care and ensuring quality and accessible health services for inmates."*

The NCCHC standards clearly state that the division director can be the responsible health authority to ensure quality medical care is consistently accessible to the inmates.

The DOC is continuing to review its internal needs to better determine what will best serve the needs of the inmates, the agency and the State's resources. We are assessing different models utilized in other correctional agencies and are meeting with other professionals in correctional health care to obtain additional information. This process, while slow and sometimes tedious, has presented an opportunity to thoroughly assess the needs of the NH DOC. This thorough review of the options will help us to make decisions that will better prepare DOC to meet the challenges of correctional health care needs in the future.

The agency is moving ahead with filling the key positions cited above and currently recruiting for the position of Quality Assurance Administrator. We expect to begin recruitment for the Chief Medical Officer and Director of Nursing very shortly. The shortages of health care providers at this time makes these recruitments more difficult but we believe these are critical positions and will work to ensure quality selections are made.

Observation No. 2

Develop A Health Services Staffing Plan

A staffing plan describes the full-time equivalent staff coverage necessary to accomplish all identified health services tasks. Without a thoughtful examination of staffing requirements and resources, health care provided to inmates

may be inadequate, resulting in unnecessary costs and greater liability. We found no evidence the DOC has ever systemically assessed the staffing needs of the division. Analysis by the consultants from the NCCHC, an accreditation organization, indicated the ratio of central office staff to heath care staff (1:28) is comparable to the mean national ratio (1:29) found in their 1999 national staffing survey.[6] The ratio of unit health staff to inmates (1:42) is significantly less than the national mean ratio of 1:35.

The NCCHC consultants reported there might be a tendency to refer inmates out for specialty care when there is insufficient staff in the prison facility. This contributes to rising costs resulting from the use of outside consultants. Staff shortages may also increase costs by forcing delayed treatment of minor health problems in favor of more serious medical problems. Delayed treatment may result in a minor health problem becoming more serious. Lack of staff may also increase institutional liability. This situation exists in the prison infirmary, where NCCHC consultants documented there was only one nurse from 9 PM to 7AM four nights a week. If the nurse responds to a medical emergency in another part of the prison, a correctional officer covers the infirmary. The consultants reported this is a violation of their standards for an infirmary and may increase liability for the department.

The national nursing shortage may impede filling all necessary nursing positions. Identifying qualifications necessary to accomplish defined tasks may open the door to the use of paramedics, medical assistants, or other auxiliary personnel to assist nurses. The NCCHC consultants recommended once a new health management team is in place, developing a staffing plan should be a top priority.

Recommendation:

The division should develop a staffing plan for health services at each facility and in the process consider augmenting the health services staff with other types of medical personnel.

Auditee Response:

We concur. The department recognizes that a staffing plan for health services for each facility must be established. The department believes, however, that an effective staffing plan cannot be achieved without the involvement of a nursing director who has the clinical experience and knowledge to make those decisions. Toward that end, it is the department's plan to formalize the reorganization of the division as noted in the response for Observation No. 1 and to complete the recruitment efforts for nursing director to meet those needs.

Observation No. 3

Better Utilize Registered Nurses

The division is not fully utilizing RNs at the Health Services Center (HSC). The NCCHC found RNs did not perform basic nursing

[6] NCCHC defined the division medical director, administrative director, and director of nurses as central office staff.

functions such as taking and recording vital signs (height, weight, blood pressure, etc.) or doing tuberculosis skin tests. RNs do not initiate long-term intravenous therapy, necessitating the use of an outside contractor to set up long-term IV lines. The former chief medical officer reported he needed some clerical assistance, and stated the lack of a 'ward clerk' position forced the RNs to do a lot of paperwork. This took time from their regular duties, shifting some of their functions to the doctors.

Inefficient use of health care provider time may create conditions that increase cost to the system. Expanding RN functions (routine procedures and treatment capabilities) and providing more time to perform these functions would result in more care delivered in the HSC. This could reduce reliance on outside providers, promote more effective utilization of physician time, and potentially reduce health care costs.

Recommendation:

The division needs to assess what RNs should be doing on a routine level and facilitate the performance of all normally expected RN functions. In addition, the division should ensure all appropriate treatment training is provided to its RNs.

Auditee Response:

We concur. The department believes that it is essential that the competency of nurses' nursing functions be assessed on an annual basis consistent with their date of hire. Such assessment may include, but is not limited to, knowledge of equipment used during medical intervention, drug administration and reactions, and certain certifications such as Advanced Cardiac Life Support (ACLS).

The department further recognizes that such efforts may be better facilitated through a system-wide nurse practice committee that will establish a method to monitor training and continually improve and enhance the nurses' skill sets within the division.

The implementation of a system-wide nurse practice committee can only occur after recruitment and reorganization efforts as described in the response to Observation No. 1 have been completed. It is anticipated that a system-wide plan to assess and facilitate the performance of all functions normally expected of registered nurses can be implemented as soon as the reorganization has been finalized.

2.2 Fiscal Management

We found serious weaknesses in how the DOC handles its contracts and agreements with health care providers. The department's oversight of contracts was poor to non-existent. We found that "agreements" between the DOC and health care providers should have obtained Governor and Council approval. Now that the DOC is directly paying medical bills, it needs to improve its review of those bills. Lastly, we suggest the division seek adoption of a State statute with similar cost ceilings now provided to county jails.

Observation No. 4

Improve Contract Management

The DOC needs to improve its oversight of medically related contracts. In June 2001, the DOC cancelled its contract with Blue Cross and Blue Shield of New Hampshire (BCBS) after discovering it had lost its discount on services provided by Concord Hospital. That facility had received more than 50 percent of the department's external health care payments through BCBS. According to RSA 21-H:4 (I)(a)(3), the director of administration is responsible for contracts. However, a past director of the division of medical and forensic services monitored the contract by reviewing utilization reports produced by BCBS; his successor did not. We found no evidence anyone was assigned responsibility for monitoring this contract.

