JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION
OF THE VIRGINIA GENERAL ASSEMBLY

Review of Inmate Medical Care and DOC Management of Health Services

A Report in a Series on Inmate Health Care

REPORT OF THE
JOINT LEGISLATIVE AUDIT
AND REVIEW COMMISSION

Review of Inmate Medical Care and DOC Management of Health Services

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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Preface

Although the United States Supreme Court has established inmates' constitutional right to health care, the Court has not determined the appropriate level and quality of care to be provided. Item 15-A of the 1992 Appropriation Act directed JLARC to examine the increasing cost of inmate health care and to determine appropriate levels of that care in Virginia. This report focuses on inmate medical care and the organization and management of inmate health care. It is the final report in a series; two previous reports examined inmate dental care and mental health treatment.

Inmate health care represents a significant and growing component of the Virginia Department of Corrections' budget, yet the department does not effectively manage these services or their costs. Central office staff lack system-wide descriptive and analytical information about many aspects of inmate health care. The department has not taken advantage of several cost saving opportunities overviewed in this report.

Consequently, in three of the last five fiscal years, department expenditures for inmate health care have exceeded appropriations. For example, in FY 1993, the department was appropriated $30.5 million to provide health care to an average daily population of 17,011 inmates. However, the department spent $36.9 million, of which $31.7 million was for medical care.

Within Virginia, inmate access to medical care generally appears to be good, but the department has not given sufficient attention to the on-site medical needs of female and handicapped inmates. Moreover, deficiencies in the documentation of care make access difficult to fully assess and may adversely affect the State in legal actions. In addition, inmate access to care could be compromised because of problems in recruiting and retaining medical care professionals to work at the facilities.

The department's experiment with privatization of inmate health care delivery at Greensville Correctional Center has been a failure to this point. The department has not adequately monitored the contract and there have been problems with inmate access to care, cost overruns, and contractor noncompliance. If the contractor does not achieve compliance, the department should deliver inmate health care at Greensville.

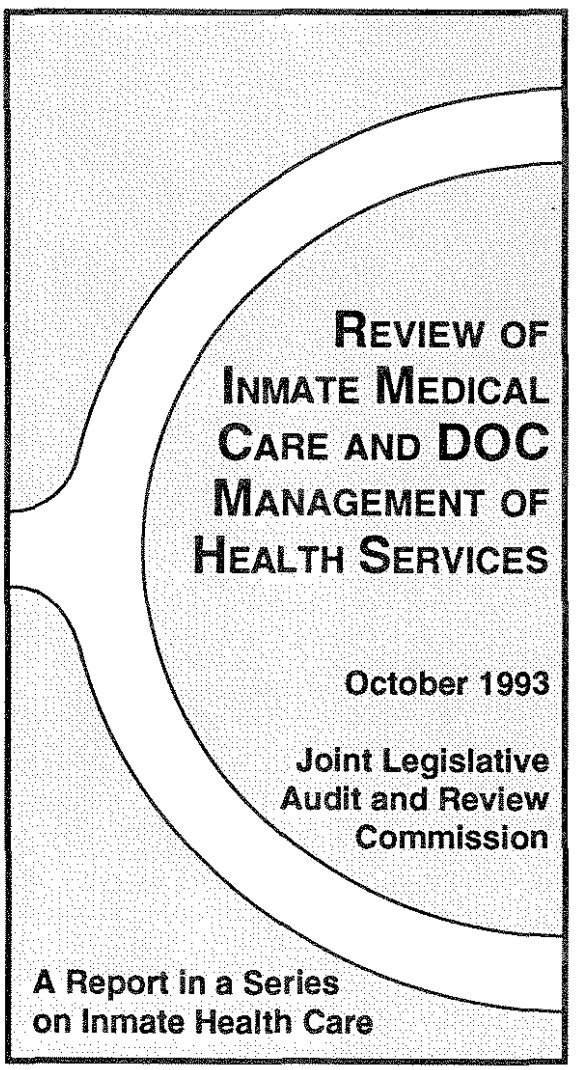
The Department of Corrections needs to clearly delineate responsibility at the central office level for health care contract oversight, the analysis of inmate health care costs, and the development of needed management systems. Although the Office of Health Services is the logical repository for these responsibilities, it has not adequately performed current responsibilities. The report contains several recommendations for improvements in oversight and management of inmate health care.

On behalf of JLARC staff, I would like to thank the director and the staff of the Department of Corrections for their cooperation and assistance during the course of this review.

Philip A. Leone
Director

October 29, 1993

JLARC Report Summary



Nationally, inmate health care has been the subject of much debate and a significant amount of court activity. The United States Supreme Court ruled in the late 1970s that inmates have a constitutional right to health care. However, questions remain concerning the appropriate level and quality of inmate health care. Consequently, correctional administrators and health care staff must make these determinations within certain legal parameters.

In fiscal year (FY) 1993, the Virginia Department of Corrections (DOC) spent approximately $36.9 million to provide health care to an average daily population of 17,011 inmates. Expenditures for inmate medical care made up the majority of expenditures for inmate health care services. The remaining expenditures were for inmate dental and mental health services.

Approximately 200 full-time State employees and additional contract personnel provide medical care services at 17 major institutions and 20 field units. In addition, the department employs four professional staff, who are assigned to the Office of Health Services (OHS) in the central office. The department has a decentralized approach to inmate health care that results in budgetary and programmatic decisions being made at the institutional and regional levels. Staff within OHS act primarily as advisors to correctional health care staff working in the facilities.

The 1992 Appropriation Act directs the Joint Legislative Audit and Review Commission (JLARC) to examine the increasing costs of health care in corrections and to determine the appropriate level for that care. This report, the third in a series of reports on inmate health care, focuses on the delivery of inmate medical care and the Department of Corrections' management of inmate health care. Previous reports addressed inmate dental care and inmate mental health care.

Although inmate health care represents a significant and growing component of the Department of Corrections' budget, the department does not effectively manage these services or their costs. Consequently, in three of the last five fiscal years, department expenditures for inmate health care have exceeded appropriations. Cost overruns

and contractor noncompliance have plagued the department's experiment with privatization of inmate health care delivery at Greensville Correctional Center. The department needs to clearly delineate responsibility at the central office level for health care contract oversight, the analysis of inmate health care costs, and the development of needed management systems. Further, the department needs to improve inmate access to medical care by correcting deficiencies in medical care staffing, documentation of medical records, and facilities for female and handicapped inmates.

Problems with the Provision of Medical Care

Overall, access to care appears to be good. However, generalizations about inmate access to medical care must be caveated, because problems with documentation of care and sick call records made it difficult to assess the delivery of primary medical care at some of the major institutions. Medical care, particularly primary care available through sick call at DOC facilities, was difficult to assess due to:

- inconsistent record-keeping at major institutions
- incomplete, disorganized, and illegible medical record documentation
- poor documentation of off-site care
- inconsistent documentation of inmate medical transfer information.

Medical record and sick call documentation are important components for assessing inmate access to medical care. Medical records document the care provided to inmates, assure continuity of care by providing treatment information to multiple medical care providers, and provide a basis for planning and assessing the quality of medical care provided. Incomplete and inaccurate documentation of care may adversely affect the State in legal actions.

Problems with medical record documentation were noted in quality assurance reviews conducted by the Office of Health Services and in Board of Corrections standards compliance reviews conducted by DOC staff. To address these problems, the following recommendation is made:

- *The Department of Corrections should ensure that institution and field unit staff improve documentation of inmate medical care. Also, the Office of Health Services should: (1) follow-up on documentation problems noted in quality assurance reviews, (2) complete the medical records manual, and (3) design and conduct training on documentation requirements for medical care staff.*

DOC Needs to Improve Methods for Medical Staff Recruitment and Retention

In general, the department employs dedicated medical care professionals who are trying to deliver quality care in the correctional environment. However, medical staff recruitment and retention problems were evident at DOC major institutions and appear to negatively affect inmate access to primary medical care. Recruitment efforts for nurses and physicians are hampered by inadequate recruitment efforts, hiring delays, the lack of continuing medical education, and inadequate compensation. The department has failed to implement existing State retention mechanisms, such as the use of shift differentials or flexible scheduling.

In addition, physician recruitment and retention could be improved by establishing better linkages to teaching hospitals, offering continuing medical education opportunities, and offering more competitive compensa-

sation. To address physician coverage problems, DOC should supplement physician care with physician extenders, such as certified nurse practitioners or licensed physicians' assistants. These positions typically supplement physician primary care in community settings. Physician extenders could enhance inmate access to primary care and provide cost effective care. However, DOC currently does not employ any licensed physician extenders in the correctional system.

The following recommendations are made to address these issues:

- *The Department of Corrections should change its nurse recruitment and retention policies and procedures to decrease position vacancy rates and use of temporary agency nurses to fill these positions. The department should work with the Department of Personnel and Training to implement a full range of methods for improving nurse recruitment and retention.*

- *The department should assess physician coverage in major institutions and consider alternatives for providing physician coverage, such as the use of physician extenders or enhanced physician recruitment efforts. The department should work with the Department of Personnel and Training to explore alternatives to improve physician recruitment.*

Medical Services for Females and Handicapped Inmates Need Improvement

Potential access to care problems affect female and handicapped inmates. The Virginia Correctional Center for Women (VCCW) has a medical facility that has inadequate clinic space, medical beds, equipment, and staffing. Currently, most inmates needing specialty care must be referred offsite for medical services. This has resulted in higher medical care costs, longer waiting periods, and increased use of overtime for security personnel. Further, the inadequate facilities negatively affect the recruitment and retention of qualified medical staff.

Deep Meadow Correctional Center is the system's designated handicapped facility, containing one 50-bed dormitory for handicapped inmates. However, Deep Meadow has no infirmary medical beds available and the handicapped dormitory is separated from the medical building by a security gate. Some handicapped inmates may have medical conditions which require close nursing and monitoring, but current facility and staffing limitations do not facilitate this.

To address medical services for female and handicapped inmates, the following recommendations are made:

- *The Department of Corrections should immediately begin to address problems in delivering on-site medical services at the medical infirmary at VCCW.*

- *The Department of Corrections should track the number and acuity levels of handicapped inmates, develop a plan to address the full range of housing and medical care needs of handicapped inmates, and evaluate the current staffing patterns at Deep Meadow Correctional Center to determine if current levels are adequate to address the medical care needs of inmates housed at the facility.*

Current Procedures Guiding Inmate Medical Transfers Are Inadequate

A number of problems affecting inmate medical transfers from one correctional facility to another were noted. Inmate medical transfers lack adequate physician involvement, notification, and documentation. DOC staff have failed to use precautions in transporting inmates with suspected infectious

diseases, and training of security staff in handling inmate medical transfers appears to be inadequate. These problems have resulted in situations in which the medical care of transferred inmates has been compromised and the State has been exposed to potential legal liability.

- *The Department of Corrections should revise policies and procedures for inmate medical transfers to address problems with physician involvement, appropriate precautions in transporting inmates with active or suspected infectious diseases, conditions under which medical staff should accompany the transferred inmate, and training for medical staff and correctional officers on medical transfers.*

The Department Does Not Manage Health Care Costs

Health care costs are a significant and growing component of DOC's budget. In FY 1993, the department spent $36.9 million on health care services, or nine percent of the department's total expenditures. Current spending on inmate health services represents an 84 percent increase over the past five years. In three of the past five fiscal years, the department's health care expenditures have exceeded appropriations. State budget problems coupled with projected growth in the inmate population in Virginia make it imperative that DOC ensure its health care expenditures are cost effective. This review, along with previous JLARC reports on dental and mental health care, indicates that DOC does not have adequate control of these expenditures.

Currently, DOC lacks data on health care expenditures, inmate morbidity, and inmate health needs. DOC does not separately track dental, mental health, and medical service costs, and the method of classifying health care expenditures is not uniform. In addition, the department's morbidity data have been inconsistently reported, and are seldom used. The department does not maintain data on the severity of inmate medical conditions. As a result, DOC cannot determine the major components of health care costs, assess whether the costs of services purchased were reasonable, and determine if services could be purchased more cost effectively.

DOC's health care budgeting is also problematic. Over the past two fiscal years, 14 of 17 major institutions had inmate health care expenditures that exceeded their appropriations. This indicates two problems. First, DOC does not support its health care budget requests with valid data on inmate health care needs and the costs of those needs. Second, on the institutional and regional levels, health care funding is appropriated on a per-inmate basis. No allowances are made for special inmate health needs or higher service levels that are required at some institutions. This leads to overruns at higher service institutions.

Five recommendations are made to address these problems with inmate health care data and budgeting. The department should:

- *use the element options to distinguish dental, mental health, and medical expenditures when processing financial vouchers for the Commonwealth Accounting and Reporting System*

- *ensure institutional and regional office accounting personnel use a system-wide classification of health care expenditures*

- *routinely collect, summarize, and analyze morbidity data; implement a systematic method of tracking inmates with special health care needs; and use the data on inmate health care needs to justify department health*

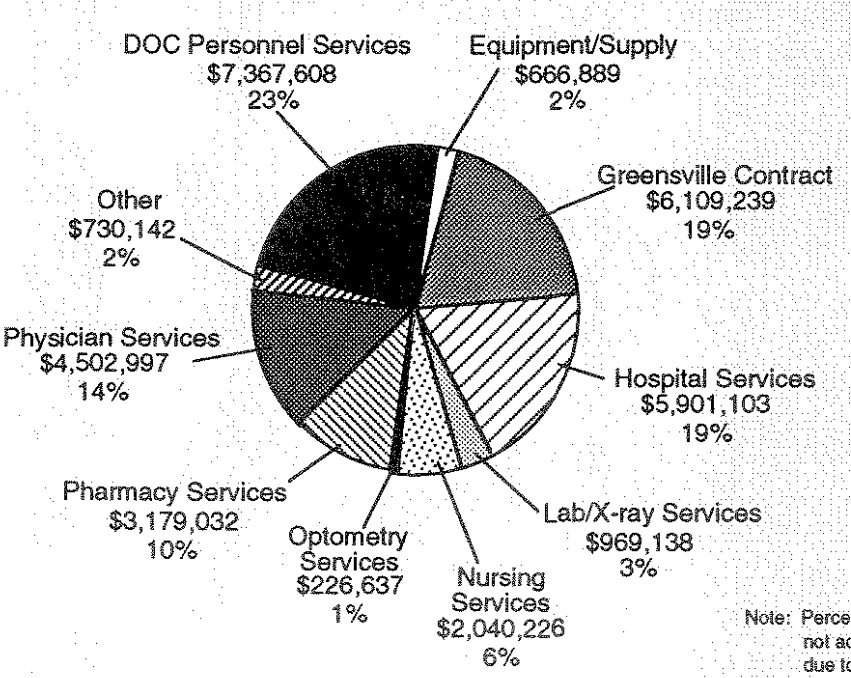
care budget requests and adjust institutional and regional health care budgets.

DOC Has Several Opportunities to Achieve Medical Care Cost Savings

JLARC staff analyzed the department's inmate health care expenditures to estimate and categorize DOC's medical expenditures. This analysis revealed that in FY 1993, approximately 86 percent ($31.7 million) of the $36.9 million in health care expenditures was for medical services. Medical expenditures were then categorized by the type of service purchased, such as personnel, hospital, or physician services (see figure below). Analysis of these expenditure categories revealed that DOC has several opportunities to achieve cost savings if the department implements basic cost management techniques. For FY 1993, more than $2.3 million in cost savings could have been realized had DOC effectively managed its medical expenditures.

Since FY 1988, the percentage of health care expenditures going to DOC personnel services declined from 49 percent to 30 percent in FY 1993. This fact combined with dramatic increases in temporary nursing expenditures indicates that DOC is using more contractual services to directly deliver inmate health care. The department's use of temporary nursing is not cost effective. Temporary nurses are typically licensed practical nurses that cost almost as much per hour as State-employed registered nurses, but have a lower level of training and a narrower scope of clinical practice. By examining three institutions with large expenditures for contracted temporary nursing services, JLARC staff estimated more than $1 million could be redirected to provide recruitment and retention incentives for State-employed nurses instead of relying on temporary nurses to staff these positions on a routine basis.

DOC Medical Expenditures, FY 1993



The department lacks cost effective negotiated payment rates for many services. DOC has negotiated payment rates with Medical College of Virginia (MCV) Hospitals for male inmate inpatient stays. However, DOC pays 100 percent of charges for female inpatient care and outpatient care at MCV for all inmates. DOC also lacks negotiated payment rates for many other medical providers, such as physician groups, specialty care physicians, and other hospitals the department uses for inpatient and outpatient services. JLARC staff estimate that if DOC had negotiated payment rates of 80 percent of charges for many services currently not covered by negotiated rates, the department could have saved almost $1.1 million in FY 1993.

DOC also lacks fundamental reimbursement policies and processes to dispute billed services that appear to be medically unnecessary. Currently, medical bills are paid without determining the accuracy or appropriateness of the services being billed. The department may be making excessive payments for medical services because no mechanisms exist to dispute inappropriate or unnecessary charges. The department should seek assistance in creating these policies from other State agencies involved in health care.

In conjunction with developing reimbursement policies, DOC could obtain additional cost savings by better utilizing its utilization review contractor. Information from hospital utilization reviews could be used to deny medically unnecessary services. In addition, DOC could expand the number of cost audits conducted to identify inappropriate payments made to hospitals for services, and increase the number of concurrent and second opinion reviews. More than $200,000 could have been saved in FY 1993 if DOC had established reimbursement policies and increased its utilization review activities.

Several recommendations are made to take advantage of cost saving opportunities.

- *The department should develop a plan to reduce its usage of temporary nursing.*

- *The Secretaries of Public Safety and Education should direct DOC and MCV to renegotiate payment arrangements for inmates receiving care at MCV Hospitals.*

- *The Secretary of Public Safety should establish a task force to assist the department in developing more cost effective mechanisms for purchasing medical care services as well as developing reimbursement policies.*

- *The department should implement a plan to conduct a full range of utilization review activities for medical services and establish agreements with hospitals notifying them of utilization review activities that could result in payment denials.*

Privatization of Health Care at Greensville Has Not Been Adequately Managed

DOC officials have indicated that privatization of inmate health care delivery is a possible direction for the future. DOC is testing the feasibility of privatization with a pilot project at Greensville Correctional Center. However, the department has not adequately managed the private contract for delivery of inmate health care at Greensville. This has led to problems with inmate access to care, costs that have significantly exceeded projected amounts, and contractor noncompliance with contract provisions. The department needs to assign responsibility for managing the contract to a single official or organizational unit at the central office level.

The contractor at Greensville, Correctional Medical Systems (CMS), has not adequately documented provision of inmate health care at Greensville. The contractor's substandard documentation of inmate tuberculosis (TB) testing violated contract provisions and public health standards. Tuberculosis testing procedures used by the contractor have threatened the health of inmates and staff. Further, the contractor has not provided adequate physician coverage in some instances. This has limited inmate access to medical care and violated contract standards on physician coverage. Problems with physician coverage have also been noted in DOC reviews of health care at Greensville.