A BCBS representative reported the discount DOC received at Concord Hospital was reduced as a result of negotiation between BCBS and Concord Hospital in the mid-1990s. BCBS sought greater discounts for its managed care business at the expense of its fee-for-service plans. The DOC was under fee-for-service. The BCBS representative never reported the loss of the discount to the DOC. Only when the department began examining high cost cases in 2000 did it realize the discount was lost. The last contract, effective June 1999, allowed the DOC to request BCBS to negotiate special pricing with identified hospitals. However, the director of administration reported the DOC never made such a request. He admitted the department did not do a good job of overseeing this contract.

Canceling the BCBS contract saved the DOC the administrative fee it paid, which ranged from 11.5 percent to most recently 14 percent of payments made to health care providers. We estimated in SFY 2000 the DOC paid about $226,000 in administration fees. However, the DOC also lost all discounts negotiated by BCBS with other hospitals and local medical providers, as well as the utilization reports the department could use to help control costs. Canceling the BCBS contract left the DOC in a position where it had to directly negotiate discounts with hospitals and other providers. Without a person assigned to monitor the contract and to analyze the outcome, it is likely no one considered the disadvantages of canceling the contract.

The DOC currently has a contract with Dartmouth Medical School to provide for clinical staffing at the SPU. The staffing includes a medical director of forensic services who administers and develops programming for the SPU and is responsible for psychiatry and mental health at all department facilities. The DOC expended $205,958 in SFY 2001 and $617,989 in 2002 for the contract. The department received an appropriation of $1,295,975 for SFY 2003, when it expects to achieve full staffing under the contract. We have seen no evidence DOC officials are properly monitoring this contract.

Effective management practices require contract monitoring by personnel with technical expertise in the area of contract services. The contract monitor is responsible for ensuring the vendor provides satisfactory performance and full value for the State.

Recommendation:

The director of administration should designate properly qualified DOC personnel to monitor all future health related contracts. The contract monitor should also assist the department with developing request for proposals and evaluating contract bids. If the department creates a division director position to be filled by a physician, as we recommend in Observation No. 1, the department should assign all health contracting responsibility to this new position.

Auditee Response:

We concur. The New Hampshire Department of Corrections, Director of Administration acknowledges statutory responsibility for contracts and has always operated under the expectation that key medical personnel and the Director of Medical and Forensic Services have front line responsibility for contract monitoring. This was accomplished by the previous Director and medical staff, but not by the latest Director of Medical and Forensic Services even though that individual was responsible for this function. We fully agree that contract monitoring should be performed by personnel with technical expertise in the area of contracted services. The recent appointment of the Administrative Director for Medical and Forensic Services is expected to strengthen the oversight of the contracts. The Director of Administration will formally designate, by letter, properly qualified Department of Corrections personnel to monitor all health related contracts. It is noted that RSA 22-H:44-I-b states the Director of Administration, subject to the supervision of the Commissioner, shall have superior authority over other division directors in areas of responsibility defined in RSA 21-H:4, which includes contracts.

The department acknowledges that working relationships with local hospital providers has often been strained, as the department sought lowest costs for inmate medical services. The department will continue to improve working relations with providers.

Observation No. 5

Utilize State Contract Bidding And Approval Process

Since canceling its contract with BCBS in June 2001, the DOC has not entered any new formal medical contracts, which forced the department to negotiate its own provider discounts. The DOC was under pressure to contain health care cost after going to the Legislature for additional funding for outside medical expenses in each of the last two fiscal years. The DOC response and the resulting agreements have harmed the department's relationship with health care providers in Concord and Manchester.

The DOC negotiated a discount agreement with Concord Hospital in May 2001. Concord Hospital requested formalization of the agreement in 60 days, along with updating a contract specifying roles and responsibilities of the parties. In September 2001, the department joined Concord Hospital in a memorandum of understanding on procedures for handling inmate care at the hospital. The memorandum did not formalize the costs of treatment. In the meantime, the department reached agreements with Elliot Hospital and Catholic Medical Center in Manchester near the end of 2001. The former division administrative director and the former chief medical

officer reported these agreements represented the best prices obtainable. The arrangement with Elliot Hospital took the form of a letter of agreement dated October 31, 2001. The agreement with Catholic Medical Center also took the form of a letter effective December 1, 2001. When Concord Hospital officials learned of the agreement the department had with Elliot Hospital, they withdrew all discounts and informed the department they would charge full rates for any emergency services provided to inmates (as the hospital closest to the prison, all emergency cases are sent there).

After intervention by the Governor's Office brought Concord Hospital and the DOC back to the bargaining table, the hospital offered per diem rates and 50 percent discounts on cardiac care and outpatient services. The DOC concluded this offer was better than Elliot Hospital's and signed letter of agreement transferring inmate medical care back to Concord Hospital.

The department did not formally notify Elliot Hospital of the policy change. Inquiries from hospital-affiliated physicians to Elliot management regarding cancellation of inmate appointments revealed the change in medical providers. Elliot Hospital management maintains they had an exclusive agreement. These events may hamper future efforts to negotiate agreements with other health care providers. Statements made by State and hospital officials indicate there may be a reluctance to do business with the department in the future.

The former chief medical officer and the former division administrative director produced the Elliot Hospital agreement, with the knowledge of higher department officials. The director of administration produced the subsequent arrangement with Concord Hospital. There was never an effort to seek a formalized contract and the commissioner approved both agreements. An administrator from the general services bureau of the Department of Administrative Services reported any service with a value over $5,000 is required to go to Governor and Council for approval. The director of administration reportedly did not consider a request for proposal or obtaining Governor and Council approval because, historically, the department had always utilized Concord Hospital with no questions asked. More recently, the commissioner reported wanting a more formalized process for developing hospital contracts.

Consultants from the NCCHC observed that contracts with specialty providers and local hospitals were not properly negotiated. Effective management practice suggests using a bidding process in selecting vendors for high cost contracts, which allows the purchaser to make careful side-by-side comparisons of vendor proposals. Competently drafted contractual agreements provide assurance to all parties on mutual expectations and often provide a mechanism for dispute resolution, including terminating the contract.

Recommendation:

The department should seek the best prices for inmate medical services through a competitive bid process. The department should establish contracts with preferred vendors and send them to Governor and Council for approval.

Auditee Response:

We concur. The department is in the process of seeking the best prices for inmate medical services through a competitive bid process. A Request for Proposal (RFP) was issued to all acute care hospitals in the state on October 1, 2002. Submission of proposals by interested parties are due by November 22, 2002. With assistance of staff from the Department of Administrative Services, Department of Health and Human Services, Department of Corrections, and a state legislator experienced with medical contracts, an RFP was issued on October 1, 2002 to formalize costs for in-patient medical and surgical care and out-patient services for our inmate population in Concord, Berlin, and Laconia. On November 5, 2002, a mandatory pre-bid conference was held to answer questions hospitals may have. All bids are due back to the Department of Corrections by November 22, 2002 at 2:00 PM at which time we expect to formalize contracts with hospitals for inmate health care. Governor and Council approval and start of services should occur in early January 2003.

The RFP was sent to every hospital in New Hampshire. Three hospitals were represented at the mandatory pre-bid conference: Concord Hospital, Catholic Medical Center, and Androscoggin Valley Hospital. Negotiated contracts will be submitted to Governor and Council for approval.

Additionally, a one (1) year contract with Elliot Hospital to provide in-patient and out-patient medical services to our female population in Goffstown has been approved by the Governor and Council.

The department is seeking three (3) year contracts with hospitals and will re-bid the contracts on a regular basis.

The Department of Corrections has always sought competitive bids for services such as pharmacy, x-ray, dental supplies, medical supplies, etc.

Observation No. 6

Improve Medical Bills Review

Since the department ended its health care claims and utilization contract in June of 2001, medical bills have not been adequately reviewed for errors and reasonableness of service. The department has been paying the bills with limited review by financial staff who have no medical expertise. As a result, according to one department employee, health care costs cannot be sufficiently verified today.

The department's fiscal unit review consists of checking if dates of service coincide with transportation records or consult orders. In addition, the unit checks for duplicate billing. These reviews for the date of service and double payment are insufficient to ensure that the services being billed are reasonable and accurately stated. The former claims vendor under contract with the department reviewed all bills for errors using special software. In addition, all inpatient charges exceeding $10,000 were audited by one of the vendor's health care professionals. For the first seven months of State fiscal year 2002, the department paid $3.4 million in medical bills that would have been reviewed under the old contract. We believe the department needs to take immediate action to strengthen its review of medical bills.

Recommendation:

The Department should develop and implement policies and procedures to review medical bills for errors and medical reasonableness. Management needs to determine the most cost efficient and effective method (use existing staff, hiring qualified staff, or contracting for services) to assure that only valid bills are paid.

Auditee Response:

We concur with the observation and have the following plan for corrective action. The department will develop a policy and procedure for review of medical bills for errors in medical reasonableness. This policy will recognize the methodologies used by medical providers such as Medicare, DRG, and APC procedures as well as being current on the billing procedures and posted charges of the providers utilized by the DOC. The DOC will utilize a staff person who will monitor all medical charges to make sure that they are consistent to the medical diagnosis and any discounts agreed upon in a provider contract. The department has set a timetable for implementation by July 1, 2003.

Observation No. 7

Seek Medicare Based Rate Legislation

Existing federal laws and a new State law limits the amount health care providers can charge for services to certain segments of the population receiving government health care coverage. States and the federal government are constitutionally responsible for providing state and federal inmates adequate health care and in some cases, inmate health care costs are legislatively controlled. Currently, county jails and the DOC are treated differently under State law.

The federal government regulates hospital charges for certain federal inmates. According to the U.S. General Accounting Office's *Federal Prisons Containing Health Care Costs for an Increased Inmate Population*: "[i]n November 1999, Congress passed legislation establishing a Medicare/Medicaid-based cap on health care payments to community hospitals for treating prisoners under the custody of [U.S. Marshals Service] and the Immigration and Naturalization Service…."

In New Hampshire, Chapter 255, Laws of 2002, requires that hospitals not charge county jails more than 110 percent of the Medicare rate[7] for inmates who receive medical services. However, the law allows the county jails to negotiate rates with local hospitals that could be higher or lower than Medicare based rates. In addition, hospitals are not required to accept inmates as non-emergency patients. These are important parts of the law, as some correctional institutions may negotiate better rate agreements than the Medicare based rates, while others may have to negotiate higher rates in order for the hospitals to accept inmates as patients for non-emergency care. Currently, hospitals closest to prisons are used for emergency room visits. Hospitals can use this location advantage to leverage all the business from nearby prisons.

[7] In some cases, financially stressed hospitals can charge 125 percent of their Medicare rate.

When the DOC started to use Elliot Hospital in Manchester for most non-emergency services, Concord Hospital sent a letter to the DOC canceling all discounts the department was receiving.

> [W]ith [the DOC's decision to use another hospital], Concord Hospital must also look out for its fiduciary responsibility in managing its services and, therefore, is withdrawing our offer to provide services on a discounted basis to the NH DOC patient inmates who present for services…. effective immediately, we will provide said services at full Concord Hospital charges and will not be offering any discount from charges for services provided.

Legislation similar to Chapter 255, Laws of 2002, could assist the DOC in negotiating contracted non-emergency services. By capping prices charged for emergency visits at Medicare based rates, hospitals would have to offer competitive discounts without threatening costly emergency room visits.

Recommendation:

The DOC should seek legislation to provide itself with the same price ceiling and other options as county jails received under Chapter 255, Laws of 2002.

Auditee Response:

We concur in part. The department has introduced legislation in the past to require that no provider of health care services to the Department of Corrections shall bill or charge the department more than the provider's usual and customary charge as defined in the proposed legislation. (The charges were to be based upon the established Medicaid rates, not Medicare rates.) However, as we are currently in the process of establishing contracts with hospitals in various areas of the state, legislation of this nature could significantly complicate the contract process. Therefore, we do not agree with the recommendation to introduce legislation as we believe the contract process will meet the goal of reducing some of our medical expenses without sacrificing quality medical care. The department anticipates implementation of the contracts by early January, 2003.