The contractor's quality improvement efforts are minimal. The contractor's clinical oversight committees were late in being organized, seldom meet, and have sparse documentation. The contractor has not lived up to its contractual obligation to implement quality improvement activities and has not fulfilled its promise to achieve accreditation by a national organization.

In addition, DOC has not adequately fulfilled its support role to ensure inmate access to care at Greensville. For example, X-ray equipment at Greensville did not function fully until more than two years after the facility's opening. Repairs were not made until after the warranty on the equipment had expired. Problems with the functioning of the respiratory isolation rooms were not discovered until more than two years after the facility's opening. DOC management of the respiratory isolation rooms has not been adequate and has violated public health standards. DOC intends to request replacement respiratory isolation rooms but has not demonstrated the need for these or the ability to manage the existing respiratory isolation rooms.

The following recommendations are made to address these problems:

- *The Department of Corrections should immediately require CMS to comply with all contract provisions regarding: (1) documentation of medical care, (2) physician access, (3) quality improvement activities, and (4) accreditation.*

- *The General Assembly may wish to defer consideration of funding for the proposed respiratory isolation beds at Greensville Correctional Center until the department demonstrates: (1) the need for the proposed respiratory isolation beds and (2) the ability to manage the existing respiratory isolation facility.*

DOC Management of Contract Costs Needs Improvement

DOC has not adequately monitored or controlled costs of the Greensville contract. DOC has failed to require the contractor to: (1) bill in a timely fashion that provides sufficient data to verify expenditures, (2) fully implement utilization review, and (3) follow proper procedures for contract modifications. As a result, the price of the contract has exceeded both appropriated amounts and projected expenditures for the contract. To better manage the contract, DOC needs to assign responsibility for monitoring it to a single official or organizational unit at the central office level.

For both FY 1992 and FY 1993, costs incurred for inmate health care at Greensville exceeded appropriated amounts by approximately $5.4 million. DOC has not finalized the costs of the Greensville contract for FY 1993. JLARC analysis projects that costs incurred for the Greensville contract for FY 1993 will exceed appropriated amounts by more than $2.5 million and projected contract costs by more than $1.5 million.

Much of this overage is caused by greater than expected costs of the medical

care pool, which pays for off-site care and on-site specialty care for inmates. DOC did not receive a bill for the medical care pool until nearly seven months into the contract, at which time it became clear that its cost would significantly exceed appropriated amounts. DOC has not yet finalized the cost of the medical care pool for FY 1993, but JLARC analysis suggests that it will exceed projected amounts by more than $1.3 million.

CMS did not implement utilization review activities until ten months into the contract. This may have contributed to the high costs of the medical care pool and violated contract provisions. CMS has still not fully implemented utilization review and has not sufficiently trained its nursing staff on utilization review.

DOC has not assigned responsibility for monitoring the Greensville contract to any single official or organizational unit at the central office level. This has created communication problems and diffused responsibility for managing the contract costs. For example, DOC officials at Greensville, in the procurement office, and in the Office of Health Services have not properly communicated contract modifications. This lack of communication has resulted in the addition of $200,000 in annual costs to the contract.

DOC has not yet required CMS to comply with many contract provisions regarding access to and costs of care. DOC should plan to directly deliver inmate health care at Greensville and should implement these plans if the contractor does not immediately comply with all contract provisions.

The following recommendations are made to address these problems:

- *The Department of Corrections should: (1) immediately clarify the costs of the medical care pool for FY 1993, (2) closely monitor and evaluate Correctional Medical Systems' performance of utilization review activities, (3) designate the health services administrator in the Office of Health Services as the central office official responsible and accountable for the contract, and (4) require Correctional Medical Systems to immediately comply with all provisions of the contract for medical care at Greensville Correctional Center. DOC should prepare a plan to deliver inmate health care directly in the event that the contractor does not immediately comply with the all provisions of the contract. The department should report the status of this recommendation to the next session of the General Assembly.*

- *The director of the Department of Corrections should ensure that DOC follows its internal policies, State contracting guidelines, and contract provisions for contract modifications of the contract for inmate health services at Greensville Correctional Center.*

- *The General Assembly may wish to restrict the department from entering into additional major contracts for direct delivery of substantially all inmate health care at major institutions until the department addresses the findings and recommendations of this report concerning privatization of inmate health care.*

DOC Management of Health Services Need Improvement

Currently, DOC has not clearly delineated responsibility at the central office level for: (1) health care contract oversight, (2) analyzing inmate health care costs, and (3) development of needed management systems, such as quality improvement and cost

containment initiatives. Improvement of DOC's oversight and management of inmate health care requires revising the mission, role, structure, and staff qualifications of OHS.

The Office of Health Services has not been assigned clear responsibility for a number of management systems needed to improve the administration of inmate health care. OHS lacks: (1) a defined mission with clear goals and objectives, (2) responsibility for inmate health care funding in the DOC system, (3) authority to enforce health care policies and procedures, and (4) direct supervisory authority over institutional health care staff.

OHS is located three levels of management below the agency director. This diffuses the office's accountability and oversight of health service delivery. Currently, 25 states have the health services director report to the director or deputy director of corrections. In addition, the Office of Health Services has not adequately performed its responsibilities for ensuring consistent documentation of medical care, data collection, quality assurance, infectious disease control, and risk management.

Recommendations to improve DOC health services management include the following:

- *The Department of Corrections should: (1) specify the goals and objectives to be accomplished by the Office of Health Services, (2) clarify the role of the OHS, (3) have the Office of Health Services report to the department's director or deputy director for adult institutions, (4) consider placing control of funding for inmate health care in a central office unit responsible for health care oversight, and (5) consider granting central office health care staff direct supervisory authority over all health care staff.*

- *The department should develop a plan to remedy management deficiencies identified in JLARC reports on inmate dental, mental health, and medical care.*

- *The department should assess the resources required to accomplish the mission and role it determines appropriate for the central office oversight of inmate health care, and assess the qualifications required of its central office health care staff.*

- *The department should require the Office of Health Services to improve its performance and to develop needed management systems in the areas of: (1) cost tracking, (2) quality assurance, (3) infectious disease management, and (4) risk management.*

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Part One:
Inmate Medical Care

I. Introduction

Item 15-A of the 1992 Appropriation Act directed JLARC to examine the increasing costs of inmate health care in the State correctional system. The mandate further directed JLARC to determine the appropriate level of inmate health care and to develop mechanisms for restraining the growth of costs.

Medical care is the largest of the three components of inmate health care provided by the Virginia Department of Corrections (DOC). The other two components, dental care and mental health treatment, have been discussed in earlier JLARC reports. This report presents JLARC staff findings on inmate medical care services provided by the department. The report also addresses DOC's management of health services across the three components of care.

National studies have shown that the United States' prison incarceration rate almost doubled in the decade of the 1980s, reaching a rate of 250 prisoners per 100,000 population. Furthermore, due to current incarceration trends towards more and longer prison sentences, the inmate population nationally is expected to grow at an even greater rate in the first half of the 1990s. The rising number of inmates alone creates a greater demand for inmate health care. In addition, inmates incarcerated today appear to be older, sicker, and staying longer than inmates in past decades. This creates additional demands on correctional health care systems to meet special health care needs. One national expert on correctional health care has suggested that meeting the needs of this growing population of older and sicker inmates may well become a major problem for correctional health care in the 1990s.

OVERVIEW OF MEDICAL CARE IN CORRECTIONS

Nationally, inmate health care has been the subject of much debate and a significant amount of court activity. The U.S. Supreme Court has determined that inmates have a constitutional right to health care. However, the level and quality of care that must be provided have not been clearly defined. Consequently, correctional administrators and medical care staff must make these determinations based on certain legal parameters. To provide some guidance, professional associations have developed standards for correctional health care.

In Virginia, inmate health care has also been an area of increasing concern. Expenditures for inmate health care in the Commonwealth increased by 84 percent over the past five years, more than twice the percentage growth of the inmate population over the same period. In FY 1993, DOC spent $36.9 million to provide health care (dental, mental health, and medical care) to an average daily population of slightly more than 17,000 inmates.

Legal Issues

State departments of corrections are legally required to provide medical care for inmates placed in their custody. Statutory and case law entitles inmates to minimum levels of care and to competently provided care. Malpractice and negligence cases involving these statutory and case law provisions for minimum levels of care are resolved in state courts and do not necessarily meet criteria to be heard as federal constitutional cases. However, deliberately indifferent failure to provide medical access or treatment violates the U.S. Constitution's Eighth Amendment prohibition against cruel and unusual punishment. Several state correctional systems are under federal court orders as a result of violating this constitutional prohibition. The Virginia correctional system has never been placed under this sort of court order.

The question of whether inmates are constitutionally entitled to receive health care was answered by the U.S. Supreme Court in the late 1970s when it held that inmates have a constitutional right to care. In 1976, the Supreme Court held in *Estelle v. Gamble*, 429 U.S. 98 (1976), that the government is obligated to "provide medical care to those whom it is punishing by incarceration." According to this decision, failure to provide timely access to medical care violates inmates' constitutional rights under the Eighth Amendment prohibition against cruel and unusual punishment.

The Court held in *Estelle v. Gamble* that "deliberate indifference" to pain by either "prison doctors in their response to prisoners' needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed" is a violation of the constitutional rights of inmates. The definition of "deliberate indifference" has evolved from several other federal court decisions. Those court decisions have recognized three inmate rights related to medical care:

- the right to access to care
- the right to care that is ordered
- the right to a professional medical judgment.

To make a constitutional claim of inadequate care, inmates "must allege acts or omissions that are sufficiently harmful to evidence deliberate indifference to serious medical needs." Deliberate indifference is demonstrated by a "treatment so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness." The essential component of deliberate indifference is that corrections officials are aware of the need to provide treatment for inmates, but fail to provide that treatment. Deliberate indifference occurs when a corrections official, through either intent or reckless disregard, overlooks "a substantial risk of danger that is either known to the defendant or which would be apparent to a reasonable person."

In order to win a decision on constitutional grounds, an inmate must demonstrate to a federal court that there was deliberate indifference on the part of the prison officials and that the inmate had a serious medical need. Additional federal rulings have outlined some elements of a sound correctional health care system such as:

- a prompt medical history
- appropriate numbers of medical staff with appropriate training
- complete and adequate medical records
- regularly scheduled clinic visits, and others.

A state's constitutional obligation to provide care does not cease when the responsibility for inmate medical care is contracted to private physicians and organizations. The state is still constitutionally accountable for any individual or organization performing state services "under color of state law." Therefore, even if delivery of inmate medical care is contracted to a private company, states are still required to provide adequate medical treatment to inmates in their custody.

Correctional systems may be held liable for damages for negligence under state malpractice provisions even though they satisfy constitutional requirements. Deficiencies in the diagnosis and treatment of inmates may be grounds for damages under State law for mere negligence. Virginia self-insures its correctional medical staff for medical malpractice. Since the State became self-insured on July 1, 1990, a total of 351 medical malpractice cases have been filed against Department of Corrections employees. As of the end of July 1993, 196 cases were open. From the time that Virginia became self-insured, there have been no adverse judgments paid by the State, although the State has made one settlement for $10,000.

Standards for Health Care

Four professional associations have examined the conditions of prison health care and developed varying sets of standards for its delivery:

- the American Correctional Association (ACA)
- the American Public Health Association (APHA)
- the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- the National Commission on Correctional Health Care (NCCHC).

Each association represents different philosophies of professions involved in the various aspects of health care. Consequently, their standards tend to reflect the different orientation each group has towards correctional health care. For example, ACA is an association of corrections administrators, and its standards focus on overall prison administration, not health care. The other three sets of standards have more of a health care emphasis. The APHA and NCCHC standards were both developed by health professionals and therefore have more of an emphasis on health care. The JCAHO standards were developed by the preeminent accrediting body for community health care, but tend to have a greater emphasis on hospital and mental health treatment facilities than on correctional health care.

Although the number and content of the standards differ among the four sets of standards, areas covered by all four sets include:

- management concerns such as legal obligations, ethical issues, documentation needs, quality assurance/quality improvement activities, and safety and environmental issues
- service delivery including personnel, space, and equipment
- service provision including emergency care, intake procedures, sick call, specialty services, infirmary care, management of communicable diseases, mental health, dental, and other special needs
- support services including laboratory and radiology, pharmacy, nutrition, medical records, and education services.

Nevertheless, the standards in all four sets are fairly general in nature. Further, none of the accreditation standards has been cited in litigation as sufficient to demonstrate that adequate health care was provided.

Correctional systems or individual facilities may become accredited in inmate health care by one or more of the above organizations when they meet or exceed the mandatory standards set by that organization. However, accreditation is a voluntary process. At this time, only one correctional facility in the Virginia system is accredited. The Marion Correctional Treatment Center has been accredited by JCAHO as a psychiatric treatment center.

PREVIOUS REPORTS ON INMATE HEALTH CARE

Two prior JLARC reports in this inmate health care series were specifically focused on dental care and mental health care. The JLARC reports identified a number of concerns pertaining to DOC's provision of services, the cost effective use of resources, and the overall management of service delivery. In addition, DOC commissioned a study of inmate medical care in the fall of 1992, citing the need to begin immediate assessment of medical services within the department.

JLARC Review of Dental and Mental Health Care

Previous JLARC reports on inmate health care found that DOC's provision of dental and mental health services was problematic. For example, a finding of the dental report was that inmates at two field units had no access to dental clinics, and that field unit inmates in general had substantially longer waiting periods for dental treatment. A key finding of the mental health report was that critical treatment components such as treatment planning, group therapy, and record-keeping were generally either non-existent or deficient in DOC's sheltered care units.

With respect to the issue of cost effectiveness, the dental and mental health reports found that DOC was incurring significant costs for the provision of services by private dentists and by contract psychologists. The charges associated with the use of the private dentists and contract psychologists are higher than the associated costs for providing the same care through the use of DOC-established positions. These reports found that these particular services could be provided more cost effectively through the allocation or use of internal resources.

Additional findings in the dental and mental health care reports were related to the issue of cost effectiveness. The dental care report found that the staffing complements used at correctional facilities did not maximize efficiency, because dentists performed duties that a hygienist or dental assistant could perform at lower cost. In the mental health area, several findings also indicated a lack of cost effectiveness. These findings included:

- problems with the inmate transfer process because inmates clinically ready for discharge from costly acute and sheltered care beds were not being discharged on a timely basis

- outpatient mental health staff spent inordinate proportions of their time on clerical types of duties, limiting the time spent on treatment provision

- the department lacked the ability to isolate and track mental health costs on an on-going basis, hampering DOC's ability to analyze cost effectiveness issues.

A broader finding of both reports was that the role of the central or regional offices at DOC is fairly limited in the dental and mental health care programs. For these programs, the DOC central office has lacked systematic, descriptive information on the services provided and the costs involved. As a consequence, DOC is hampered in efficiently and effectively planning and providing oversight of the programs. The department has difficulty in accurately assessing its needs in these program areas, and providing State budget-makers with quality data to assess the need for its budget requests. Further, in the area of mental health, DOC has allowed the correctional facilities almost complete autonomy, which has meant that there is little consistency in the treatment provided across facilities for similar levels of care.

DOC Consultant Review of Inmate Medical Care

Shortly after JLARC received its mandate to perform this study, DOC contracted with a South Carolina consulting firm to perform a similar review of inmate medical care in the Virginia Department of Corrections. The contract was for $45,000. The consultant submitted a final report to DOC in May 1993. The consultant's recommendations included:

- centralizing health care supervision and control of funding
- increasing the central office health care staff

- implementing a management information system for health care
- automating inmate medical records
- improving the department's tracking of health care expenditures
- restructuring the department's health care morbidity reporting system
- assessing staffing needs at major infirmaries
- improving quality control and standards for health care
- emphasizing preventive health programs
- improving utilization review of inmate hospitalizations
- revising the department's approach to health care budgeting.

CURRENT JLARC REVIEW OF MEDICAL CARE AND HEALTH CARE MANAGEMENT ISSUES

This report addresses two final topics related to inmate health care. The first topic is inmate medical care. By comparison to inmate dental and mental health care, medical care and treatment is the largest and most costly of the health care programs, accounting for approximately $31.7 million of the $36.9 million spent by DOC on all health care services in FY 1993. This review of medical care assesses:

- the adequacy of inmate access to medical care services
- the cost effective delivery of services
- the adequacy of DOC oversight of the provision of quality medical care services.

The second topic of this report is DOC's overall management of inmate health care. This review assesses DOC's oversight of privatization of inmate health care at Greensville Correctional Center and DOC's management of dental, mental health, and medical care services. The report concludes by considering whether there is a need for DOC to change direction or make improvements in managing inmate health care services.

Study Issues

The mandate for JLARC's series of reports on health care directed JLARC to examine the costs of care, appropriate levels of care, and mechanisms for restraining the growth of costs. These items were examined within the context of legal precedents for care and the litigious environment of correctional health care. Six major study issues were developed to address DOC's provision of medical care. These issues were designed to:

- determine whether the medical care provided by DOC meets the current legal requirements for such services

- determine whether inmates have adequate access to needed medical care
- identify the primary costs associated with the provision of inmate medical care
- evaluate whether the department is providing medical care services in a cost effective manner
- evaluate whether the current organization and staffing for the delivery of medical care services result in the efficient use of resources
- identify and evaluate options the Department of Corrections has to contain the costs of medical care for inmates without jeopardizing the quality of care or incurring additional legal liability for the State.

In addition, a seventh issue was defined to assess the overall impact of inmate health care management on current access and cost issues. This issue addresses whether inmate health care is managed in a manner to effectively control costs, provide necessary services, and ensure quality control and accountability for services provided.

Research Activities

Several research activities were undertaken to address the study issues. Because centralized information on the services provided within the system was limited, JLARC staff focused efforts on collecting data on costs, services, providers, and delivery of care through on-site reviews at several institutions, mail surveys, and analysis of Department of Accounts (DOA) health care expenditure data for DOC facilities and the central office. Structured interviews and document reviews were also conducted to examine service provision in more detail and to develop cost estimates for medical care.

Site Visits. Site visits were conducted at ten major institutions, one field unit, and two regional offices. Major institutions were selected based on whether the institution was designated as a major DOC infirmary, the number of infirmary beds at the institution, and the scope of medical services provided. In addition, several institutions were selected based on the types of special populations they served, such as aged, handicapped, or female inmates. Institutions visited include: Bland, Buckingham, Deep Meadow, Dillwyn (just recently opened), Greensville, Keen Mountain, Marion, Powhatan, Staunton, and the Virginia Correctional Center for Women. The Pulaski field unit, and the DOC central and northern regional offices, were also visited.

During the visits, JLARC staff conducted interviews with medical care staff; reviewed inmate medical records, sick call logs, and medical care invoices; and toured the facilities, including the dispensing areas for medical care. A total of 167 inmate medical records were selected at random and reviewed.