2.3 Quality Assurance

We found the division lacks effective medical management tools. Treatment protocols could help control costs and provide a baseline for effective care. These protocols, when implemented, would require evaluation and updating provided by a quality improvement (QI) program. The division once had a QI program, but management failed to keep it fully active when the QI administrator moved on to another position. DOC health care administration has ignored an administrative rule calling for periodic inspection of the prison infirmary by an external agency. This is a lost opportunity for a quality review.

Observation No. 8

Establish Treatment Protocols

The NCCHC found the division of medical and forensic services lacked treatment protocols. Without adequate treatment protocols medical care is not standardized and may not be efficient, effective, or the most economical. A number of division personnel mentioned the division's lack of protocols, including an advanced registered nurse practitioner who wrote that she "repeatedly asked for creation of protocols and guidance in clinical practice."

Treatment protocols are an essential part of a cost containment program; lack of clinical protocols can result in escalating costs. In describing these types of guidelines, the American Medical Specialty Organization web site states:

> [y]ou may hear these referred to as practice parameters, clinical practice guidelines or protocols. These are statements by authoritative bodies as to the procedures appropriate for the physician to employ in making a diagnosis and treating it. The goal of guidelines is to change practice styles, reduce inappropriate and unnecessary care and cut costs.

National level organizations develop clinical protocols for their own use or as guides for others. NCCHC has developed clinical guidelines for chronic disease management in correctional institutions. The former director of nursing said adoption of NCCHC standards would contain costs. The Federal Bureau of Prisons has established clinical guidelines for care they will (or in some cases, will not) provide to inmates. Even the current insurance plan for State workers has some clinical guidelines available on its website. However, protocols or guidelines are just that – guidelines – clinical judgment plays an important part in medical treatment. In fact, an NCCHC official stated many clinical policies in correctional institutions include the phrase "upon recommendation of the Medical Director." The Federal Bureau of Prisons, in its health care regulations, permits exceptions to protocols based on what is medically necessary in the clinical judgment of health care professionals.

The division had pre-existing guidelines for treating elevated cholesterol and triglycerides, as well as guidelines for chronic care clinics. According to the most recent chief medical officer (CMO), these were dated guidelines and not closely followed. Both the most recent CMO and former administrative director stated that the CMO was developing new protocols. In fact, there were protocols developed for cancer detection by physical examination, cholesterol, triglycerides, and asthma. The CMO said the administrative director advised against implementing some guidelines because it could increase outside consults. In addition, there was a draft protocol for treating Hepatitis C, but the necessary medication was currently unavailable according to the CMO.

The lack of clinical protocols can open the door to indiscriminate use of outside consults. The NCCHC's review of the division found rising health care costs were partially a result of a lack of clinical protocols, as part of its overall concern with the lack of clinical leadership. One former division official said policies and procedures, such as treatment protocols, define the level of cost effective care. These policies and procedures can evolve from a quality improvement program

and utilization review, which are not occurring within the division. In the absence of these activities, this official said medical treatment had become a "free for all."

Recommendation

The department should institute treatment protocols. Treatment protocols can be established by adopting nationally recognized clinical guidelines and adapting them for a correctional setting. Once established, protocols must be evaluated and updated regularly.

Auditee Response:

We concur. The department will begin the process of revising or establishing clinical guidelines/ protocols in accordance with generally recognized standards for clinical practice. The department recognizes that the establishment and revision of clinical protocols must involve a multi-disciplinary approach, oftentimes using outside resources to accomplish this task. Toward that end, a clinical practice committee will be created in early 2003 and be charged with the responsibility of establishing and revising such guidelines. The committee will be comprised, but not necessarily limited to, representatives from the medical and psychiatric staff, nursing, pharmacy, nutrition, and rehabilitation services in order to ensure a comprehensive approach to care.

The department realizes, however, that a comprehensive and multi-disciplinary approach to overseeing clinical guidelines cannot occur immediately because certain key members of the team as observed in part in Observation No. 1 is not yet in place. The plan, therefore, will be to create the clinical guidelines committee with incumbents giving attention to guidelines that may already exist, but are in need of revision. The committee will methodically focus on the development of new guidelines based on priorities established by the committee.

The department believes that the process of developing and revising clinical guidelines is ongoing and will measure its progress based on when the protocol was revised (at a minimum of one time per year, or if the standards have changed, whichever comes first) and the number of guidelines in place as compared to recommendations by such organizations as the National Commission on Correctional Health Care (NCCHC) and the Federal Bureau of Prisons (BOP).

Observation No. 9

Re-establish Quality Improvement Program

A quality improvement (QI) program is one way management can review and improve programs and services by identifying problems or best practices, and implementing changes to improve the efficiency and effectiveness of those programs and services. According to the NCCHC's 1991 report, *Prison Health Care: Guidelines for the Management of an Adequate Delivery System*:

> The primary objective of quality improvement efforts should not be to fix blame when things go wrong, but rather, to make systems work so that the "right things" are done right the first time. Improving the quality of care has its own intrinsic rewards, not the least of which is higher staff morale. An organization that

> emphasizes quality is able not only to attract but to retain qualified health professionals. Reducing turnover and "burn out" among the staff results in cost savings to the system…. The relationship between quality and cost is somewhat paradoxical. A lack of quality increases costs. Improved quality reduces costs, but at the same time, there are costs associated with improving quality.

After reviewing medical services at the division of medical and forensic services, NCCHC recommends the division create a system-wide multi-disciplinary quality improvement committee to design improvement monitoring activities and implement corrective actions. This committee should conduct one process and one outcome quality improvement study a year, in addition to annual reviews of:

- access to care,
- screening and health assessments,
- continuity of care,
- emergency care and hospitalizations,
- adverse patient occurrences,
- infirmary care,
- nursing care,
- pharmacy services,
- diagnostic services,
- mental health care,
- dental care,
- critiques of disaster drills,
- environmental inspection reports,
- inmate grievances, and
- infection control.