Expenditure Analysis and Cost Estimates. JLARC staff estimated the primary costs involved in providing medical care for fiscal years 1992 and 1993. These estimates were made using DOC budget information and Commonwealth Accounting

and Reporting System (CARS) reports of expenditure details provided by DOA. For FY 1992 and FY 1993, medical costs were separated from dental and mental health costs by examining each expenditure's object code and vendor name. Based on analysis of CARS expenditure data and reviews of institutional financial vouchers, JLARC staff categorized expenditures into ten types of medical care services.

Structured Interviews. In addition to the interviews during the site visits, structured interviews were conducted with the following:

- DOC central office staff with responsibilities for medical care programs, procurement, budget, classification and transfer of inmates, and design and planning of new facilities
- Medical College of Virginia staff
- Department of General Services risk management staff
- Virginia Department of Health staff
- Department of Medical Assistance Services staff
- Department of Personnel and Training staff
- Correctional Medical Systems Inc. (the private contractor at the Greensville Correctional Center) staff
- legislators with special interest in medical care issues for inmates
- individuals representing associations in Virginia with knowledge of and an interest in inmate medical care issues (Virginia CURE and Offender Aid and Restoration).

Mail Surveys. JLARC staff conducted a survey of medical care services provided within the Department of Corrections. Due to the variation in the type of medical care services provided in each facility, surveys were customized. The surveys were completed by the highest ranking medical care professional at the major institutions and by the head nurse at each field unit. Thirty-five of the 38 surveys were completed for a response rate of 92 percent.

Document Reviews. In addition to corrections health care literature, JLARC staff reviewed documents to assess legal issues related to correctional medical care treatment and to examine the Virginia Department of Corrections policies in response to the legal requirements. Staff reviewed pertinent sections of the *Code of Virginia*, and selected U.S. Supreme Court, Fourth Federal Circuit Court of Appeals, and State court decisions relating to medical care. To assess the department's medical policies, department and institutional operating procedures relating to medical care were reviewed.

JLARC staff also reviewed internal DOC reports. These DOC reports included Board of Corrections standards compliance reviews, Office of Health Services' quality assurance reviews, a DOC consultant's review of medical care in DOC, and Internal Affairs investigation reports. In addition, JLARC staff reviewed DOC morbidity reports and DOC medical contracts for the entire system. These documents were used to examine DOC compliance with legal standards as well as the level and quality of care provided throughout the system. As noted earlier, while on-site at individual institutions, JLARC staff also reviewed medical financial invoices, institutional medical service logs, and inmate medical records.

Report Organization

This report is organized in two parts: (1) DOC medical care and (2) DOC health services management. The first part of this report, DOC medical care, focuses on DOC's provision of medical care to inmates. This chapter has provided a brief overview of the legal issues and national standards which apply to medical care treatment within corrections as well as an overview of the JLARC review. Chapter II describes the medical care services currently provided to inmates within the Virginia DOC system and the organizational structures which support medical care within the department. Chapter III assesses the adequacy of access to medical care in the Virginia correctional system, and presents findings related to access to care and legal liability. Chapter IV discusses the costs of inmate medical care in Virginia, and makes suggestions for cost savings and cost containment, as well as for better financial record keeping. It also explores alternatives for future provision of cost effective, quality inmate medical care.

The second part of this report, DOC health services management, addresses DOC's management of dental, mental health, and medical care. Chapter V assesses the cost effectiveness and performance of the department's pilot project to privatize the delivery of health care services at Greensville Correctional Center. Chapter VI examines health care management in the Department of Corrections and makes recommendations for improvement.

II. Inmate Medical Care Services in Virginia

All Department of Corrections (DOC) facilities housing inmates must be capable of providing a level of medical care that meets legal requirements. DOC facilities have varied resources for medical care. Generally, the level of care depends on the type of facility and its specialized mission. As of July 1, 1993, the Virginia correctional system for adults included four types of facilities:

- 17 major institutions providing secure residential facilities for minimum, medium, and maximum security with a high degree of supervision by correctional officers
- 17 field units housing inmates who are generally able to work, are near their release dates, and have minimum security needs
- three "in-filled" field units which are field units that are equipped with double fencing with razor wire, and guard towers
- nine reception and classification centers that assess the dental, mental, and medical health of inmates entering the correctional system, and provide temporary housing until an appropriate permanent placement can be made.

Major institutions typically have more resources for medical care than field units. The resources at reception and classification centers are provided to perform initial medical assessments rather than to meet acute or chronic (ongoing or recurring) medical care needs.

Management of health services within the Virginia Department of Corrections is largely decentralized to the facility level. Prison wardens and field unit superintendents have supervisory authority for the medical staff at their respective facilities. However, four staff in the DOC central office serve in an advisory capacity to medical staff at the correctional facilities. Inmate health care is also budgeted and expenditures are controlled at the institutional level, except for field units, which are budgeted through the four regional DOC offices, and inpatient hospital care, which is budgeted at the central office level.

DOC SYSTEM TO PROVIDE MEDICAL CARE SERVICES

The department's medical care system has evolved over time as: (1) federal court decisions have clarified states' responsibilities for providing inmate health care, (2) the inmate population has increased, (3) new facilities have become operational, and (4) inmate medical needs have changed. DOC provides medical care to inmates at a variety of institutions and field units throughout the State. Figure 1 illustrates the types of facilities currently operated by DOC, the location of each facility, and the administrative region for each facility.

Figure 1

Location of the Major Institutions and Field Units of the Department of Corrections

REGION I - WESTERN

Major Institutions
5 Bland Correctional Center
12 Marion Correctional Treatment Center
17 Nottoway Correctional Center
11 Keen Mountain Correctional Center

Field Units
1 Pulaski
9 Rustburg
15 Chatham
18 Wise
25 Botetourt
28 Patrick Henry
29 Appalachian
31 Tazewell

REGION II - NORTHERN

Major Institutions
6 Staunton Correctional Center
15 Buckingham Correctional Center
16 Augusta Correctional Center
◆ Dillwyn Correctional Center
◆ Haynesville Correctional Center

Field Units
2 Caroline
7 White Post
8 Harrisonburg
10 Cold Springs
17 Haynesville
21 Stafford
30 Fairfax

REGION III - CENTRAL

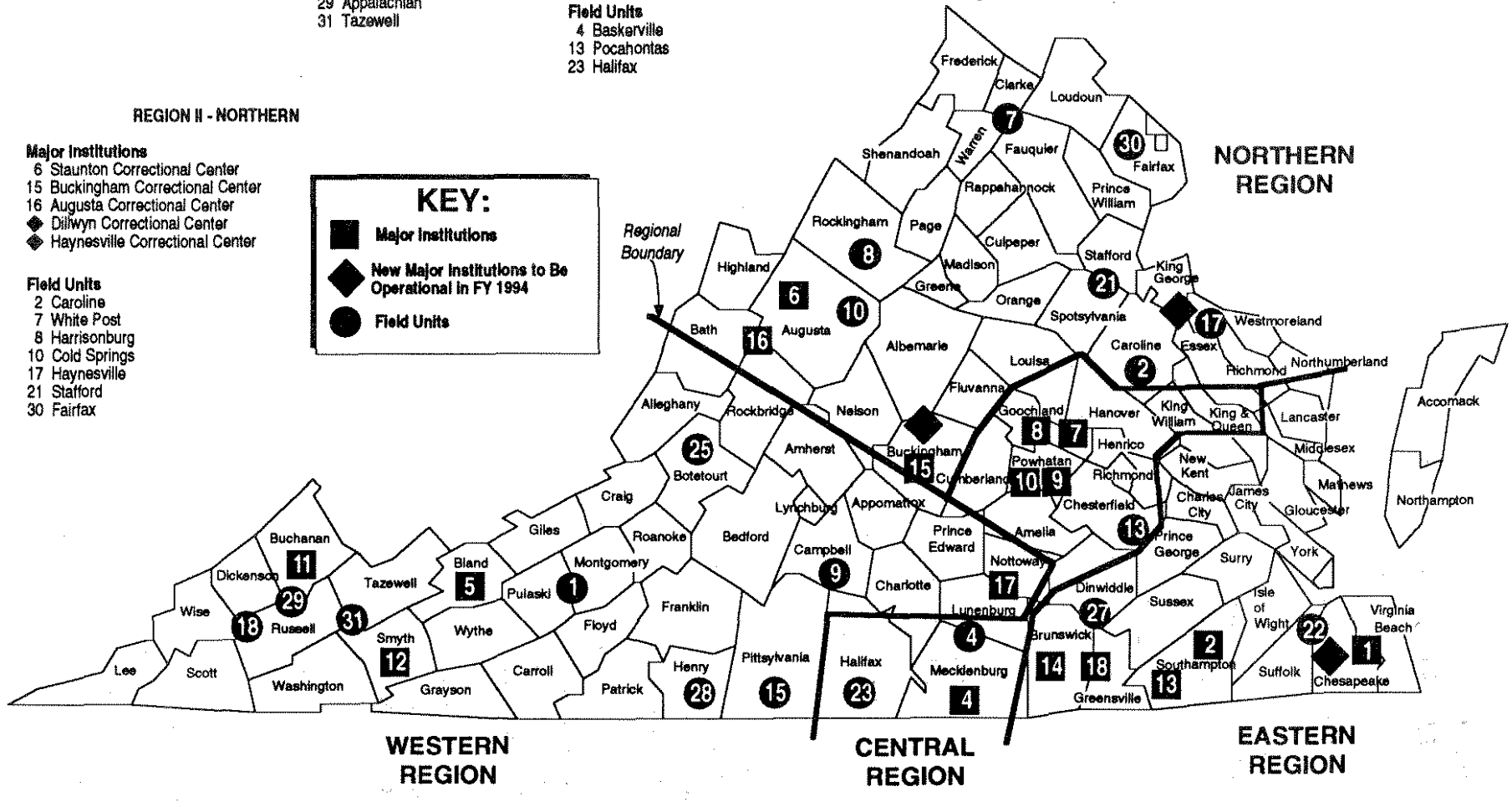
Major Institutions
4 Mecklenburg Correctional Center
7 James River Correctional Center
8 Va. Correctional Center for Women
9 Powhatan Correctional Center
10 Deep Meadow Correctional Center

Field Units
4 Baskerville
13 Pocahontas
23 Halifax

REGION IV - EASTERN

Major Institutions
1 St. Brides Correctional Center
2 Southampton Correctional Center
13 Southampton Intensive Treatment Center
14 Brunswick Correctional Center
18 Greensville Correctional Center
◆ Indian Creek Correctional Center

Field Units
22 Tidewater
27 Dinwiddie



Note: Numbers used to designate the facilities are those assigned by the Department of Corrections. Locally operated pre-release and work-release facilities and reception and classification centers are not shown.

Source: JLARC staff depiction of DOC Employee Relations Unit Map of DOC facilities published in "Vacancy List," August 20, 1993.

Inmates may receive a range of medical care services while incarcerated in State correctional facilities. Upon entry into the State correctional system, inmates are medically screened. If medically necessary, primary care, specialty care, and some outpatient surgical services are available to inmates. Specialty care services are made available, if necessary, at two DOC major institutions, the Medical College of Virginia (MCV) Hospitals, or at community hospitals or clinics.

Three facilities are designated as major infirmaries with 24-hour nursing coverage to provide system-wide care. Seven institutions have smaller infirmaries that provide 24-hour nursing care and may staff infirmary medical beds on an as-needed basis. Another seven institutions and all field units provide only nursing and physician coverage for primary care and emergencies. When care is not available at their own facility (such as 24-hour infirmary care), inmates are often transported to other correctional institutions for non-emergency treatment. If non-emergency hospitalization is necessary, inmates are transported to MCV for hospital inpatient care. For emergencies, inmates are transferred to the nearest community provider.

Several major institutions have special missions within the department that affect the type of medical care available at those institutions. Inmates may be assigned to these institutions if they meet the placement criteria, space is available, and security considerations do not preclude assignment. For example:

> *Handicapped inmates may be assigned to Deep Meadow, an 825-bed medium security institution. Deep Meadow has one 50-bed dormitory that is accessible to handicapped inmates. The medical care unit at Deep Meadow provides nursing coverage 24 hours per day in the event that medical services are required for these inmates. However, infirmary beds are not available if these inmates require acute care.*

Exhibit 1 illustrates the major institutions with special missions that impact medical care availability.

DOC Procedures for Inmates to Access Medical Care

Department operating procedure (DOP) 717 requires completion of a medical assessment of all inmates who enter the correctional system. This assessment, which is referred to as reception screening and classification by the department, is done to determine each inmate's medical status and to facilitate provision of medically necessary care. There are nine reception and classification centers in the DOC system. Inmate medical records are initiated through the reception and classification process. All medical contacts must be recorded on standard forms in these records.

A physical examination and health appraisal is generally completed for each newly-received inmate within the first ten days of incarceration within the State system. This screening process identifies inmates with communicable diseases, mental disturbances or suicidal tendencies, maintenance medication needs, and alcohol or drug

Exhibit 1

DOC Major Institutions with Special Missions

Facility	Special Mission	Avg. Daily Population*	Description
Deep Meadow	Handicapped facility	829	One 50-bed dormitory houses handicapped inmates.
Greensville	Respiratory isolation and dialysis treatment; secondary infirmary for discharged MCV patients	2,444	The 40-bed medical infirmary has ten single bed medical cells with a special ventilation system to provide respiratory isolation for inmates with tuberculosis. The infirmary also is equipped with eight dialysis chairs to treat inmates with end stage renal disease requiring dialysis.
Marion	Psychiatric treatment	171	Facility has 120 beds designated for male inmates with acute mental health treatment needs.
Powhatan	Designated AIDS facility; primary infirmary for discharged MCV patients	830**	The infirmary has 46 medical beds. If inmate with AIDS requires ongoing medical care and supervision, an infirmary bed is made available.
Virginia Correctional Center for Women	Female inmates	661	A 15-bed infirmary serves only female inmates.
Staunton	Aged inmates	730	A 48-bed dormitory houses inmates age 60 and older.

*Population figures are based on the FY 1993 average daily inmate population of the entire facility. The special needs population is a subset of the facility population.

**Population figure for Powhatan does not include the average daily population of the reception and classification center located at Powhatan. The average daily population for the reception and classification center in FY 1993 was 415.

Source: JLARC staff site visits to DOC major institutions and interviews with DOC medical care staff, April to July 1993; and staff analysis of *Average Daily Inmate Population* (Fiscal Year 1992-93), July 12, 1993, received from the DOC Budget Office.

withdrawal symptoms. In addition, inmates who are urgently in need of medical attention are immediately referred for needed care. Male inmates are assigned to a major institution or field unit with consideration given to their medical needs. All female inmates are housed at the Virginia Correctional Center for Women (VCCW), as there are no other State facilities for women.

Primary Care Services

Primary care refers to the inmate's first-level contact with medical staff for routine consultation, diagnosis, and treatment of a medical problem or chronic condition. Primary care also includes preventive care such as periodic screenings for the early detection of disease, immunizations, counseling about health risks, and patient education. Inmates generally receive primary care on-site where they are incarcerated. Primary care services are generally accessed through institutional procedures for "sick call."

DOP 718 requires that inmates have the opportunity to request medical attention daily. Institutional procedures for sick call vary, but most facilities hold sick call every week day. According to DOC medical personnel, inmates with serious ailments are likely to be treated the next sick call day, while inmates with less serious medical needs may be scheduled later. An inmate with urgent or emergency medical needs would be treated immediately and, as necessary, transported for needed care.

At some institutions, inmates may be required to complete a form describing their illness or injury and submit the form in advance to the medical department for scheduling, or inmates may ask a correctional officer to place their name on the sick call list. Some institutions and field units allow inmates to attend sick call without signing up; inmates go to the medical department during sick call hours and wait for treatment. Other maximum security institutions (as well as those on lock-down) require nurses to go to inmates' cells to administer medications and screen inmates who need medical treatment.

Typically, inmates are initially seen by a nurse or a correctional health assistant (a paramedic-type position comparable in grade to a licensed practical nurse) and then are referred to a physician as needed. Inmates must access sick call if they need medications, medical treatment, or special accommodations due to medical conditions. Special items or accommodations may include special shoes, special insoles, a lower level bunk, or a first floor cell. Consequently, DOC nurses and physicians may spend a significant amount of time screening requests that would not typically require medical attention in a community environment.

Specialty Care

Inmates are referred to specialty care when determined medically necessary by the institutional physician. Specialty care refers to medical care that requires services of a medical professional with specific training in a particular type of medicine, such as orthopedics, urology, dermatology, cardiology, or ophthalmology. Specialty consulta-

tions are provided on-site at Powhatan and Greensville Correctional Centers. In addition to serving their own inmate populations, these facilities serve inmates from other institutions. However, the inmates' assigned institution or field unit must provide the transportation and security to Powhatan or Greensville in order to receive these services.

In addition, many specialty clinics are conducted on an outpatient basis at MCV Hospitals. For example, almost all oncology services and infectious disease services are provided by MCV Hospitals. Some institutions and field units rely primarily on local community specialty providers. Generally, these facilities are located far from MCV.

Infirmary Care

Currently, the department has ten infirmaries established at major institutions that are fully operational (three additional infirmaries will be added to the system as new correctional facilities become fully operational during FY 1994). Infirmaries are capable of providing 24-hour nursing care for inmates in designated medical beds. Three institutions are designated "major" infirmaries: Greensville Correctional Center, Powhatan Correctional Center, and VCCW. They are designated as such because they have the greatest number of medical beds staffed on a routine basis. In addition, Greensville and Powhatan have several medical specialty services available at their infirmaries.

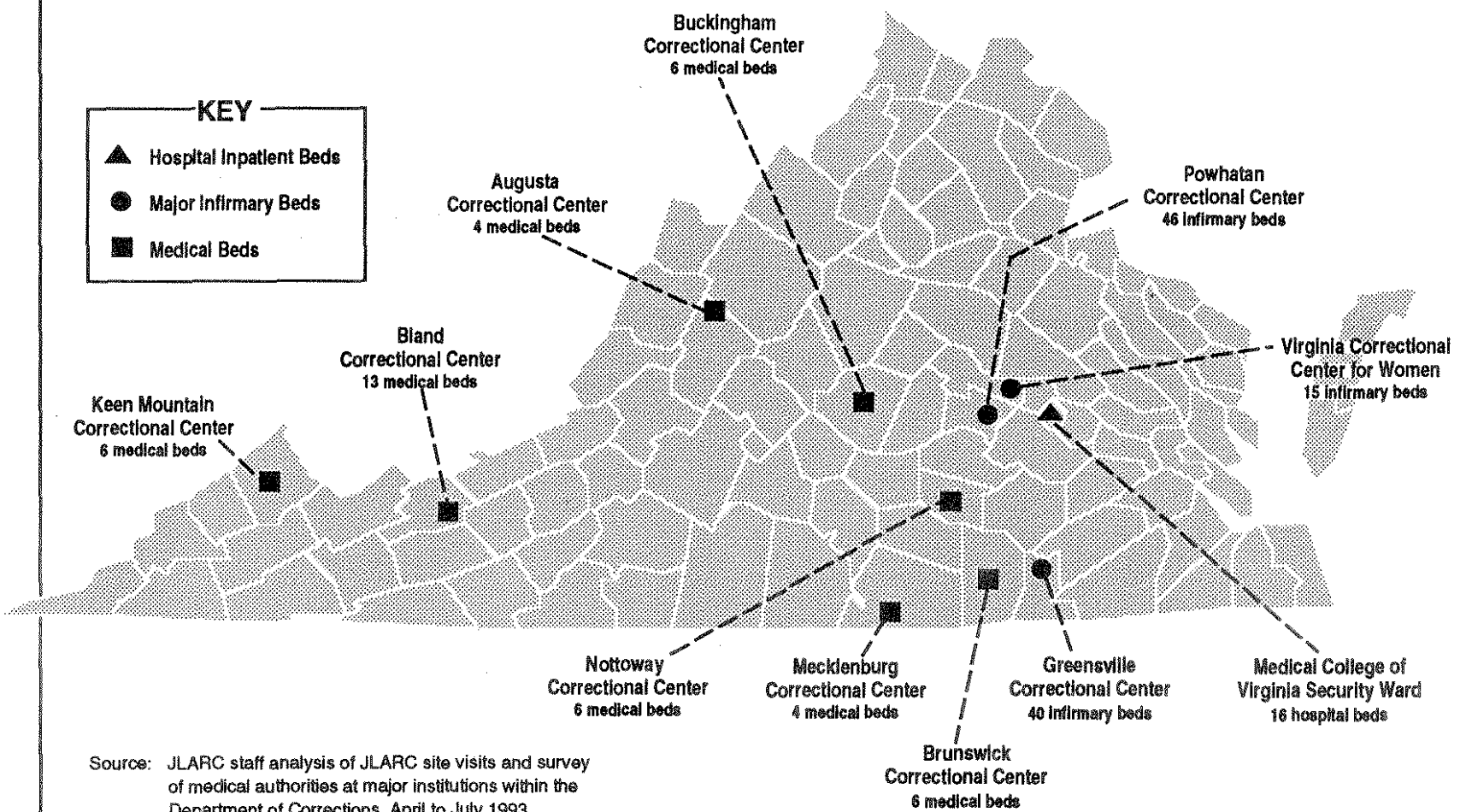
Typically the major infirmaries will provide care for inmates who are recovering from surgery or have an acute or chronic illness requiring 24-hour care. Each of these institutions has isolation beds that can be used for inmates who are contagious, exhibit behavior problems, or have known enemies at the facility. Currently, only Greensville is equipped with respiratory isolation cells containing ventilation systems designed for housing inmates with active tuberculosis. However, three institutions which will become fully operational in FY 1994 have two respiratory isolation rooms located in each medical infirmary.

Seven other institutions also have infirmary care available on a more limited scale. These institutions have fewer beds, and while they may have a nurse available in the infirmary 24 hours per day, they may not routinely staff medical beds to provide 24-hour care. However, the medical beds may be staffed at these institutions if the infirmaries at Powhatan and Greensville are full and additional infirmary beds are needed. Figure 2 illustrates the location of infirmary beds within the DOC system.

When inmates are discharged from hospitals, they can either be sent back to the general population at their assigned institution or they can be sent to one of the infirmary beds in the system for convalescence. For MCV discharges, the department has prioritized the receiving institutions for inmates who require infirmary care before they can be released into the general inmate population. DOC refers to this type of care as "step-down" care. Powhatan has been designated as the primary medical step-down infirmary for the State. Although Greensville has not been officially designated as the secondary step-down infirmary, it appears that it is being used as such.

Figure 2

Location of DOC Medical Care Beds



Source: JLARC staff analysis of JLARC site visits and survey of medical authorities at major institutions within the Department of Corrections, April to July 1993.

Inpatient Hospital Care

Whenever possible, the department meets inmate medical care needs at one of its institutions. However, inmates who need inpatient medical care that is beyond the scope of care that the department can provide must be hospitalized. DOP 720 specifies that adult inmates should be taken to MCV for routine, scheduled inpatient hospital care. Inpatient care is available through local community hospitals in emergency situations.

MCV has a secure unit for adult male inmates that contains 16 beds. DOC correctional officers are assigned to the unit to provide security. However, hospitalized inmates at MCV are not always provided care in this unit. Females are presently housed throughout the hospital in the appropriate unit for their condition. In addition, male inmates who are in intensive care or have special needs which cannot be met in the security unit are cared for elsewhere in the hospital. This requires additional security staff who must remain posted at the inmate's bedside or door. Currently, the secure unit at MCV is being renovated to accommodate female inmates.

Since the mid-1980s, DOC and MCV have had an agreement on the payment rate for hospital care of DOC inmates. At that time, DOC agreed to pay $545 per day for acute inpatient care in the secure unit. By FY 1993, the payment rate had increased to $833 per diem for acute inpatient hospital care and $1,865 per diem for intensive care. DOC also agreed to pay 100 percent of all inpatient charges for female inmates.

For inpatient care provided in local community hospitals, the department also pays 100 percent of charges unless the inmate's institution has a contract or agreement with the local hospital. Currently, Greensville is the only facility that has a separate contract with a local hospital. Greensville inmates may be referred to John Randolph Hospital in Hopewell for hospital care, at a per diem rate of $650.

Medications

The department has a central pharmacy that fills prescriptions for most institutions. This pharmacy is located in Richmond and is open during regular business hours Monday through Friday. Prescriptions are either sent via facsimile, the mail, or an institutional courier to the central pharmacy. According to the DOC chief pharmacist, most prescriptions are filled within one day of receipt and are then delivered by a parcel service to the appropriate institution. According to survey responses by DOC medical authorities, on average it takes two working days to receive a prescription from the DOC central pharmacy. However, all institutions and field units use local pharmacies to fill emergency prescriptions during the week and for weekend prescriptions.

Three major institutions provide pharmacy products for their inmates in a manner different from that described above. Powhatan maintains a pharmacy on-site to fill prescriptions for inmates served by the institution. Marion Correctional Treatment Center (MCTC) obtains its pharmacy products from Southwest Virginia Mental Health Institute (located next to MCTC) which operates a pharmacy through the Department of Mental Health, Mental Retardation and Substance Abuse Services. Greensville provides

pharmacy products to inmates through a contract with a mail order pharmacy in Alabama.

Inmates obtain their medications in one of three ways. First, they can come to the "pill line" for their daily dosage. Pill lines are usually set up in the infirmary area of the institution, in the housing unit, or possibly near the dining room. Pill lines may be held from two to four times a day to accommodate all types of dosages.

Second, inmates can sign a contract with the physician or charge nurse for self-medication. The inmate is given up to a one-month supply of medications at a time. According to DOC medical staff, inmates with chronic medication needs such as ulcers, asthma, or arthritis may be good candidates for self-medication. Certain medications, such as controlled substances that have a potential for abuse, cannot be dispensed by self-medication. In addition, other criteria are used to determine whether an inmate can participate in the self-medication program.

Third, nurses may administer medications directly to inmates if they are being treated in the infirmary. In addition, nurses may administer medications directly to inmates in their cells. Nurses must do this for inmates who are in isolation or segregation cells, and when there is a lock-down and inmates are confined to their cells.

PRIVATIZATION OF HEALTH CARE

DOC is currently operating a pilot project to test the feasibility of privatizing inmate health care in the Virginia correctional system. Therefore, unlike all other institutions, medical services at the Greensville Correctional Center are provided through a private contractor instead of relying on State personnel to provide medical services. The Greensville contract provides medical staffing and services for its four inmate housing units and a 40-bed infirmary. During FY 1992 and FY 1993, combined expenditures for medical services at Greensville were about $14.5 million, or about 20 percent of system-wide medical expenditures during those years.

Since the institution's opening in 1990, inmate health care at Greensville has been provided by two different private contractors: Southside Correctional Care (Southside) and Correctional Medical Systems (CMS). Most medical services at Greensville have been provided by contract personnel. However, Greensville has retained a few State employees from the Virginia State Penitentiary to administer the contract and perform some medical services.

Southside Contract. Southside Medical Systems, Inc., was selected as the first contractor to provide medical care services beginning September 1990 at Greensville Correctional Center. Southside Medical Systems, Inc., a local health care corporation, eventually established a separate corporation and assigned the contract to the new corporation, Southside Correctional Care, Inc. The price of the contract for FY 1992 was about $3.9 million, based on costs plus fixed fees for services.

Under the contractual arrangement, Southside handled the coordination of medical services and hired medical personnel to staff the institution. The Southside contract provided for a staffing complement of 118 full-time employees (FTEs). The actual costs of personnel hours, pharmaceuticals, and supplies were billed to DOC, for primary care services, on-site clinic services, and on-site surgical services. The contract price did not include the costs to provide inmates with medical care off-site or dialysis services. However, it did specify preset fixed fees to be charged for off-site clinic visits, outpatient and inpatient hospital services, and dialysis services.

Southside notified DOC of its intent to terminate the contract in January 1992 because of disagreements with DOC on oral modifications made to the contract. Southside contended that DOC officials agreed to adjust the contract terms to pay additional amounts for employee sick and annual leave taken while employed at Greensville, and to allow Southside a ten percent mark-up on pharmaceuticals provided to DOC inmates. According to the DOC procurement director, DOC did not agree to these terms and therefore was not obligated to make additional payments to the contractor for items not stipulated in the written contract. According to Southside officials, they could not make a profit on the contract without modifications. DOC paid Southside about $5.2 million during FY 1992 and an additional amount of approximately $840,000 in FY 1993 for services provided to Greensville inmates in FY 1992. DOC paid additional amounts to Southside for services provided to other facility inmates. The contract with Southside terminated on June 30, 1992.

CMS Contract. Correctional Medical Systems, a division of ARA Health Services Inc., was awarded the Greensville contract beginning July 1, 1992, for a five-year term. Like the previous contractor, CMS is responsible for coordinating health care services and hiring most health-related personnel. Currently, CMS provides dental, mental health, and medical services through its contractual agreement with DOC. In terms of medical services, CMS provides primary medical care services and some specialty care clinic services, conducts limited outpatient surgeries on-site, operates the 40-bed infirmary at Greensville, operates the X-ray equipment located at the infirmary, and provides some on-site laboratory services. CMS medical staff are responsible for making referrals for medically necessary off-site care for inmates.

The contract terms to provide inmate health care services vary significantly from the Southside contract. The projected price of the contract was approximately $5.9 million during the first year (FY 1993), to be paid in a fixed monthly installment of $491,000. A majority of this amount was for personnel costs associated with employing 75.675 FTE positions. For each subsequent year of the contract, the terms of the contract include provision for an adjustment of 6.5 percent from the previous year's fixed price. The current projected price of the contract in FY 1994 is almost $6.3 million.

State Employees Providing Medical Services at Greensville. During the phase-out of the Virginia State Penitentiary and as the Greensville Correctional Center became operational, the State transferred medical personnel to Greensville to begin providing medical services to inmates as they were assigned to the new facility. DOC has retained a few State employees to monitor the private contract and perform some medical

services. Currently, nine State employees remain employed at Greensville with responsibilities related to the provision of medical care services at Greensville. These include:

- one mental hospital administrative services supervisor
- two correctional health assistants (paramedic-type positions comparable in salary grade to a licensed practical nurse)
- three correctional nurse technicians (licensed practical nurses)
- one storekeeper
- one medical records technician
- one office services assistant (secretary).

Two additional positions are also currently employed as State employees with responsibility for dental care services. The State employee positions are under the clinical supervision of the contractor, CMS. However, the mental hospital administrative services supervisor retains administrative supervisory authority for these employees.

LIMITATIONS ON MEDICAL CARE SERVICES

Although DOC has a policy to provide care to inmates comparable to that available in the community (DOP 701), there are some limits on the medical care services available for inmates. DOC does not maintain a list of medical service limitations. However, it has processes in place to ensure that only medical services that are medically necessary are provided to inmates. Medical necessity is determined through the utilization review process set forth by the Office of Health Services (OHS) in the DOC central office.

Routine, non-emergency specialty care consultations may be recommended by the chief physician at the inmate's assigned institution. Any specialty care that is required to be provided off-site (at a location other than the inmate's assigned institution) must be approved in advance by the department's chief physician, located in OHS. However, certain medical conditions are exempt from this prior approval process, including coronary artery disease, Human Immunodeficiency Virus (HIV) infection and Acquired Immunodeficiency Syndrome (AIDS), chronic eye conditions, radiation therapy, and major trauma. Other medical conditions must be approved prior to referral for specialty care, including corrective surgery for chronic and pre-existing conditions and deformities, asymptomatic hernias, chronic low back pain, and podiatry services. The prior authorization process can take up to one month. However, according to the DOC chief physician, requests are often handled in one day if made electronically.

DOC contracts with the Medical Society of Virginia Review Organization (MSVRO) to provide a second opinion review for specialty consultations denied by the

DOC chief physician. A physician reviewer for MSVRO will review the case and make a determination about whether the care should be provided. According to MSVRO staff, about 80 percent of the cases denied by the DOC chief physician are also denied by MSVRO.

The department contracts with MSVRO to pre-certify off-site outpatient services that are approved and to review the inpatient admissions to MCV. The purpose of these activities is to ensure that only appropriate medically necessary care is provided to inmates. During FY 1994, MSVRO will be conducting a pilot project to review ambulatory care services provided at Powhatan Correctional Center. The object of this project is to track expenditures for ambulatory care of Powhatan inmates and compare costs of similar care provided on-site and off-site. MSVRO will provide this information to DOC to assist the department in making medical management decisions.

ORGANIZATION OF HEALTH SERVICES WITHIN DOC

According to DOP 703, OHS is responsible for "developing and monitoring adherence to policies, standards and procedures for health care services for inmates." Nevertheless, institutional wardens and field unit superintendents have supervisory authority for the medical staff at their respective facilities. Consequently, the warden or superintendent has the authority to hire and fire medical personnel. All institutions are required to have a medical authority. At major institutions the medical authority is generally a physician; however, the medical authority at field units is usually a nurse.

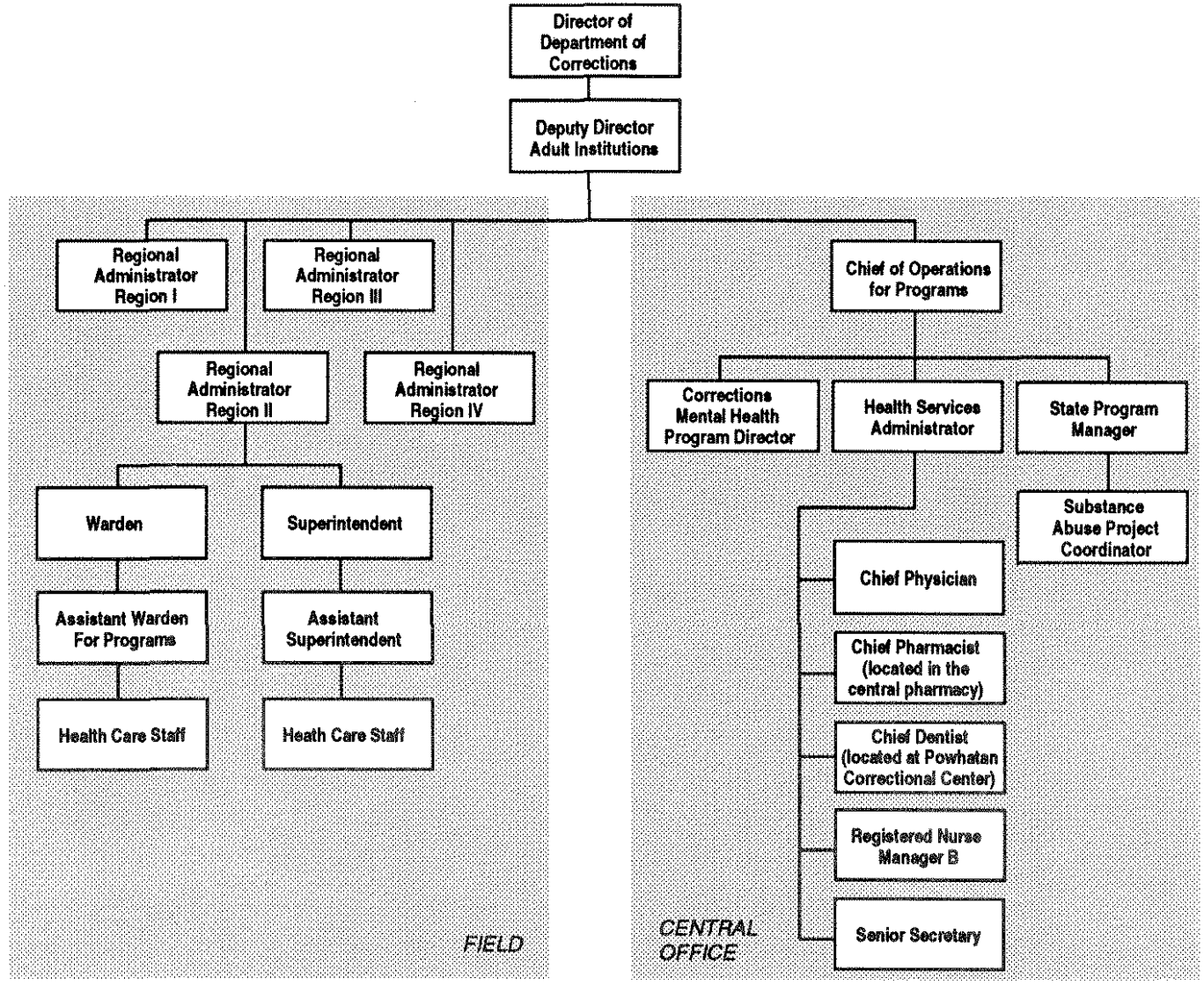
OHS Structure and Responsibilities

Three staff within the Office of Health Services have primary responsibility for system-wide medical policies and procedures. These staff positions include: the health services administrator, a corrections chief physician, and a chief of nursing services (registered nurse manager B). OHS support is also provided by a DOC chief pharmacist who works out of the DOC central pharmacy, a DOC chief dentist who works out of Powhatan Correctional Center, and a senior secretary. OHS is headed by the health services administrator, who reports to the chief of operations for programs within the Division of Adult Institutions (Figure 3). The office currently performs advisory and other staff functions; it does not have any line authority over medical staff in the field, who report to individual facility wardens and superintendents. OHS staff functions include:

- budget development
- development of medical policies and procedures
- providing recommendations on medical personnel management policies and procedures

Figure 3

Organization of Health Care Within the Department of Corrections



Source: JLARC staff graphic based on Department of Corrections organizational chart.

- initiating inquiries into inmate medical grievances

- conducting quality assurance reviews of institutional and field unit medical departments.