Under the Laaman Consent Decree, the DOC agreed to establish a quality improvement program. The last full-time person responsible for the quality improvement program was the program coordinator between 1994 and 1999. This person sought and received a new position and the DOC changed the program coordinator position to the lower paying system development specialist III. The department has not filled this position because for nearly a year the department has sought to reclassify it to an administrator I position (similar in labor grade to the program coordinator). The Department of Administrative Services has reclassified it lower to a program evaluation specialist. The department has continued to seek reconsideration of the position classification, given the scope of the medical services and medical budget. Under the April 2001 settlement agreement between the DOC and NH Legal Assistance, the department agreed to:

> establish and maintain a QI program for [the Mental Health Unit], psychiatry, and the treatment of [New Hampshire State prison] inmates in [the Secure Psychiatric Unit]…. The QI program for [the Mental Health Unit] shall include a review of [the Mental Health Unit] emergency interventions, mental health services in [the Special Housing Unit], and the [Residential Treatment Unit] Pilot Program, in addition to such other periodic reviews as are deemed appropriate by the Division of Medical and Psychiatric Services of the Department of Corrections and the QI director.

The head of medical records is currently responsible for the QI function. Annual statistics are produced, but little if any qualitative analysis is done. The head of medical records readily admits not having the time to devote to this function. A number of division officials and staff believe a quality improvement program is an important function the DOC needs to perform.

Without this function, the department does not have adequate information on which to base medical and policy decisions regarding inmate health care services and expenditures.

Recommendation:

The DOC should establish a quality improvement committee and fill the quality improvement position. Depending on the placement of this position within the division, the DOC may want to continue to seek its reclassification. This position should report directly to the medical services division director, and should play a key role in carrying out initiatives made by the quality improvement committee.

Auditee Response:

We concur. After several months of working with the Department of Administrative Services, Division of Personnel, the Department of Corrections received approval for a properly classified position as Quality Assurance Coordinator and will begin the recruitment process subject to Governor and Council approval. Consistent with the recommendations in Observation No. 9, the department believes that a Quality Assurance Coordinator must be responsible for the function and oversight of quality assurance and promote the widely accepted principles of Continuous Quality Improvement (CQI) in health services. This individual must possess a clinical background so as to have a general appreciation of all health services processes. The individual, although not expected to take the lead in every CQI process being reviewed, must coordinate the successful completion and dissemination of information involving quality assurance.

The department will establish a system-wide, multi-disciplinary, quality improvement committee to design improvement monitoring activities, and implement corrective actions. It is the intent of the committee to perform annual reviews of various systems of care.

The plan is to establish a multi-disciplinary, quality improvement committee that will coincide with a Quality Assurance Coordinator coming on-board. It is anticipated that a qualified individual will be selected for this position by the end of February 2003.

Observation No. 10

Request Inspections Of Health Care Facilities

The DOC has not requested that its medical facilities be inspected by the Department of Health and Human Services (DHHS). According to the DOC's administrative rule Cor 303.01 (o):

> The chief administrator of the facility shall request of the New Hampshire DHHS, office of community and public health[8] that the infirmary be inspected at least once every 6 months. The chief administrator of the facility shall comply with the orders, requirements and recommendations of the New Hampshire DHHS, office

[8] The office of program support has taken over responsibility of licensing and regulation services from the office of community and public health.

> of community and public health or request a waiver from these orders, requirements and recommendations. Items that require additional funding shall be reported by the commissioner for inclusion in appropriate budgetary documents.

According to the manager of DHHS' licensing and regulation services, the men's prison has not been inspected for approximately ten years. The manager was unaware of this rule and said it is DOC's responsibility to request an inspection. There is nothing in licensing and regulation services' rules requiring an inspection. The manager also stated inspecting every six month does not make sense; hospitals are only inspected once a year and similar criteria would be used to inspect the prison infirmary. While 'infirmary' is not defined by the DOC rules, the manager commented that his office may want to inspect all four institutions to get a complete picture of health care services within the department. Licensing and regulation services would inspect for safety and patient care issues.

Recommendations:

The DOC should request DHHS inspect the health care facilities in all four institutions. In addition, the department should update its administrative rules to take into account reasonable inspection intervals and organizational changes at DHHS.

The Legislature may wish to consider enacting legislation requiring DHHS' licensing and regulation services to regularly inspect State correctional medical facilities instead of relying on the DOC to request said inspections.

Auditee Response:

We concur with the observation and have requested that the department of health and human services, office of program support visit and inspect all four prison infirmaries using the appropriate criteria for the correctional environment. This will be done in accordance with department of corrections administrative rules. In as much as inspections of this type are typically intended for community health care providers, inspections in the correction's venue will be safety-oriented. Additionally, the department regularly seeks accreditation and it is through this process that delivery of care practices are measured.

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OTHER ISSUES AND CONCERNS

In this section we present issues and concerns we encountered during our audit not developed into formal observations, yet we consider noteworthy. The Department of Corrections (DOC) and the Legislature may consider these issues and concerns deserving of further study or action.

Contracting Correctional Health Care Services

The issue of contracting medical services for the DOC in a prior administration. A former commissioner was considering taking department medical services in this direction. Currently, the department retains the medical director of forensic services, all psychiatrists, and all psychiatric nurse practitioners through a contract with Dartmouth Medical School. This contract provides psychiatric services to the secure psychiatric unit (SPU) and psychiatric/mental health services to the rest of the department's incarcerated population. We do note the authors of the Ohio Report and the National Commission on Correctional Health Care (NCCHC) offered some caveats regarding privatization.

The Ohio Report authors did not take a position on privatization. They said the idea was not adequately analyzed. Their report did state if this was the way the department chose to proceed, it would have to be justified by cost-benefit analysis, clearly communicated, negotiated in good faith with the union, and set up to minimize hardship on current staff members affected. The NCCHC recommended the formation of an exploratory task force to analyze the desirability and feasibility of contracting prison health services. The NCCHC said:

> According to NCCHC's 1999 survey of health care systems, 32 percent of 861 responding prisons contract out some or all of their health services. Some DOCs contract with medical schools and universities (e.g., Georgia, Texas). The current forensic contract with Dartmouth Medical School makes it an ideal candidate for a health services contract. The missions of the medical school and prison system may be highly compatible.
>
> An important benefit of contracting is that by bringing in an experienced health care contractor, managed care practices can be quickly instituted. Contract health providers can hire and terminate personnel with greater ease than civil service health care systems. Another benefit to contracting is that government gains a partner in sharing the risk and costs of health care. With an experienced partner, who has an economic stake, health care costs can be closely monitored. The contractor can be directed to be cost effective and penalties can be built into the contract for failing to meet specific objectives…. It has been shown that prisons with contracted health services score higher on accreditation quality scores than publicly run facilities….
>
> The use of independent contractors does not relieve the institution (or the contractors) of legal responsibility for health care. The Supreme Court ruled that private companies or independent contractors who provide medical care to

inmates are held to the same eighth amendment standards as state civil service employees *(West v. Atkins*, 1988).

As shown in Table 4, four out of the other five New England states contract their correctional health care services; only Rhode Island does not. Maine uses a limited number of state employees in conjunction with contracted inmate medical services. As of January 1, 2003, two states will utilize contracted services provided by state university hospitals.

Table 4

Contracted Health Services In New England State Prisons	
State	**Level of Contracted Services**
Connecticut	Corrections in Connecticut contracts with the University of Connecticut Medical School and its affiliated hospital to provide all medical and mental health services at its facilities. They do not consider this privatized, as another state entity is providing the services. The medical school makes a budget request each year and negotiates with corrections if the cost is too high. Once the budget is established, the medical school is responsible for keeping costs within the budget.
Maine	State employees fill nursing and some clerical staff positions. A contract firm (Prison Health Services) provides health care practitioners, dentists, mental health, pharmacy, hospitalization, and higher-level health care management. The firm's representative reports to an associate commissioner. In June 2002, Maine moved from a flat fee payment to the contractor to a management fee plus cost arrangement for a six-month period. Maine audits the contractor using NCCHC consultants.
Massachusetts	Previously, a private contractor provided all inmate medical services. As of January 1, 2003, the department contract for inmate health care will be with the University of Massachusetts Medical School. This expands a contract the department already had with the University for mental health services. The arrangement is similar to the one in Connecticut.
New Hampshire	A contract with Dartmouth Medical School provides psychiatrists and nurse practitioners for mental health services; physicians and some dentists are contracted; all other health care workers are State employees. Practitioners make referrals to outside providers and medical facilities.
Rhode Island	State employees handle correctional health care. They make referrals to outside providers and medical facilities as necessary.
Vermont	Vermont uses a private contractor for all health care services, including pharmacy and mental health. There is a contract monitor employed by the state who oversees this contract, along with the director of clinical services. Vermont uses a capitated contract with some built-in exceptions for high cost cases.
Source: LBA survey of New England correctional health care officials.	

We present this information for informational purposes only and do not make any recommendations.

CONCLUSION

Administratively, inmate medical services at the Department of Corrections (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 current commissioner inherited a poorly organized division of medical and forensic services with inadequate data to make decisions. While the DOC does not have control over all the causes of cost increases, the National Commission on Correctional Health Care (NCCHC) identified three themes from their review of factors influencing DOC health care costs:

1. The medical program has been clinically underdeveloped, never having strong medical administrative leadership.
2. The health services staffing for the DOC is inadequate and under utilized.
3. Customary cost controls seen in managed care are absent in the DOC health services.

We found the current DOC organizational structure to be ineffective in managing medical services. The department does not have protocols or policies on what treatments it will and will not provide, and on how to provide such care. Its quality improvement program is inadequate and not currently staffed. Health care services at the DOC need to operate as a managed care system. In addition, it does not properly manage medically related contracts and has improperly attempted to enter into service agreements without Governor and Council approval.

Since State fiscal year 2000, the DOC's leadership has been in a reactionary mode in dealing with health care costs; this includes the commissioner, the director of administration, the division administrator, and the chief medical officer. As a result, actions were short sighted, poorly organized, and not based on proper information. In addition, a number of division personnel left, agreements with hospitals were in dispute, there are few if any discounts with outside physicians, and the medical staff is overworked. The hiring of an assistant commissioner and an administrative director may allow the DOC to improve its fiscal controls over medical costs and plan the restructuring of the division. However, the department still needs a chief physician for proper clinical oversight.

Fortunately, the NCCHC found the health care provided to DOC inmates was adequate and met legal and medical requirements. It found minimal inmate grievances and that inmates interviewed had a high degree of satisfaction with the health care system. However, the quality of care provided under the two former chief medical officers has been a major issue and directly related to the cost increases starting in 2000. NCCHC and DOC officials agree the two physicians approached the treatment of inmates differently. While NCCHC did not find that either practiced outside the norm, they said the most recent acted more like an emergency room doctor who was more likely to send patients to specialists, and the previous chief medical officer was idiosyncratic and conservative in his approach. We note the State Board of Medicine found the earlier chief medical officer provided an inadequate treatment for a number of inmates.

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APPENDIX A

DOC Commissioner's Letter To The Fiscal Committee

State of New Hampshire

JEANNE SHAHEEN
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PHIL STANLEY
COMMISSIONER

December 24, 2002

Fiscal Committee of the General Court:

The performance audit of the Department of Corrections recently completed by the Legislative Budget Assistant is very thorough and contains many excellent suggestions for improvement. The Department appreciates the time and effort the auditors invested in the compilation of this report and the accuracy with which they reflected much of what has transpired within our agency over the past few years.