Role of the Health Services Administrator. The health services administrator has primary responsibility for ensuring that the department's mission to provide inmate health care services is implemented. In carrying out this responsibility, the administrator develops medical policies and procedures, verifies inmate inpatient bills, conducts quality assurance reviews, responds to inmate grievances on medical care, and plans for future medical and dental care needs within DOC. The health services administrator supervises the chief nurse, the chief physician, and one senior secretary.

Recently, the health services administrator has been involved in, but not formally responsible for, the oversight and monitoring of the private contractor at Greensville. The administrator attends and monitors meetings between DOC and contract employees regarding the provision of health care at Greensville and the implementation of the contract, files vendor complaints if necessary, and recommends changes to the contract as needed. The health services administrator position is a grade 15. Compensation ranges from $36,696 to $56,029.

Role of the Chief Physician. The chief physician acts as a medical consultant for the department, according to the position description. The chief physician exercises clinical oversight in DOC, performs secondary reviews for institutional physicians, approves referrals for non-emergency outside care, and develops policies and clinical protocols. The chief physician is also responsible for medical education and training for DOC physicians. In addition, the chief physician tracks certain infectious diseases for the department to facilitate health care planning and management.

The chief physician's position description also delineates responsibilities for coordinating budgetary, medical personnel, equipment, and other related medical needs with the health services administrator. As mentioned earlier, the chief physician reports to the health services administrator. Currently, the chief physician position is a grade 22 ($68,466 to $104,537).

Role of the Chief Nurse. The chief nurse develops nursing policies and procedures within DOC, conducts site visits to institutions and quality assurance reviews, acts as an advocate for DOC nursing staff, arranges medical transfers of inmates, and arranges jail inmate intakes into the department for medical reasons. The chief nurse is responsible for training and education of DOC nursing staff.

In addition, the chief nurse is specifically assigned responsibility for monitoring inmate ambulatory care and inpatient care at MCV Hospitals. This responsibility entails regular site visits to MCV to ensure proper utilization of the clinics and to ensure that inpatient admissions and lengths of stay are medically necessary and appropriate. The chief nurse maintains data on all MCV admissions and clinic visits.

The chief nurse position is a grade 17. The current compensation for the position ranges from $43,854 to $66,958. As already mentioned, the chief nurse reports to the health services administrator.

Institutional Medical Care Organization and Staffing

At the institutional level, DOC employs a variety of medical professionals to provide inmate medical care services. Nurses — both registered nurses (RNs) and licensed practical nurses (LPNs) — provide most of the direct medical care to inmates in the institution. All institutions and field units should have a primary care physician available to supervise medical screenings, order needed prescriptions, order specialty care services if needed, review laboratory and X-ray reports, and respond to medical emergencies. For adults, a primary care physician is usually a physician with a specialty in family practice, internal medicine, or general practice.

In major institutions, the physician usually serves as the medical authority. However, at the field units, typically a registered nurse functions as the medical authority. In addition, major institutions may employ correctional health assistants (paramedic-type positions), X-ray technicians, laboratory technicians, and medical records technicians. All LPNs and correctional health assistants are classified as correctional nurse technicians.

A DOC report indicated that, as of June 30, 1993, DOC had 221 filled medical care positions (Table 1). Another 40 positions were not filled. Nearly all of these 221 positions are filled by full-time DOC employees. However, institutions employ a number of contract personnel to provide medical care services for a set period of time (usually one year or more). In addition, institutions employ temporary agency nurses to fill many vacant nursing positions and for temporary support.

Currently, many physicians at the institutions are working on a contract basis (eight of 17 total institutional physicians). At these institutions, often the head nurse who is a State employee is designated as the medical authority. DOC has been contracting with private physicians to provide certain services for quite some time. However, as discussed earlier, the department has recently expanded that approach by contracting with a private company for all health care at Greensville.

All field units have at least one nurse allocated to them. Five field units have more than one nurse allocated, two units have two nurses allocated each, and three units have three nurses allocated each. Three field units with more than one nurse assigned to them are the in-filled units which house more inmates and provide a higher level of security through double perimeter fencing and the use of razor wire. Two of these units function as reception and classification centers for new inmates. As such, they have responsibility for comprehensive medical screening of the new inmates received at their unit.

Table 1

Number and Type of Filled Medical Positions within the Department of Corrections as of June 30, 1993

Medical Position	DOC Positions Full-Time	DOC Positions Part-Time	Contract Positions	Total Filled FTE Positions*
Institutional Physician	8	2	8	17
Registered Nurse Coordinator	4	0	0	4
Registered Nurse Clinician B	12	0	0	12
Registered Nurse Clinician A	3	0	0	3
Registered Nurse	40	0	0	40
Nurse Technician	121	0	7	128
Radiologic Senior Technician	2	0	0	2
Radiologic Technician	1	0	0	1
X-ray Technician	2	0	3**	3***
Medical Technologist	2	0	1	3
Laboratory Technician Senior	6	0	0	6
Pharmacist	1	0	0	1
Pharmacist Assistant B	1	0	0	1
Total	203	2	19	221

*Total full-time equivalent (FTE) positions does not include all temporary nursing employees.

**Part-time positions.

***A total of three FTE positions are filled based on two full-time DOC positions and three part-time contract positions.

Source: JLARC staff analysis of Department of Corrections *Department Medical Positions/Employee Report*, dated June 30, 1993.

III. Inmate Access to Medical Services

The Virginia Department of Corrections (DOC) has department operating procedures (DOPs) which set forth guidelines for inmate access to medical care. The purpose of these procedures is "to ensure that all inmates have unhindered access to regularly scheduled, medically staffed sick call" (DOP 718). Sick call provides inmates with primary medical care, including: (1) routine medical consultation, diagnosis, and treatment of an acute or chronic condition; (2) screening for the early detection of disease; (3) immunizations; (4) counseling about health risks; and (5) patient education. During site visits to major institutions, medical staff stated that they try to screen all inmate requests for medical care within 24 hours of receiving the request.

To assess inmate access to medical care, JLARC staff conducted site visits to ten major institutions, and reviewed medical expenditures and invoices for specialty and inpatient hospital care. During the site visits, JLARC staff toured the medical facilities, interviewed medical care staff, reviewed medical records and sick call logs, and examined medical expenditure data. In general, JLARC staff found that the facilities employ dedicated health care professionals who are trying to deliver quality care in the correctional environment. Access to care appears to be generally good overall. This is further evidenced by the fact that Virginia has not been under any court orders regarding its provision of health care like some other states. In addition, staff review of specialty and inpatient hospital care information revealed that referrals for off-site care appear to occur regularly for needed care, indicating access to these services.

However, any conclusions about the department's provision of care must be caveated, because problems with documentation of care and sick call records make broad generalizations regarding inmate access to primary medical care difficult. In some cases, compliance with department procedures concerning documentation was inadequate. Also, medical care staff in some facilities were concerned about the adequacy of staffing, particularly nursing and physician coverage in the facilities. Several facilities have staff vacancy problems. These problems affect access to and continuity of care for inmates at their facilities. Further, staff appeared frustrated with the overall lack of management and direction for medical care services in the department.

DOC needs to address several issues which negatively affect inmate access to medical care. These include problems regarding:

- documentation of care provided to inmates
- recruiting and retaining registered and licensed practical nurses
- physician coverage at some institutions
- services for female and handicapped inmates
- medical transfers.

PROBLEMS AFFECTING DOCUMENTATION OF INMATE CARE

Accurate and complete documentation of inmate medical care is an important tool in protecting health care workers, correctional staff, and inmates. Documentation of medical care provides a permanent record of when and how health care professionals address inmate medical care needs. It provides medical providers with important information to ensure continuity and quality of care for the inmate treated. Further, federal court decisions have emphasized the importance of documentation of care as one component for an adequate correctional health care system. Incomplete and inaccurate documentation of care may adversely affect the State, when the State is legally challenged by inmates for alleged violations of their constitutional rights to care, and in medical malpractice cases.

The variation among institutions in documentation of primary care received by inmates at sick call makes an overall assessment of inmate access to primary care difficult. While on-site at correctional facilities, JLARC staff observed sick call being conducted. However, the quantity and quality of the medical care through sick call was sometimes difficult to ascertain because of inconsistent record-keeping. Medical record documentation of care provided was at times incomplete and lacked organization, sick call logs were indecipherable, and sick call logs of who was seen did not always match dates of care documented in the medical records. In addition, inmate medical transfer information was not consistently documented, and care received off-site was not well documented in the medical records.

Department operating procedure 723 sets out general provisions and the rationale for documenting inmate health care in inmate medical records. According to DOP 723:

> The purpose of the medical record is to provide written documentation of all medical services rendered to inmates; to serve as the means of communication to assure continuity of care; to provide a basis for planning individual care and evaluating the quality of that care; to assist in protecting the medico-legal interests of the individual, institution, and providers of care; to serve as a basis for statistical analysis for Office of Health Services use for planning, staffing and budget analysis.

JLARC staff's review of a sample of medical records at eight major institutions noted problems with medical record documentation in DOC facilities (Exhibit 2). In addition, documentation problems were noted in Office of Health Services (OHS) quality assurance reviews conducted in 1992 and 1993 and Board of Corrections standards compliance reviews conducted by DOC in 1993. Further, a quality review conducted at one institution in 1992 by the Medical Society of Virginia Review Organization (MSVRO) noted serious concerns with documentation of care.

Exhibit 2

Comparison of Audit Findings on DOC Documentation of Care

	JLARC Review	OHS Quality Assurance Reviews	Board of Corrections Standards Compliance Reviews
Consent and release of information forms missing	●		
Documentation of off-site care or hospitalization missing	●		
Incomplete medical records	●	●	●
Inconsistencies between dates of care documented and sick call logs	●		
Inmate medical transfer sheets missing	●	●	
No documentation of inmate medical screenings within 24 hours of arrival at institution	●		●
Progress notes illegible	●		
Records not maintained in order or format according to department operating procedures	●	●	●

● = problem noted in at least one facility reviewed

Source: JLARC site visits and JLARC staff medical record reviews at eight major institutions, April - July 1993; JLARC staff analysis of OHS quality assurance reviews conducted from January 1992 to July 1993 and DOC standards compliance audits of three major institutions, FY 1993.

DOP 723 gives OHS responsibility for developing and publishing the standard format for maintaining medical records. In addition, OHS assesses the adequacy of institution and field unit compliance with standards for documentation in its quality assurance reviews. Further, OHS is responsible for assessing medical staff resources and making recommendations for changes based on justified needs. While OHS has been aware of problems concerning the documentation of care at major institutions and field units, the office lacks enforcement authority, and consequently, little has been done by OHS or the institutions to address these problems.

JLARC staff reviewed 30 OHS quality assurance reviews conducted between January 1992 and July 1993 at 14 major institutions and 16 field units. During these reviews, OHS staff noted problems with medical record documentation at one-half of the major institutions. Problems with medical record documentation at field units were minimal and focused on the lack of clerical resources to address documentation problems.

Some of the concerns regarding documentation of care were noted as "serious" by OHS staff. For example in a memo on one institution's quality assurance review conducted in 1992, OHS staff noted:

> More attention needs to be paid to documentation in the medical record. Any health care provider picking up a medical record should be able to get a clear picture of the inmate's medical condition, what is being done for him, reason for treatment (treatment plan), medication, etc. **This is a systems problem** [emphasis added]. OHS is soon to publish a medical records manual. When this is done there will be formal training on documentation and evaluation of documentation.

OHS staff also appear to have provided institutions with conflicting information on how to document care in medical records. For example:

> *DOC requested that MSVRO conduct a review at one major institution. MSVRO found that the medical record documentation was inadequate. Documentation requirements to note subjective observations, objective observations, assessment of the medical problem, and the plan of care (termed SOAP charting) were not followed. Further, the review noted, "It is impossible for a reviewer or outsider to determine what is going on in the [medical] chart. The care does seem to be rendered in an appropriate manner, but it is only by the [sic] insinuation that one can elicit this, since the records do not document the same."*
>
> *A later quality assurance review by OHS staff at this same institution noted the previous deficiencies found by MSVRO. Further, the review stated that the problems with documenting according to SOAP procedures were due to directions by the chief nurse to use the charting methodology differently from standard practice. It is not clear why OHS staff provided institutional nursing staff with information on documenting care which conflicts with established procedures.*

OHS has not developed a medical records manual and training has not occurred. Further, JLARC site visits from April to July 1993 indicated that medical record documentation continues to be problematic for a number of major institutions. JLARC staff found a variety of problems with documentation in reviews of institution medical records (Exhibit 3).

A number of factors contribute to documentation problems including a lack of priority or attention to the function, a lack of training, or a lack of record-keeping support. The central regional administrator noted problems with documentation of care in major institutions and attributed them, in part, to clerical shortages in major institutions. Medical staff at the institutions and field units also reported problems with the lack of clerical staff and the negative impact this has on record-keeping.

Exhibit 3

Medical Record Reviews at Major Institutions Reviewed by JLARC Staff

Problems Noted With Medical Records	Bland	Buckingham	Deep Meadow	Greensville	Keen Mountain	Powhatan	Staunton	VCCW
Consent and release of information forms missing	●	●		●	●	●	●	●
Documentation of off-site care or hospitalization missing			●	●		●		●
Illegible progress notes		●		●			●	●
Inmate medical transfer sheets missing				●				
No documentation of inmate medical screenings within 24 hours of arrival at institution		●						
Records not maintained in order or format according to DOPs		●		●		●		●

● = problem noted

Source: JLARC staff analysis of medical records at major institutions visited between April and July 1993.

According to DOP 707, OHS staff are responsible for assessing resource needs of medical departments in institutions and developing justifications for changes. While OHS has developed budget justifications for additional nursing staff, OHS has not formally assessed and documented the needs for additional clerical staff in order to support the medical record-keeping function in institutions and field units.

Recommendation (1). **The Department of Corrections should ensure that institution and field unit staff take immediate steps to improve documentation of inmate medical care. The Office of Health Services should: (1) follow-up on problems noted in quality assurance reviews to monitor problems with compliance at the institutional and field unit level, (2) complete the medical records manual for facility medical care staff, and (3) design and conduct training on documentation requirements for medical care staff. Additional training on documentation procedures should be provided to all institutional staff with medical record-keeping responsibility.**

RECRUITMENT AND RETENTION OF NURSING STAFF

Nursing coverage at DOC facilities is an important component in ensuring inmate access to medical care, because nurses serve as the first contact for inmates seeking care. During the past few years DOC has experienced difficulties with maintaining adequate nursing coverage at major institutions and field units. DOC medical care staff and other officials indicated in interviews that the current complement of established nursing positions is inadequate. However, nursing coverage also appears to be critically affected by DOC problems in recruiting and retaining a full complement of nursing staff for currently established positions.

According to DOC staff, problems with recruitment and retention of nursing staff occur for several reasons, including:

- low salaries relative to other large employers of nurses
- lack of shift differentials, on-call pay, and flexible working schedules
- limited training and educational opportunities
- difficulties in providing care in a prison environment.

DOC's recruiting of registered nurses (RNs) and correctional nurse technicians (CNTs) is hampered by its unwillingness to use several incentives available to State agencies for recruiting health care professionals. DOC officials indicate that they have studied all of these issues and various department officials express support for one or more of the potential incentives. Nevertheless, none have been implemented.

Problems Exist with Nursing Vacancies

Registered nurses and correctional nurse technicians provide most of the direct inmate medical care at major institutions and field units. Nurses are responsible for assessing inmate medical complaints to determine who will be seen immediately by a physician and who will have to wait for care. In addition, they are responsible for conducting health screening, administering medications, treating minor medical problems, screening for tuberculosis, educating patients, recording physician orders for treatment, and arranging for inmate laboratory and X-ray tests as well as off-site outpatient and inpatient care.

Analysis of authorized and filled nursing positions as of June 30, 1993 showed that DOC was experiencing a 19 percent vacancy rate for RN positions and a 19 percent vacancy rate for CNT positions. Table 2 illustrates the vacancy rates for these positions at DOC facilities. Some of these positions have been vacant for at least 18 months. According to Department of Personnel and Training (DPT) staff, DOC risks losing a number of nursing positions if these are not filled soon.

Often staffing shortages are addressed by supplementing nursing coverage using temporary agency nurses. According to a number of DOC staff, use of temporary nursing is not an optimal solution, because these personnel sometimes lack dedication

and knowledge of the correctional medical care system. In addition, they lack training on security procedures and temporary nursing staff, by definition, do not ensure continuity of care for inmates receiving medical treatment.

Table 2

Medical Nursing Vacancies in DOC Facilities

DOC Facility	Authorized RN FTEs*	RN FTEs Filled	Percent Vacant	Authorized CNT FTEs**	CNT FTEs Filled	Percent Vacant
Augusta	3	2	33%	9	9	0%
Bland	5	5	0%	8	7	13%
Brunswick	1	1	0%	7	7	0%
Buckingham	3	1	67%	7	5	29%
Deep Meadow	2	1	50%	9	5	44%
James River	1	1	0%	4	4	0%
Keen Mountain	3	1	67%	5	4	20%
Marion	14	14	0%	0	0	NA
Mecklenburg	4	4	0%	9	9	0%
Nottoway	3	2	33%	9	8	11%
Powhatan/PRCC	6	5	17%	27	19	30%
St. Brides	2	2	0%	3	3	0%
Southampton/SITC/SRCC	4	2	50%	11	11	0%
Staunton	4	3	25%	6	5	17%
VCCW	3	2	33%	13	7	46%
Central Region Field Units	6	4	33%	2	2	0%
Eastern Region Field Units	1	1	0%	1	1	0%
Northern Region Field Units	3	3	0%	4	4	0%
Western Region Field Units	6	6	0%	6	4	33%
Total	74	60	19%	140	114	19%

Key:
PRCC = Powhatan Reception and Classification Center
SITC = Southampton Intensive Treatment Center
SRCC = Southampton Reception and Classification Center
VCCW = Virginia Correctional Center for Women

Note: Does not include Greensville, which is staffed primarily through a private contract, or new institutions opened in FY 1994.

*Registered nurse full-time equivalent positions (FTEs) include registered nurse (RN), RN Clinician A, RN Clinician B, and RN Coordinator positions.

**Correctional nurse technicians (CNTs) are comprised of licensed practical nurses and correctional health assistants (paramedic-type positions).

Source: JLARC staff analysis of Department of Corrections *Department Medical Positions/Employee Report*, dated June 30, 1993.

The department's use of temporary agency nurses is also costly. DOC has paid approximately $3.7 million to fund use of temporary agency nursing staff over the past two fiscal years. This indicates that DOC uses temporary nursing as a remedy to nursing shortages the department experiences over an indefinite period of time. This type of staffing arrangement appears to be contrary to the rationale for hiring temporary employees, that is, to assist the employer in addressing short-term staffing needs. Temporary nursing staff appear to be used to: (1) fill nursing vacancies indefinitely, (2) staff undesirable nursing shifts, and (3) fill short-term staffing needs. Chapter IV provides additional information on the cost impact of DOC's current use of temporary nursing services and how those funds could be better used to assist the department in providing additional nurse recruitment or retention incentives.