The Department is pleased to report that the organizational structure of the Health Service Unit (HSU) is continuing to improve while overcoming a number of key human resource vacancies and system issues. We recognize the organizational structure has contributed to some of the difficulties cited in the audit report. We are taking aggressive steps to resolve the weaknesses and ensure supervision, consistency and accountability throughout the agency.

Following our exit conference with the Legislative Budget Assistant's staff, we consulted the 2003 edition of the *Standards for Health Services in Prisons,* a publication of the National Commission on Correctional Health Care (NCCHC). A standard in this edition does not require a health care authority (i.e. the person responsible for arranging quality health care and ensuring it is accessible to inmates) to be a physician. This person may be an administrator as long as he/she has the experience, training or certification. With this in mind, we have constructed a new organizational structure for the NH DOC Health Services Unit utilizing the administrator model. However, we are continuing to consider several modifications that will promote best practices for the correctional environment. To that end, the Department is recruiting for the key positions.

The recent appointment of the Administrative Director of Medical and Forensic Services has improved our ability to effectively deliver correctional health services system-wide. The Administrative Director is responsible to properly manage health care and be held accountable for costs. In collaboration with clinical personnel, the Administrative Director is overseeing medically related policy. In addition, a physician at each of the facilities is making clinical decisions on medical matters.

Despite the challenging past few years, HSU has been able to sustain a number of significant accomplishments, many of which are noted in your report. These accomplishments include:

- Appropriate clinical outcomes
- American Correctional Association accreditation
- Favorable financial indicators for medical costs per inmate when compared with comparable correctional systems
- Pharmaceutical and Therapeutic committee review of medication to ensure clinical appropriateness and cost effectiveness

- Multi-state pharmacy buying group that enables the Department to obtain medications at significant discounts.
- Contractual relationship with Dartmouth-Hitchcock Medical Center to provide mental health services
- In-house rehabilitation services that provide appropriate post-hospital care and decreases hospital per diem costs
- Establishment of specialty clinics mitigating the need to transport inmates outside the facilities

In addition to the above mentioned accomplishments and consistent with the observations made in the audit report, the Department is initiating the following measures:

- Developing internal controls for monitoring current and future medical provider contracts
- Establishing a continuous quality improvement system and the recruitment of a quality assurance administrator
- Revision of outside medical payment processes including a billing audit and reconciliation system
- Creation of a clinical utilization committee to improve case management and monitor the use of medical resources
- Revision and development of clinically-appropriate protocols and algorithms

Clearly, the Department is not immune to the significant challenges facing our nation's health care system. Needless to say, an increase in communicable diseases, mental health and social issues, and risky life styles are more pronounced for those entering the correctional system. Unfortunately, for many who have lacked preventive care, there is the need for immediate clinical intervention and these clinical demands put a strain on the Department's human and financial resources. The Department will continue to treat inmates through the prudent and appropriate use of clinical resources.

The issues confronting the Department have been varied and complex. These issues have grown over a period of time and were exacerbated by several factors. However, through it all, the inmate population received acceptable medical care. As referenced in the audit report, the cost of this care was below the average annual cost of similar correctional systems cited in the audit report. This speaks to the fact that, while parts of our system need to be strengthened, we are able to deliver health services to the inmate population for a rate comparable to similar departments of corrections. Given the steps we are taking, we expect to be able to be more efficient in our expenditures while providing necessary services more effectively.

In closing, the Department views the Legislative Budget Assistant's recommendations as a tool for continuous improvement. The professional and thorough approach has resulted in a useful document for NH DOC to make effective decisions in the future.

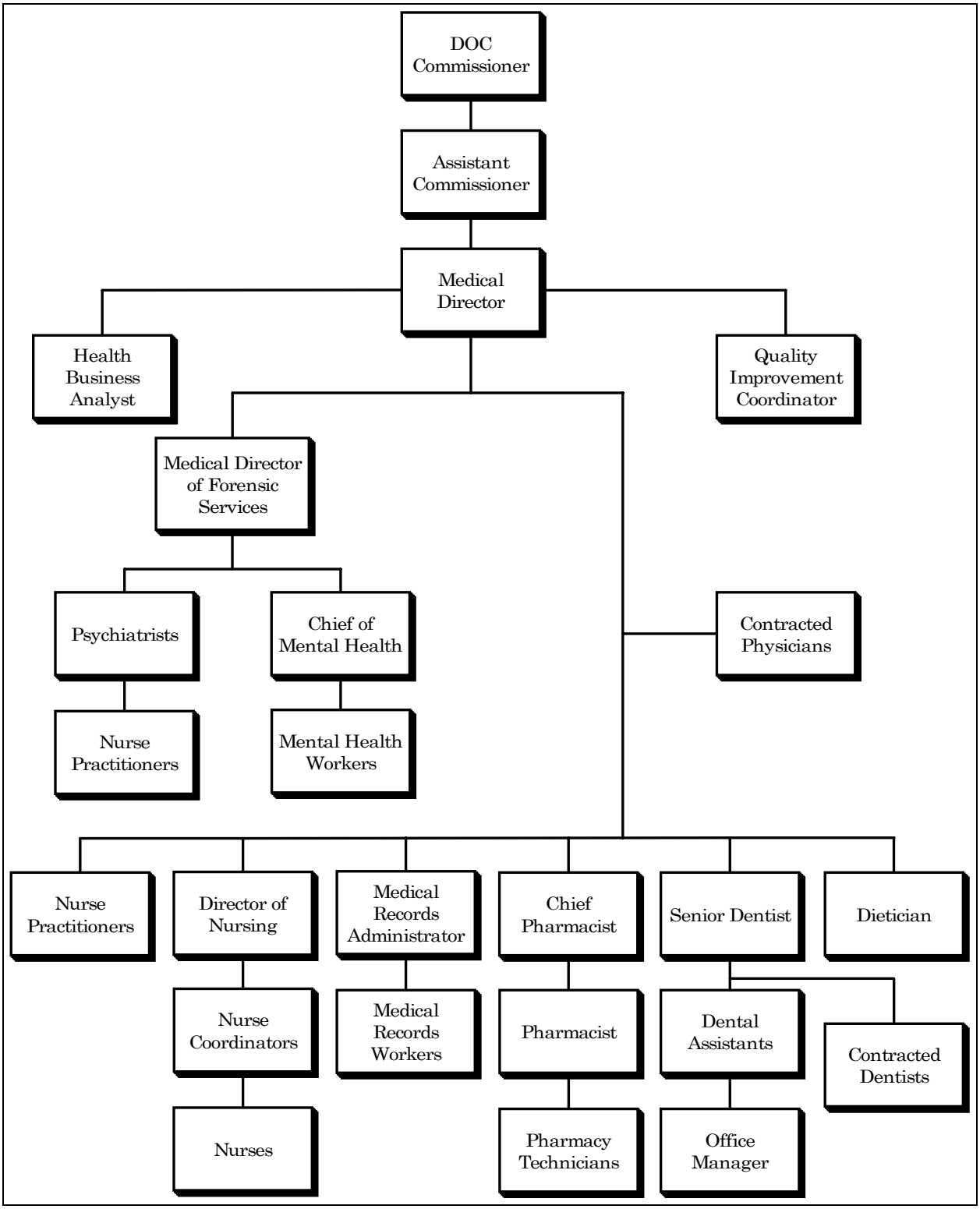
Sincerely,

Phil Stanley
Commissioner

lsdlbsmed.122402

APPENDIX B

LBA Recommended Organization Chart



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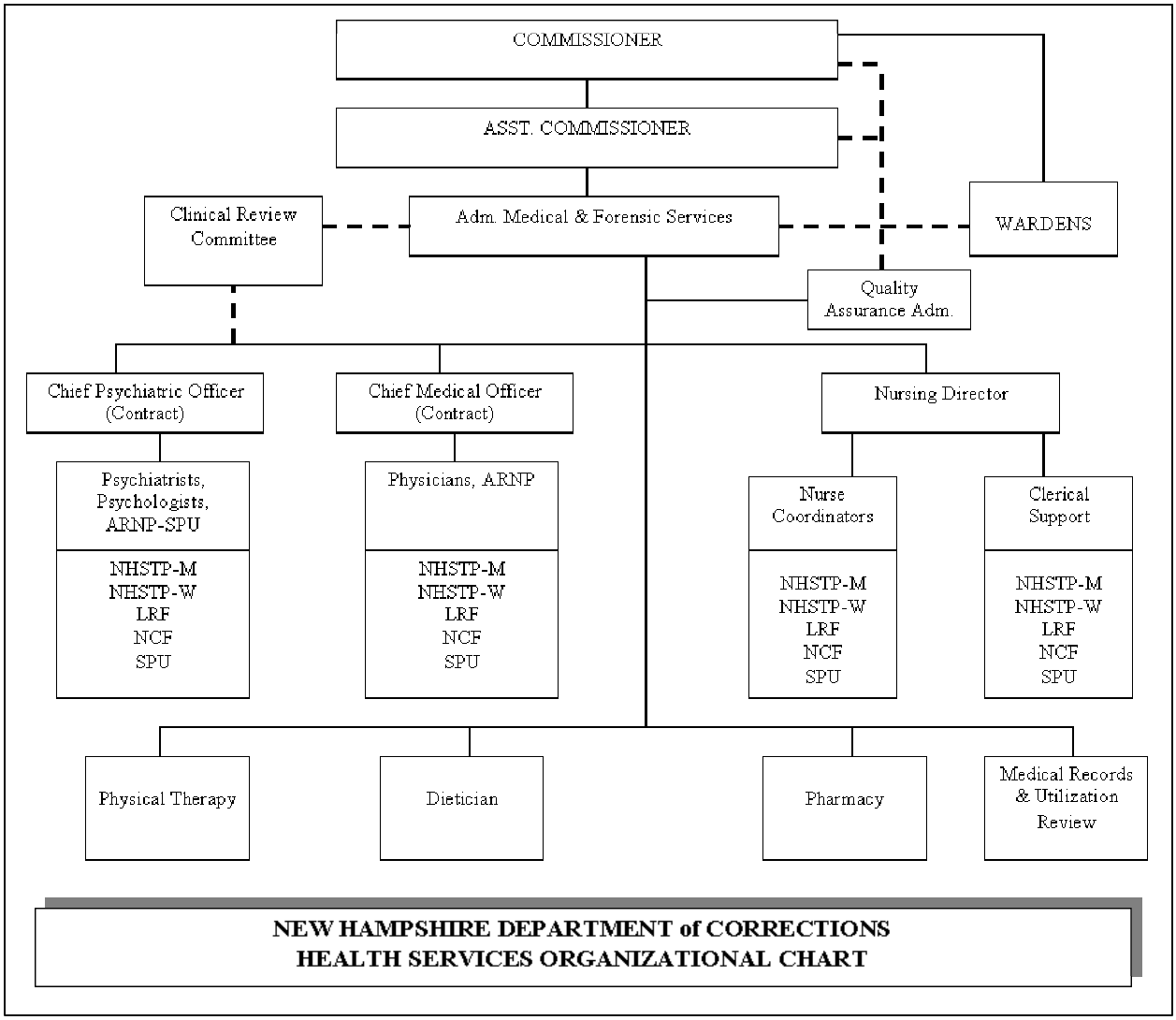
APPENDIX C

DOC Draft Organization Chart



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APPENDIX D

Current Status Of Prior Audit Findings

The following is a summary of the status of the observation related to the Department of Corrections' medical care found in the 1992 audit report of the State of New Hampshire Prison Expansion Performance Audit. A copy of the prior audit can be obtained from the Office of Legislative Budget Assistant, Audit Division, 107 North Main Street, State House Room 102, Concord, NH 03301-4906.

Prior LBA Observation	Status
Adequacy of Medical Care	● ● ●

Status Key

Fully Resolved	● ● ●
Substantially Resolved	● ● ○
Partially Resolved	● ○ ○
Unresolved	○ ○ ○

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