Focus of DOC Responses to Nursing Coverage Problems Needs to Change

DOC responses to nursing coverage problems have focused on justifying the need for additional nursing positions. In FY 1993, problems with nursing coverage led the department to develop a request for 66 additional nursing positions for its facilities and to establish four regional nurse positions. According to the OHS chief nurse, the 1993 General Assembly approved funding for: (1) 15 additional nursing positions (2 RNs and 13 CNTs) as of July 1, 1993, and (2) three additional nursing positions (CNTs) as of January 1, 1994. The request and new positions notwithstanding, DOC has not been able to recruit or retain nurses in a number of its established nursing positions. This suggests that the department needs to consider alternative solutions to addressing problems with nursing coverage in its facilities.

DOC needs to explore better approaches to recruiting nursing staff. In addition, DOC needs to examine methods to retain nurses once they have been hired and oriented. The State currently has several mechanisms available to assist agencies in retaining their nursing personnel. DOC has not seriously explored using any of the mechanisms available.

DOC Needs to Implement Improvements in Its Current Methods to Recruit Nurses. Better approaches are needed to recruit and to hire nursing staff to ensure inmate access to and continuity of care. Currently, DOC does not systematically attempt to attract nursing staff from nursing schools. In addition, there are no formal linkages between State teaching hospitals and the correctional medical care system. Medical care staff in the DOC system have suggested that these types of links could enhance their ability to recruit and retain medical care staff. Further, with the advent of reductions of U.S. military forces, DOC could enhance recruitment efforts to attract military medical staff.

In addition, DOC needs to streamline the hiring process for nursing staff. Interviews with medical staff in institutions revealed that long delays characterize the hiring process when nursing positions become vacant. These delays can negatively impact access and continuity of care for inmates. Nurses in institutions complained that often they lose good candidates for positions because of the delays in hiring. It was not clear where the delays in hiring occurred within DOC.

Organized recruitment efforts may be one way in which DOC could attract larger pools of qualified candidates. Currently, DOC relies primarily on the Department of Personnel and Training's publication *Recruit* to advertise nursing vacancies, although some facilities place local newspaper advertisements. Institutions in the central region recently experimented with a combined recruitment effort to hire nurses at Powhatan, Deep Meadow, and James River Correctional Centers as well as at the Virginia Correctional Center for Women (VCCW). According to nurses at Powhatan and VCCW, by combining recruitment and hiring efforts, they were able to attract a larger pool of candidates and have been able to fill a number of the vacant positions more easily than in the past.

DOC Should Consider Implementing Effective Methods to Retain Nursing Staff. Nursing vacancies negatively impact inmate access to care and continuity of care, and result in significant costs to the system if temporary nurses are used to fill these positions. (Chapter IV provides additional detail on the costs of temporary nursing services.) The State has several mechanisms available to help retain nursing staff. However, there is no evidence that DOC has seriously considered implementing any of these, even though the department has trouble maintaining a full complement of nursing staff. There appears to be some concern by DOC about staff morale if these mechanisms are used for nursing staff but not for other positions. Nevertheless, nursing staff have unique skills and abilities needed in the correctional environment and vacancies have been problematic.

DOC should consider implementing more effective means of retaining existing nursing staff, because nursing vacancies cause access problems and current use of temporary agency nurses is not cost effective and does not ensure quality care. Some methods DOC could implement include: (1) use of shift differentials, (2) use of flexible scheduling, (3) tuition reimbursement for continuing education, (4) establishment of on-call pay, (5) development of a floating regional nurse position to cover temporary shortages at facilities, or (6) in-grade adjustments for nurses who have received written competitive offers from outside State government for comparable positions.

Recommendation (2). **The Department of Corrections should implement changes in its nurse recruitment and retention policies and procedures to decrease position vacancy rates and use of temporary agency nurses to fill these positions. The department should work with the Department of Personnel and Training to implement a full range of methods for improving nurse recruitment and retention.**

PHYSICIAN COVERAGE AT DOC FACILITIES

Access to physician services is the most important part of inmate access to medical care. Department operating procedures (DOP 702 and DOP 717) dictate that a physician must supervise medical personnel conducting medical screenings of all inmates received and classified in the correctional system. Further, physicians must review and approve the medical treatment and care provided by other medical care

professionals. In addition, they are responsible for approving off-site care, admitting inmates from other facilities into infirmaries, and prescribing medication (DOP 718).

Due to difficulties in physician recruitment, primary care is hampered at several major institutions. For example, limited physician coverage at three institutions has resulted in delays in providing inmates with physician services. In addition, recruiting difficulties require DOC to use more expensive contract physicians at a number of facilities. Physician extenders (licensed physicians' assistants and certified nurse practitioners) could enhance the primary care coverage provided at institutions which have part-time physician coverage, or have other needs for additional physician coverage. However, currently, DOC does not make extensive use of physician extenders.

DOC Should Assess Methods to Enhance Current Physician Coverage at Certain Institutions

Problems with physician coverage at major institutions appear to fall into two categories: (1) several institutions have only part-time physician coverage which is inadequate and (2) some institutions have vacancies for institutional physician positions. Medical staffing standards maintained by the Office of Health Services recommend a physician position at all major institutions.

Inadequate full-time physician coverage at major institutions has a negative effect on continuity of care and often results in long inmate waiting times for physician primary and specialty care. This limits access to care, because only physicians can perform certain needed medical treatments and prescribe controlled substances. A physician must sign-off on most treatment orders, approve medical transfers and admissions to medical facilities, and order changes to inmates' medications.

A number of major institutions employ contract physicians to provide physician services to inmates. Contract physicians are employed to provide physician coverage in three types of situations: (1) the institution has a State institutional physician position established and cannot fill the position with a State employee but can fill the position with a nearly full-time (30 hours per week) contract physician, (2) the institution has a State institutional physician position but cannot recruit either a full-time State employee or a full-time contract physician, and (3) the institution does not have a State institutional physician position established and must rely on a part-time contract physician. The first situation appears to have worked well in terms of providing continuity of care and access to care at Bland and Keen Mountain Correctional Centers. Because of their remote locations, these institutions face unique recruiting challenges and department officials are satisfied to have provided nearly full-time physician coverage, albeit through contract physicians.

The second situation, use of one or more part-time contract physicians, creates problems with continuity of care at Buckingham and Mecklenburg Correctional Centers. One or several part-time physicians are used to fill one full-time position. This means that inmates do not consistently see the same physician and/or it is difficult for the part-time physician to perform needed follow-up. According to nursing staff at these

institutions, communication about patient status and follow-up is difficult, because part-time physicians rarely work together on the same day, and when only one is available, delays in seeing inmates occur.

The third situation, the lack of an established State institutional physician position and reliance on a part-time contract physician, causes problems with timely access to care and the delivery of cost effective care. Brunswick and Nottoway Correctional Centers must rely on a part-time contract physician to provide care. Even if a full-time physician were available, the physician could not be hired as a State employee because there is no established institutional physician at these institutions.

Further, Deep Meadow and Mecklenburg Correctional Centers have recently experienced vacancies in their institutional physician positions. DOC should continuously monitor physician coverage to ensure that it is adequate at its major institutions. Monitoring would allow DOC to immediately address coverage problems when they arise.

Problems with Physician Coverage Negatively Impact Inmate Access to Care. Lengthy inmate waiting times to see a physician were reported by medical authorities at Brunswick, Buckingham, Mecklenburg, and Nottoway Correctional Centers in a recent survey by JLARC staff. Long inmate waiting periods to see a physician occurred even after the inmate was seen and referred to a physician by institutional nurses. Long inmate waiting periods for physician services are particularly disturbing because only a physician has the authority to diagnose illness, sign-off on recommended treatments, prescribe controlled substances (or any other medications absent a licensed physician's assistant or certified nurse practitioner), and order off-site care for inmates. These institutions currently rely on part-time contract physicians to provide physician services to their inmates.

DOC major institutions reported average waiting periods to see a physician of between four and five days. However, inmate waiting periods at the four institutions mentioned above ranged from seven to 30 days. Long waiting periods can result in delayed medically necessary treatment of inmates and creates potential liability for the State if an inmate's medical care needs are not addressed. In addition, it can result in the use of less cost effective care for inmates who have urgent medical needs. Inmates with relatively minor medical needs must be sent out to the community for care, often to hospital emergency rooms.

Medical staff at institutions with physician coverage problems expressed a number of concerns regarding access to care. For example:

> *One institution's medical authority reported that they have only one part-time contract physician even though they have more needs than can be handled currently by that physician. Due to problems with physician coverage, they must use a local medical facility or the local hospital to obtain services. The medical authority stated, "we need a full-time physician, but we have no position for it."*

* * *

One institution reported that its medical staff to inmate ratio is currently inadequate. While the institution's population is high (more than 1,000 inmates), the contract physician is only on-site three days per week. This institution reported a 30-day wait for inmates to see a physician. Therefore, if inmates need prescriptions modified they may have to wait a month to be seen. This could be especially problematic because most prescriptions must be renewed every 30 days. For inmates with serious medical needs requiring maintenance medications such as those with heart disease, diabetes, HIV, and other conditions, this type of a delay could be potentially harmful.

The DOC chief physician expressed some concerns about part-time physician contract coverage at major institutions. The chief physician indicated that the department is able to obtain better continuity of care and commitment from a full-time State-employed physician. Concerns about adequate physician coverage were also expressed by regional administrators. For example:

One regional administrator stated that physician coverage had been a real problem at one of his institutions. The department had been trying recently to fill in with physicians from two other institutions, by assigning each of them to provide one day of care during the week. Nevertheless, this institution had been without a physician for more than ten months.

Physician Vacancies at Some Institutions Have Negatively Impacted Access to Care. As of July 1, 1993, five institutions had vacancies in their institutional physician positions: Bland, Buckingham, Deep Meadow, Keen Mountain, and Mecklenburg. As mentioned earlier, Bland and Keen Mountain have been able to satisfactorily meet the primary care needs of their inmates by employing contract physicians. However, three of these five institutions have limited physician coverage at the present time: Buckingham, Deep Meadow, and Mecklenburg. A number of DOC staff have expressed concerns about the impact of these vacancies on inmate care. For example:

The DOC chief physician indicated that physician vacancies at Buckingham, Deep Meadow, and Mecklenburg are limiting access to care. In an interview with JLARC staff, the chief physician stated that only the emergency cases are being seen at each of these institutions and staff are barely able to cover these cases.

* * *

One major institution with a full-time State physician position has had physician coverage for only one day a week since early June. The regional administrator indicated in an interview on July 30, 1993 that

physician coverage at this institution has been a tremendous problem. The medical authority at this institution stated that the facility has a waiting time of two to three weeks and occasionally as much as a month for inmate sick call requests which require a physician. She stated that the absence of a physician unfairly exposes nursing staff to increased liability.

Medical care staff at these institutions are not optimistic that the vacancies will be filled in the near future. The chief physician shared this concern, stating that it takes so long to process a physician's application in the department that all of the promising applicants obtain employment elsewhere rather than await the outcome of the DOC hiring process. The medical authority at one institution with a vacant physician position stated that no one had told her about when candidates might be interviewed for the position or when a candidate would be hired. To her knowledge, no progress had been made on recruiting for a physician.

Recommendation (3). **The Department of Corrections should assess physician coverage in major institutions. At institutions which are experiencing problems with adequate physician coverage, DOC should consider alternatives for providing physician coverage such as the use of physician extenders or enhanced physician recruitment efforts.**

DOC Should Increase Its Use of Physician Extenders

To address problems with physician coverage at institutions, DOC should explore ways to increase its use of physician extenders to provide additional primary care coverage. "Physician extenders" typically refer to certified nurse practitioners and licensed physicians' assistants. These positions are used in community settings to provide routine health care formerly provided only by physicians, such as: medical histories and physicals, medical assessments, prescription of non-controlled drugs, and responsibility for minor invasive procedures (such as minor suturing and intravenous injections).

Physician extenders could improve inmate access to care by allowing DOC to stretch scarce salary dollars and by providing primary care coverage when a physician is not available. DOC could potentially save about 50 percent of the cost of a physician position by hiring physician extenders to supplement primary care in institutions lacking adequate physician coverage.

Currently, DOC does not employ any certified nurse practitioners. Only one licensed physician's assistant works within the system; however, this individual works for the private medical care contractor at Greensville Correctional Center. DOC does employ 15 correctional health assistants, a paramedic-type position that may function in a role similar to a physician's assistant or as an operating room technician in corrections environments. However, these positions have a narrower scope of practice than licensed physicians' assistants, and typically have only two years of clinical education as opposed

to the minimum of six years for certified nurse practitioners and licensed physicians' assistants.

The difference in the responsibilities of correctional health assistants and licensed physicians' assistants or certified nurse practitioners is also reflected in their associated position classifications. A licensed physician's assistant or certified nurse practitioner is classified as a grade 13 in the State personnel system with a starting salary of $30,707. A correctional health assistant is considered equivalent to a licensed practical nurse and is classified as a correctional nurse technician at grade 7 with a starting salary of $17,992.

OHS officials indicated that they support the concept of physician extenders but have met resistance to the idea from DOC's top management. The chief physician stated that use of physician extenders is an excellent concept in situations where you have the physician extender conducting basic, but time consuming, medical histories and physicals under the direct supervision of the institutional physician. Only one institution, Marion Correctional Treatment Center, has actively attempted to hire a certified nurse practitioner to supplement primary care for inmates. DOC is considering the merits of hiring a nurse practitioner to provide care at VCCW. It appears that VCCW could particularly benefit from such a position. For example:

> *Nurse practitioners are often used by local health departments to provide primary medical care to women and children, including obstetrics and gynecological services. VCCW could benefit from the use of a nurse practitioner to supplement current physician obstetric and gynecological services. Because the facility also processes a number of inmates into the system every month, the nurse practitioner could be used to supplement reception and classification medical screenings.*

The department currently does not encourage, or compensate, existing medical care staff to obtain additional education and training which could assist institutions in filling the gaps in current physician coverage. In fact, staff informed JLARC that some of the existing correctional health assistants in the correctional system who work as operating room technicians received additional training in emergency medical techniques through employment sources outside the department. DOC should consider upgrading the skills of existing staff as well as active recruitment of physician extenders to enhance physician coverage at its institutions.

Recommendation (4). **The Department of Corrections should expand its use of physician extenders as a cost effective mechanism for delivering primary care at institutions which it determines require additional physician coverage. The department should consider providing existing staff with additional education and training to enhance the number of physician extenders at its facilities.**

Recruitment Process for Physicians Should Be Improved

Physician recruiting appears to be hampered by several problems, some of which are beyond the ability of DOC to control. For example, many areas of the State are medically underserved, which makes it difficult to attract viable applicants. Further, the corrections environment is not an optimal work environment because patients are often non-cooperative and manipulative. In addition, State compensation for physicians in DOC is not comparable to that physicians can obtain through private practice or other work environments. These factors make it imperative that DOC initiate proactive steps to address current problems with recruiting physicians. DOC could more aggressively recruit potential applicants by offering additional recruitment incentives such as continuing medical education. Further, DOC could streamline its hiring process to ensure attractive candidates are not lost due to hiring delays.

Problems with current recruitment practices have contributed to the need for many major institutions to turn to contracts with community physicians to provide necessary physician care to their inmate population. While this has ensured access to care at a number of institutions, in some instances the use of contract physicians has not solved problems related to timely access to care and continuity of care, as discussed earlier. In addition, as discussed in Chapter IV, the use of contract physicians is not as cost effective as the employment of State institutional physicians.

DOC Should Ensure Physician Recruitment Efforts Are More Proactive. DOC's ability to identify qualified candidates is hampered by its lack of proactive and innovative methods for recruiting. DOC could implement a number of methods for recruiting such as better targeting of potential applicants and offering continuing medical education as an incentive for physicians to apply and remain employed in the correctional environment. Currently, DOC recruitment efforts are inadequate to attract viable, qualified applicants.

Currently, when institutional physician positions become vacant, DOC does not typically recruit for these positions in a systematic way. For example, DOC does not target potential applicants from the pool of medical students who are enrolled in family practice and internal medicine programs in the State. DOC could also begin to systematically recruit military medical personnel, given potential losses in military employment over the next several years. Or, DOC could target retiring physicians who may not be able to perform specialty services, but wish to continue practicing medicine.

In addition, newspaper advertisements for physicians are funded by the institutions and often compare poorly, in terms of size and timeliness, with advertisements for other State positions at significantly lower pay grades. In fact, DOC primarily relies on the Department of Personnel and Training's publication *Recruit* to identify physician candidates. No effort is made to recruit in medical journals.

DOC employee relations staff also indicated that the department needs to do more networking to effectively hire physicians. They stated that they try to network with the military to develop physician contacts. However, this appears to be conducted on an informal *ad hoc* basis.

Recruitment Is Hindered by Hiring Delays. Currently, when institutional physician positions become vacant, DOC experiences long internal delays in filling positions. These problems were noted by staff in the DOC central office as well as medical care staff in the institutions. In survey responses and interviews, DOC medical care staff repeatedly stated that long delays affect the physician recruitment process. For example:

> *The DOC chief physician noted that recruitment delays affect physician hires at every level of the bureaucracy. Delays affect the scheduling of the applicant interview, processing the application through multiple department divisions, and obtaining the background investigation of the applicant.*

Other medical care staff stated that some recruitment delays were the result of poor coordination between the staff of the Office of Health Services who act as advisors and the institution's warden who makes the hiring decision. One institutional physician suggested that institutional wardens and field unit superintendents should not control hiring decisions for physicians because they do not have knowledge of or expertise in medical matters. Other medical care staff stated that delays were the result of conflicting department hiring priorities. For example:

> *One institutional nurse indicated that DOC places a higher priority on hiring institutional physicians at new institutions than existing institutions. This nurse's facility has been without a full-time institutional physician for almost one year. Nevertheless, a new physician had been recruited and hired to provide services at a nearby new DOC facility. Consequently, the nurse's institution still lacked a full-time institutional physician even though it had an average daily population of 943 inmates in FY 1993.*

DOC medical staff indicated that, once an application is received from a qualified candidate, a minimum of three months is required before the candidate is hired and ready to begin working. In contrast, DOC employee relations staff indicated that the recruitment process takes about six weeks from the scheduling of the applicant interview to the date of the offer of employment. However, this does not include the time it takes to announce the position vacancy, place advertisements, and receive and process the applications.

DOC Should Become Involved in Physician Compensation Issues. Compensation for institutional physicians is set at pay grade 20 in the State personnel system which ranges from $57,291 to $87,474. DOC employee relations staff stated that the department attempts to offer physicians as high a salary as possible within the pay grade to attract them. Nevertheless, according to the chief physician, once a candidate becomes aware of a vacancy within DOC, he or she is eligible for a starting salary that is roughly one-half of the average physician's income statewide.

Employee relations staff stated that they believe the main problem in attracting physicians is the correctional working environment, not compensation. However, they did mention that other agencies such as the Department of Mental Health, Mental

Retardation and Substance Abuse Services (DMHMRSAS) have various classification levels for physician positions, while DOC only has one classification level. For example, DMHMRSAS has three classification levels for physicians in the mental health system. These classifications range in compensation from $62,230 to $114,278.

In addition, other State agencies have begun offering scholarships to medical students to provide an incentive to increase the number of primary care physicians in Virginia and encourage medical students to set up their medical practices in medically underserved areas of the State. DOC could also explore the use of scholarships for medical students to obtain additional physician coverage in its facilities.

Because of difficulties in several State agencies with recruiting physicians, the Department of Personnel and Training is studying new approaches to physician compensation with concerned State agencies. Given their recruiting difficulties, DOC officials need to become actively involved in these efforts. Further, DOC could pilot test several initiatives to determine whether these will enhance its current recruitment efforts.

Recommendation (5). **The Department of Corrections should begin improving its procedures for recruiting institutional physicians. Efforts to make improvements should include working with the Department of Personnel and Training to explore physician compensation issues, establishing linkages to State teaching hospital programs for physician primary care, better advertisement of positions, and exploring potential scholarships for physicians with a correctional health care emphasis.**

MEDICAL CARE SERVICES FOR FEMALE AND HANDICAPPED INMATES

Access to care for female and handicapped inmates was difficult to assess because the Office of Health Services does not keep aggregated data on their medical needs. Nevertheless, site visits, interviews with DOC medical care staff, and medical record reviews suggest that current provisions for the care of some special populations need to be improved. Access to medical care for female inmates is hampered by an inferior medical facility, resulting in fewer on-site services for female inmates than are available to male inmates in the current DOC system. Further, this results in increased costs for care of these inmates. DOC also needs to address the adequacy of infirmary care services available to handicapped populations.

On-site Medical Services for Female Inmates Are Not Comparable to Those Available to Male Inmates

The Virginia Correctional Center for Women is the only DOC facility housing female inmates. The inmate population at VCCW has more than doubled over the past eight years from approximately 300 inmates in 1985 to an average daily population of 661 inmates in FY 1993. The medical infirmary at VCCW is located in an antiquated building

which has 15 infirmary beds. Clinic space, availability of infirmary beds, equipment, ventilation, and staffing have all been problematic. Consequently, the primary care physician at VCCW has had to refer most female inmates off-site for specialty services. This has resulted in higher costs to deliver services, longer waiting periods for needed care, and increased use of overtime for security personnel to cover inmate transfers and security posts at the facility.

According to interviews with DOC staff, construction of a new facility for women is planned to be completed in FY 1997 and will contain the necessary medical and mental health treatment units and will serve as the women's primary medical facility. In the meantime, DOC is implementing plans for minor renovation of the existing medical care facility at VCCW. This entails renovating the basement of the medical building to create a dispensary with several examination rooms so that some specialty services can be brought on-site. In total, VCCW expects to spend about $25,000 on renovations to the facility. In contrast, the department is planning to move forward with new construction at the Greensville infirmary to add more state-of-the-art respiratory isolation beds. The cost of this project is approximately $2.1 million. In addition, the department is planning on constructing a new medical infirmary for men at Powhatan Correctional Center which is slated to cost about $1.6 million.

It is important to note that planned renovations at VCCW may not solve some of the problems affecting the antiquated medical facilities or lack of needed infirmary beds. For example:

> *During a JLARC interview, the medical authority at VCCW stated that the medical facility has problems with equipment and ventilation. Much of the equipment is antiquated. The medical authority expressed concerns about the inability to control the climate and ventilation. Further, the ventilation system is inadequate to handle the spread of air-borne infectious diseases. While the additional clinic space will provide more space for dialysis and specialty clinics, it will not provide clinic space comparable to that of the two major DOC infirmaries for male inmates.*
>
> *Further, the infirmary conditions affect the facility's ability to attract medical staff. The warden and head nurse at VCCW expressed concerns about medical staff turnover which they attribute to the less than optimal working conditions in the infirmary.*
>
> *JLARC staff also observed that the infirmary at VCCW had no X-ray equipment (in contrast to a number of the other major institutions), the ventilation system was inadequate, and adequate access for handicapped inmates was lacking. At times, especially this summer, the infirmary was uncomfortably hot for sick inmates. In contrast, the infirmaries at Powhatan and Greensville are both air-conditioned.*

* * *

The institutional physician and head nurse both stated in interviews with JLARC staff that the 15 infirmary beds are usually full. The medical authority estimated that the occupancy rate of the infirmary beds averaged 90 to 100 percent during FY 1993. While VCCW staff could not provide historical data on the use of infirmary medical beds, JLARC staff observed the infirmary to be full during each site visit to the institution. The physician stated that they are scrambling to create some bed space such as a convalescent unit on another hall. However, the physician stated that this would require increasing the nursing staff, which was in the process of being approved at the time of the JLARC interview.

Concerns about the adequacy of the current medical facility and services offered on-site to female inmates resulted in DOC developing a six-year master plan which included construction of a new medical facility at VCCW. DOC's justification cited the following problems with the existing facility:

> The Institution provides medical and mental health services on both a routine and emergency basis to 670 adult female inmates. This is currently being accomplished in a crowded, overwhelming environment that provides little working space for staff and scant privacy for the patients. The current medical hall contains only sixteen [sic] beds for all special needs patients, including long term geriatric, pregnancy and infectious disease cases. The medical staff must deal with the needs of both infirmary and ambulatory patients; the general medical needs of the entire population; the needs of an ever growing mental health/ substance abuse population; and provide medical screening and classification for all newly received inmates.

According to the warden and regional administrator, the plan for the construction of a medical facility at VCCW was not approved. Instead the department decided to make minimal renovations while awaiting construction of the new women's facility.

The institutional physician and the regional administrator stated in interviews that female inmates have tended to have much higher utilization of medical care services than male inmates. Further, the warden stated the population at VCCW turns over by 50 percent annually. Therefore, it is questionable whether the planned clinic space will be sufficient to meet the needs of the growing and diverse population at VCCW. High utilization, combined with rapid turnover in the female inmate population, places enormous demands on institutional medical staff who must conduct medical screenings as part of the reception and classification process, as well as treat general population inmates and handle the medical care needs of pregnant, chronically ill, and acutely ill inmates.

Given the increases in the numbers of female inmates and the fact that the inmates place high demands on the medical facilities, the department needs to be better

equipped to address medical needs of female inmates at VCCW. Additional renovations and equipment could actually be more cost effective than transporting inmates off-site for more costly services. Since the department plans to continue to use the facility after the new women's facility is completed, it may be cost effective to more fully renovate and expand the current medical facilities at VCCW.

Recommendation (6). **The Department of Corrections should take immediate steps to begin addressing problems in delivering on-site care at the medical infirmary at VCCW.**

Potential Problems Affect Access to Care for Handicapped Inmates

While physician and nurse recruitment difficulties create potential problems with access to care for the general inmate population, handicapped inmates face immediate problems with access to medical care. Deep Meadow Correctional Center has been designated as DOC's facility for handicapped inmates. Facilities for handicapped inmates at Deep Meadow consist of 50 dormitory beds. These beds are located in one housing unit which is handicapped accessible. While 24-hour nursing coverage is available at the institution, this coverage consists of a nurse on duty in a separate building from the handicapped housing unit. No medical infirmary beds exist in the medical building. This is no different from nursing coverage provided at a number of other institutions with general population inmates and no infirmary beds.

However, the lack of infirmary beds at Deep Meadow limits this facility's usefulness as the designated handicapped facility within the DOC system. Handicapped inmates often have special medical needs and experience multiple medical problems. In addition, to receive needed medical care these inmates must be mobile enough to walk or be transported via wheelchair to the medical unit to receive medical services.

The lack of an infirmary presents several problems in DOC's designation of Deep Meadow as the system's handicapped facility. Currently, the institution is not able to provide a full complement of medical services to handicapped inmates. For example:

> *According to one DOC registered nurse, several problems are evident in the current provision of services to handicapped inmates. Paraplegic and quadriplegic inmates often have many additional health problems, such as renal and cardiac diseases which require close monitoring. Currently, only those who function well can be housed at Deep Meadow. Those with additional medical care needs must remain in infirmary beds, generally at either Powhatan or Greensville, because other available infirmary beds in the State are not routinely staffed. If infirmary beds were available at Deep Meadow or if other infirmary beds in the DOC system were staffed, some handicapped inmates currently located at the infirmaries at Powhatan or Greensville could be discharged, thereby freeing up much needed infirmary beds at the two regional medical facilities.*

* * *

During a JLARC site visit to Deep Meadow, the institutional physician expressed concerns about the type of inmates being assigned to the handicapped unit. The unit houses blind and deaf inmates; inmates with asthma, diabetes, seizure disorders, and cardiac diseases; paraplegic inmates; inmates requiring crutches and/or wheelchairs to be mobile; and some inmates requiring indwelling urinary catheters. Deep Meadow also serves some geriatric inmates with disabling conditions. All of these conditions require close nursing attention to prevent infections, bed sores, and other potential problems. However, there is no nursing station in the unit nor infirmary medical beds available if needed.

In addition, the physician expressed concerns about the ability of medical staff to respond to emergency medical situations. The medical building is separated from the handicapped unit by a security gate. If emergency situations arise, medical staff reported that it takes about 15 minutes to get to the building. This time lag could be potentially deadly if a medical emergency occurs.

* * *

The physician at Deep Meadow also expressed serious concerns about physician coverage at the facility. In April, Deep Meadow had only one established physician position. Because Deep Meadow is also designated as a reception and classification center, the physician must supervise medical screenings and classifications of all inmates received into the facility, as well as provide care and treatment to handicapped and general population inmates. The physician believed this was too much work for one physician, one registered nurse, and five licensed practical nurses.

DOC lacks the capability to address the needs of handicapped inmates across the entire correctional system because it does not collect demographic and medical data to identify these needs. Medical staff in institutions and OHS staff suggested in interviews that Deep Meadow does not have sufficient capacity for the number of handicapped inmates in the system. However, these suggestions are only anecdotally based, as DOC does not maintain a central listing of handicapped inmates.

Physicians and nurses at other major institutions reported waits of up to six months for a bed for a handicapped inmate at Deep Meadow. These physicians were not generally aware of the limited scope of services available for handicapped inmates at Deep Meadow. DOC physicians appeared to be aware only that Deep Meadow is the assigned facility for handicapped inmates.

In addition, the current designation of Deep Meadow as the system's designated handicapped facility does not appear to meet the full medical care needs of handicapped

inmates. These needs include immediate availability of physician and nursing care and special programs to allow individuals to reach their maximum level of functioning. Correctional literature indicates that a primary concern in caring for handicapped inmates is providing assistance with activities of daily living such as bathing, dressing, feeding, and transportation to programs and recreation. The literature also suggests that medical case management of this population is important due to the multiple health needs most handicapped inmates have.

The department has recently received funding for additional nursing positions for Deep Meadow. As of July 1, 1993, the institution received three additional nursing positions. Deep Meadow will receive two additional nursing positions January 1, 1994. However, it is important to note that some of these positions will be used to provide medical care services to the general inmate population, and to meet the medical requirements for inmate reception and classification screenings as well as the medical needs of handicapped inmates. While this should enhance the facility's ability to conduct reception and classification screenings and inmate sick call, it will not fully address fundamental problems related to the lack of a full range of infirmary services for handicapped inmates who have chronic care needs. Further, Deep Meadow has been without a full-time institutional physician since July 1, 1993, which negatively impacts inmate access to care and continuity of care.

Recommendation (7). **The Department of Corrections should track the number and acuity levels of handicapped inmates in the correctional system to better plan future facilities for handicapped inmates. Once these data are collected, the department should develop a plan to address the full range of housing and medical care needs of handicapped inmates within the system.**

Recommendation (8). **The Department of Corrections should evaluate the current staffing patterns at Deep Meadow Correctional Center to determine if current levels are adequate to address the medical care needs of inmates housed at the facility. The assessment should include consideration of acuity levels of handicapped inmates housed at the facility.**

INMATE MEDICAL TRANSFERS

During this review of inmate medical care, JLARC staff noted a number of problems affecting inmate medical transfers from one correctional facility to another, including:

- lack of adequate physician involvement in inmate medical transfers
- lack of adequate notification and documentation of inmate medical needs for institutions receiving medical transfers

- absence of necessary precautions in transporting inmates with suspected infectious diseases

- lack of medical staff supervision of inmate medical transfers

- inadequate training of security staff in handling inmate medical transfers.

These problems have resulted in situations which have compromised the care of transferred inmates and put the State at risk for legal liability concerning the medical care and treatment of transferred inmates.

Physician Oversight of Medical Transfers Is Problematic

Department operating procedures provide guidance regarding the transfer of inmates between institutions and into the community for off-site care (DOP 719). Current procedures place responsibility for determining whether an inmate needs a transfer for medical care with the institutional physician. These procedures do not reflect actual inmate transfer practices.

Transfers appear to be frequently arranged by nursing staff, with little physician involvement. Institutional physicians are not adequately notified of inmates arriving at their facilities or of the medical needs of these inmates. The DOP for inmate medical transfers states that a medical summary should be completed and sent to the receiving institution at the time an inmate is transferred for medical reasons. This summary should contain information on the inmate's current treatment, current medications being administered to the inmate, and current medical complaint. JLARC staff noted in reviews of medical records that inmate transfer sheets often did not contain detailed information on inmate medical conditions, medications, or current medical complaints at the time of the transfer. Nor is consideration always given to whether the receiving institution is prepared to accommodate the inmate. For example:

> *The chief physician at one major infirmary noted that inmates frequently arrived at the institution without advance notice. This included inmates with infectious diseases and acute care needs who arrived late at night when the nursing staff was not adequate to meet the inmates' needs.*
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> * * *
>
> *The chief physician at another major infirmary observed that he has no role in deciding whether to accept an inmate but is simply told by central office staff that a particular inmate is being transferred to the facility. Often, the physician stated, the institution is not adequately staffed to*

Department Procedures Guiding Notification, Documentation of Transfers, and Training Need Improvement

Department operating procedures do not provide sufficient guidance for institutions on how to transfer an inmate with a serious medical condition. These procedures need improvement to protect against the potential spread of infectious diseases and to ensure that inmates' physical needs are met during transfers. For example:

> *One Buckingham inmate was sent to Greensville for an assessment of whether the inmate's symptoms were caused by tuberculosis. According to the head nurse at Buckingham, the inmate was called to the infirmary and informed about his possible condition and the need to use precautions to prevent the spread of the disease; and security staff were called and briefed on precautions needed during the transport. During transit, however, the inmate did not wear a respirator to prevent the potential spread of the disease, and the security officers did not follow necessary precautions, such as wearing protective masks. Another inmate and correctional officer were picked up during transit and exposed to this inmate. Further, correctional officers and inmates at Greensville were exposed to this inmate upon entry into the compound. According to the director of nursing at Greensville, they had not been given adequate notice of the transfer.*
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> *An inmate being treated at the Greensville infirmary for dehydration was transferred from Greensville to Marion for treatment of his psychiatric conditions. Prior to his transfer, the inmate had been receiving additional fluids through an intravenous solution. Marion was not notified that they were receiving the inmate. The inmate was transported in the back of an ambulance for an eight-hour ride, with no intravenous solution to provide needed fluids, and restrained with ankle shackles and handcuffs. The inmate arrived at Marion severely dehydrated, badly bruised from struggling with his restraints, and soaked in his own urine. The chief physician at Marion noted that the inmate was in "poor shape" and appeared to have suffered serious neglect. The physician also noted that only minimal documentation had accompanied the inmate and that the documentation that did accompany the inmate was disorganized. This made assessing the inmate's medical needs difficult. Because Marion lacks a medical infirmary, the physician did not feel the facility was appropriate to meet the inmate's medical needs.*

Department operating procedures state that "When an inmate needs to be transported to another facility or clinic, medical staff should cooperate with security personnel in determining conditions of transportation and necessary security precautions in accordance with the custody classification of the inmate." Clearly, in this situation, medical staff also needed to ensure that the inmate's physical and medical care

personnel in determining conditions of transportation and necessary security precautions in accordance with the custody classification of the inmate." Clearly, in this situation, medical staff also needed to ensure that the inmate's physical and medical care needs were met during the inmate's transport. Department operating procedures do not go far enough to address situations in which medical staff need to accompany medical transfers. There appears to be no clear policy that is followed for when medical personnel should accompany an inmate on the transfer.

Absent the presence of medical personnel, it is unclear whether transporting correctional officers are adequately trained for transporting inmates. Correctional officers receive some training during orientation on working with inmates in a medical setting, but this training and DOC policies regarding transfers are insufficient to prevent problems with some transfers.

Recommendation (9). **The Department of Corrections should revise policies and procedures for inmate medical transfers to: (1) provide for adequate and appropriate notification of and input from institutional physicians concerning inmate transfers; (2) emphasize the need for appropriate precautions in transporting inmates with active or suspected infectious diseases; (3) specify conditions under which medical staff should accompany the inmate and what provisions to make for an inmate's access to food, fluids, and bathroom facilities while in transit; and (4) implement training for medical and correctional officers on these revised medical transfer procedures.**

IV. Costs of Inmate Medical Care

In the last decade, corrections has been an increasing component of the State budget, and today the Department of Corrections (DOC) budget is a major component of general fund costs. The department has been challenged to handle substantial increases in the inmate population. The increases in the inmate population have meant that the department has needed to oversee the establishment of several new facilities and the dismantlement of obsolete facilities. Further, DOC has had to increase the provision of certain services such as medical care. While responding to these changes, the department has had a good record of security control over the facilities during recent years.

However, State budget problems, coupled with the fact that the size of the corrections system has grown, make it particularly imperative that DOC ensure that its expenditures are made in an efficient and cost effective manner. Health care costs are a significant and growing component of DOC's expenditures, yet this review indicates that DOC does not have adequate control over these expenditures. Due to the complexity of health care cost issues, DOC should seek assistance in managing the costs and the provision of health care from other State agencies that have specialized experience in health care.

DOC spends a significant portion of its budget on health care services. In FY 1992 and FY 1993, DOC expended approximately $34.4 million and $36.9 million on health care which includes dental, mental health, and medical care. This represented roughly nine percent of the department's expenditures each year. Of the total health care expenditures, approximately $28.1 million and $31.7 million was spent on medical care in FY 1992 and FY 1993 respectively.

DOC health care appropriations and expenditures have increased over the past five years. In addition, expenditures have surpassed appropriations three of those five years. Health care expenditure growth and overspending is a consequence of DOC's inadequate management of health care services and costs as well as two external forces: the growing inmate population and health care inflation.

Two primary problems inhibit the department from adequately managing the costs of inmate health care. First, DOC lacks detailed data on health care expenditures, services provided, and inmate health needs. Without specific health cost data, uniform cost classifications, service detail, and inmate health care needs, the department does not possess the tools to effectively control health care costs, systematically plan specialized inmate health services, place inmates according to special health care needs, achieve economies of scale, and substantiate health care budget requests. As a result, some medical services are not provided in the most cost effective manner. Second, the department has not taken advantage of cost saving opportunities such as establishing provider reimbursement policies, increasing utilization review, and promoting more on-site services at current DOC facilities.

DOC needs to proactively pursue these approaches to achieve potential cost savings. JLARC staff estimate more than $2.3 million could be saved from implementing

the options outlined in this chapter and summarized in Table 3. Besides the specific cost saving options in Table 3, a number of additional savings may be realized. However, this will require DOC to implement a number of recommendations related to utilization review, the establishment of reimbursement policies, and better use of existing DOC infirmaries.

Table 3

Potential Cost Savings from Cost Management Activities

Area of Savings	Amount
Offsetting temporary nursing charges with improved nurse recruitment	$1,012,727
80 percent payment rate for MCV outpatient hospital services	145,890
80 percent payment rate for services from MCV Associated Physicians	265,074
80 percent payment rate for female inpatient hospital stays at MCV	118,782
80 percent payment rate for all other inpatient hospital services	222,632
80 percent payment rate for all other outpatient hospital services	323,482
Reviewing medical bills and disputing inappropriate charges	205,482
Conducting additional cost audits, estimated savings of $1,500 per audit*	15,000
Total	$2,309,069

*Based on the number of audits (ten) conducted by MSVRO in FY 1992. Additional audits and savings may be feasible.

Source: JLARC staff analysis of potential cost savings, based on medical cost data from the Department of Corrections.

DEPARTMENT MANAGEMENT OF HEALTH CARE COSTS

Over the past five years, the growth in health care expenditures for DOC has outpaced the growth in the inmate population. While health care costs per inmate vary widely at different institutions, overall spending for health services in DOC has risen 84 percent in the past five fiscal years. During the same period, the average daily number

of inmates has increased about 35 percent, from approximately 12,600 to slightly more than 17,000. Consequently, the per-inmate cost has grown by approximately 36 percent. The growth of both inmate health expenditures and the inmate population are illustrated in Table 4.

Table 4

Comparison of Health Care Expenditure Growth versus Inmate Population Growth

Fiscal Year	Health Care Appropriation	Health Care Expenditures	Annual Percent Increase in Health Care Expenditures	Expenditures Per Inmate	Average Daily Population	Annual Percent Increase in Inmate Population
1989	$20,984,581	$20,068,707		$1,592	12,605	
1990	$23,723,278	$25,748,524	28%	$1,813	14,203	13%
1991	$33,352,673	$31,282,455	21%	$2,103	14,872	5%
1992	$29,708,653	$34,383,298	10%	$2,064	16,659	12%
1993	$30,541,546	$36,855,316	7%	$2,167	17,011	2%

Source: JLARC staff analysis of FY 1989 through FY 1993 Appropriation Acts, Department of Corrections reported health care expenditures, and Department of Corrections reported inmate population.

Department health care expenditures have exceeded health care appropriations in three of the last five years. The department has failed to implement previous JLARC recommendations from the 1980s on data collection and analysis, and still lacks the capability to systematically collect and analyze health care costs, service levels, and inmate health needs within the department. The lack of data complicates attempts to determine: (1) what services comprise DOC's health expenditures, (2) whether expenditures are reasonable, and (3) if health services are purchased in a cost effective manner. In addition, it inhibits the department from formulating cost management techniques based on knowledge of its expenditure patterns. Furthermore, planning the direction of health care costs and services in the future is difficult without knowing current costs, services, or health service needs.

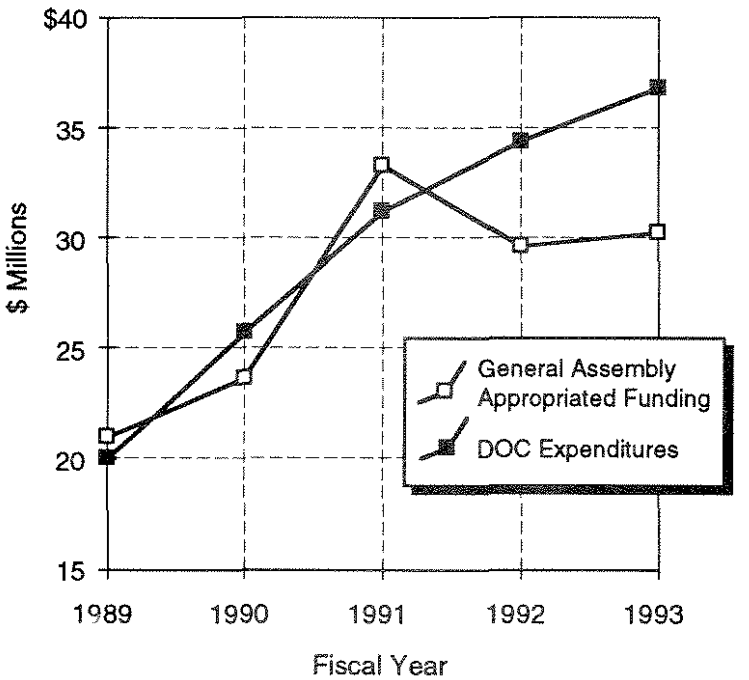
While the decentralized structure of DOC gives institutions and field units flexibility to meet health needs, it does not encourage a meaningful comparison of health costs and services between institutions or over time. Effective management and direction of inmate health services has been hindered by the lack of uniform cost data and a disjointed method of compiling health services or inmate patient-level data. Consistent classification of health service costs and collection of meaningful service detail would allow DOC to improve its planning and decision-making. Furthermore, decisions about staffing, provision of services, design of health facilities, and cost control measures all depend on the availability of reliable data that define the population to be served. Better data and correspondingly better health care cost management could help DOC justify needed appropriations and keep its health expenditures within appropriated amounts.

Health Care Expenditures Exceed Appropriations

During three of the last five fiscal years, DOC health care expenditures have exceeded health care appropriations (Figure 4). For example, DOC health care expenditures surpassed health care appropriations by 16 percent in FY 1992 and 21 percent in FY 1993. For these years, DOC was appropriated $29.7 million and $30.5 million respectively for health and clinical services in major institutions and field units. Expenditures for health services were $34.4 million in FY 1992 and $36.9 million in FY 1993. To fund unbudgeted health expenditures, DOC must transfer funds from other programs.

Figure 4

DOC Health Care Appropriations and Expenditures, FY 1989 - 1993



Source: JLARC staff analysis of FY 1989 through FY 1993 Appropriations Acts; and Department of Corrections memoranda dated September 9, 1992, October 5, 1992, and July 23, 1993.

Among all the major institutions in operation in FY 1992 and FY 1993 and the regional offices, only four of 21 had expenditures less than their appropriations for both fiscal years. Major institutions accounted for the majority of overruns. Greensville and the Virginia Correctional Center for Women (VCCW) had the largest overruns in dollar amounts. In FY 1993, Greensville spent $1.9 million more than its initial health care appropriation while VCCW spent $1.4 million more than its health care appropriation using a cash accounting methodology. (Chapter V provides additional information on

Greensville's expenditures indicating that using an accrual accounting methodology, Greensville overspent its appropriation by about $2.9 million.) By examining expenditures as a percentage of appropriations, VCCW spent almost 275 percent of its appropriation while the next highest institutions were Brunswick and Buckingham at approximately 150 percent of their appropriations. (Again, Chapter V shows that Greensville's expenditures as a percentage of appropriations was highest among male institutions based on an accrual method of accounting for FY 1993 expenditures.) Details on each institution's expenditures versus appropriations for FY 1992 and FY 1993 are listed in Appendix C.

DOC Does Not Adequately Track Expenditure Data to Assess Primary Costs for Health Care

Due to the increasing proportion of the DOC budget that health care consumes, it is important for DOC to obtain health care services in the most cost-effective manner. Uniformly tracking health care costs and analyzing those costs would provide baseline information to determine the major components of those costs, assess whether the costs of services provided were reasonable, and determine if services could be purchased more cost effectively. However, DOC is unable to make these determinations because: (1) detailed health care cost tracking is not conducted and (2) cost data are not uniformly reported or collected.

The Department Does Not Track Detailed Health Care Costs. While the DOC budget office tracks health care costs to ensure that expenditures are appropriately made and reported, DOC does not track these costs from a programmatic standpoint. Currently, health care costs include dental, mental health, and medical service costs. DOC does not use cost centers that would separate medical costs from dental and mental health costs. Cost centers allow agencies to internally track expenditures in a manner that is more useful for that agency. DOC has asserted that such tracking is not possible unless the department is allocated substantial funding to expand its computer system. However, by simply adding an element to Commonwealth Accounting and Reporting System (CARS) financial vouchers, DOC could easily track this information.

Recommendation (10). **The Department of Corrections should use the element option to distinguish dental, mental health, and medical expenditures when processing financial vouchers for the Commonwealth Accounting and Reporting System to supplement the program and subprogram designation for non-inpatient health services (379 10).**

DOC Does Not Use Uniform Procedures for Reporting Health Care Expenditures. The second problem with summarizing the cost of health services is that the methods of classifying health care expenditures are not uniform throughout the department. All health care service expenditures incurred by the institutions are paid by each facility's accounting staff. Health service expenditures for field units are paid by regional office accounting staff. As payments are made, these staff classify each expenditure with an object code which describes what was purchased with the expenditure. While the use of the object codes does not appear to deviate from Department of

Accounts and Department of Planning and Budget guidelines, specific health care services are not classified consistently throughout all DOC facilities.

Some facilities classify temporary nursing services as "medical services" while others classify temporary nursing as "skilled services." For example:

> *JLARC site visits and surveys revealed that both VCCW and Buckingham are large users of temporary nurses. VCCW reported temporary nursing costs of nearly $460,000 in FY 1993 under the skilled services object code. Under the same object code, Buckingham reported spending $0. By analyzing expenditures by vendor name, JLARC staff estimated Buckingham spent approximately $400,000 on temporary nursing services. Buckingham included all temporary nursing services under the medical services object code.*

In addition, while some facilities classify the evaluation and interpretation services of a radiologist as "X-ray and laboratory services", other facilities classify this service under "medical services." Furthermore, in the disposal of infectious medical waste, one institution classified this expenditure as "refuse service charges", another used "skilled services", and a third institution called this "custodial repair and maintenance materials."

A final example of classification inconsistencies results from the different methods facilities use to record the costs reflected in hospital bills. It is not uncommon for a hospital bill to include physician evaluation services, laboratory and X-ray services, and pharmacy services among other items. Some institutions lump all these costs under one classification such as "clinic services" or "hospital services." However, one institution breaks out all the services and lists the physician evaluation services as "medical services", the laboratory and X-ray services as "laboratory and X-ray services", and the pharmacy services as "medical and dental supplies."

To obtain meaningful summaries of health service expenditures, DOC should ensure that service classifications are consistent. Similar health services should be classified the same way at all institutions. In addition, all facilities should classify and itemize services on health care bills on the same basis throughout DOC.

Recommendation (11). **The Department of Corrections should issue a department operating procedure to institutional and regional office accounting personnel to ensure there is a system-wide uniform classification of health care expenditures. Compliance with these procedures should be incorporated into the Board of Corrections standards compliance review.**

DOC Still Does Not Systematically Collect or Analyze Morbidity Data

In addition to cost data, statistical information on health care services and utilization patterns is needed to plan and monitor health services. In the past, DOC's morbidity data have been inconsistently reported and are seldom aggregated or used.

Without these data, DOC has no specific knowledge of the quantity and location of services that are purchased with its expenditures and no data with which to develop workload and staffing standards. This hinders determinations of cost effectiveness because comparisons cannot be made among institutions or over time. In addition, the lack of morbidity and workload data precludes systematic analysis of whether services currently provided off-site could be provided on-site at less cost.

Health care service data are also needed for the development of workload standards. Currently there are no staffing standards for medical personnel in the institutions and field units. One staff member in the Office of Health Services (OHS) is trying to develop standards for the facilities based on facility categories. However, the standards appear to reflect historic patterns with no apparent rationale for current staff levels. Further, this staff member acknowledged that the standards lacked any validity other than "they seem to work well that way." Service level data should provide workload measures which would provide a better method for developing staffing standards.

Due to its unsystematic approach to morbidity data collection, DOC lacks aggregate information on what different types of health care services, such as physician services, outpatient hospital services, and nursing services, are purchased with its expenditures. Morbidity data needs to be tied to service level expenditures to determine the cost effectiveness of those services. For example, the cost of X-rays performed on-site could be compared to the cost of X-rays performed off-site with this information.

Despite recommendations by JLARC, as far back as 1986, to improve its morbidity data collection, OHS has only recently revised its morbidity data collection form. The new form appears to be an improvement over the past forms submitted by the institutions and field units. Whether useful information will be obtained, however, depends on whether the needed data will be reported uniformly by facilities and then systematically compiled and analyzed by DOC.

Recommendation (12). **The Department of Corrections should ensure that morbidity data are routinely collected, summarized, and analyzed. The department should use these data to evaluate the cost effectiveness of care and develop workload standards.**

DOC Does Not Maintain Data to Assess the Health Needs of Inmates

Maintaining data on the severity of inmate medical conditions is important to identify special inmate needs, plan and provide appropriate care, and justify costs. One correctional health care expert projects that nationally, the number of inmates with special health needs will escalate during the 1990s. As mentioned earlier, DOC has experienced an increase in its inmate population of approximately 35 percent in the past five years. However, DOC has only anecdotal knowledge of the health needs of the inmates currently in its system and has no basis for forecasting needs in the future.

Currently, the cost of care for inmates with chronic conditions, Acquired Immunodeficiency Syndrome (AIDS), end stage renal disease, and others cannot be

tracked. DOC needs to develop a plan to systematically monitor the special health needs of inmates and budget for these needs in the future. The system need not track specific health details of every inmate in its custody but must be capable of adequately tracking inmates with special and chronic care needs such as those receiving kidney dialysis, zidovudine (formerly called AZT) treatments, or cardiac medications to treat heart disease.

DOC's current method of classifying health conditions and tracking this information is insufficient for health care planning. As mentioned in the overview, the department makes some basic assessments of health conditions during classification which are used to assign an inmate to a facility. The current classification process appears to have two problems limiting the usefulness of the health condition categories now employed. First, categories may not be uniform because reception physicals and classifications for males are performed at nine different facilities.

Second, some DOC health condition classification categories are too broad to be analytically useful. One example of a broad category for health conditions is the category for "hematological" conditions. This category contains all immunodeficiency disorders, including Human Immunodeficiency Virus (HIV) seropositivity and AIDS. The category also includes other disorders such as sickle cell anemia and leukemia. However, the differences in the services and costs for treating an inmate who is HIV positive but asymptomatic compared to one with full-blown AIDS are significant. The amount and cost of care provided to inmates in the same broad category can vary greatly. Cost comparisons based on these broad conditions would be questionable, making planning difficult.

The lack of better health condition data inhibits DOC's ability to plan and justify costs. National studies have indicated that along with increasing prison populations, the number of inmates with special health care needs will rise. However, while many institutional health staff anecdotally claim they are receiving sicker inmates which lead to higher health expenses, no data exist to support their assertion. The extent to which sicker inmates contribute to increases in inmate health care costs cannot be analyzed unless meaningful health conditions are documented and health classifications are systematically maintained.

An improved method of describing health conditions should provide better information for planning. Once a new system is in place, DOC could track the number of inmates with certain conditions, develop institutional profiles of inmate health conditions to explain costs, forecast future needs and costs, and plan accordingly. Health programming for the various needs of inmates can have significant implications for staffing, housing, space, and equipment provided in DOC facilities. All of these areas will affect costs.

Recommendation (13). **The Department of Corrections should develop and implement a systematic method of tracking inmates with special health care needs. Summaries of these data should be used to compile the cost of care for inmates with special needs, forecast trends, and justify health budget requests.**

Inmate Health Needs Should Be Incorporated into DOC's Method of Health Care Budgeting

The lack of comprehensive data on expenditures, services, and inmate health conditions is one of the main reasons why DOC does not stay within its health care appropriation. Exceeding health care appropriations department-wide and at most institutions indicates two budgeting problems. First, with respect to surpassing health care appropriations as a department, DOC does not support its health care budget requests with valid data describing the inmate health care needs, costs to meet those needs, and related trends. Second, with respect to individual institutions exceeding their health care budgets, DOC does not adjust institutional budgets based on the health care needs of inmates housed at those institutions.

Data Are Lacking to Justify Budget Requests. While the department budget requests include some detail about inmate health care needs, these requests are not compelling because DOC lacks specific data to link inmate health care needs, health care service levels, and attendant costs for care. Valid and verifiable data from the department on the number of inmates with high-cost health care conditions, such as HIV infections, full-blown AIDS, end stage renal disease, and high-risk pregnancies, could help budget decision-makers in assessing the need for additional resources. The State could better plan and manage resources to meet inmate needs if service levels provided to these inmates, and their attendant costs, were routinely tracked.

Recommendation (14). **When submitting its budget proposal for health care, the Department of Corrections should include statistics showing inmate health care trends and costs associated with those trends. Statistics should include, but not be limited to, the number of inmates with chronic conditions such as AIDS, end stage renal disease, and other conditions such as the number of pregnancies.**

Internal Budget Adjustments Should Be Made Based on Inmate Health Needs. The current method of formulating the budget for health care does not take into account the health care needs of the inmates at each of the different institutions. Funding for DOC's direct inmate costs, including health care, is largely appropriated on a per-inmate basis. Therefore, all major institutions receive the same amount of funding per inmate without making allowances for institutions which have higher fixed health care costs or inmates with special needs.

Budgeting for health care should encompass inmate health care needs and services required to address those needs. Under the current method, no allowances are made for special inmate health conditions that are cared for at some institutions. For example, Deep Meadow has a concentration of handicapped inmates. Since these inmates are expected to have greater needs in terms of physician and nursing services as well as pharmaceuticals and supplies, an adjustment for extra costs should be made to this institution's budget, otherwise budget overruns should be expected. Each individual institution's compliance with appropriated amounts cannot be fairly assessed without taking into account inmate health needs and required services. In addition,

inappropriate allocation methods raise an equity concern, because facilities with expenditures that exceed appropriations in the health care area are generally expected to fund the overrun from elsewhere in their budget.

An extreme example of institutions' different health care needs is illustrated with the health care appropriations and expenditures for St. Brides and VCCW. The size of the inmate populations is not that dissimilar, however, the health needs between the two populations are very different. Appropriations, made on a per-inmate basis, were similar. However, actual expenditures clearly did not mirror allocations made on a per-inmate basis (Table 5).

Table 5

Comparison of FY 1993 Health Care Appropriations and Expenditures on Per-Inmate Basis at St. Brides and VCCW

	St. Brides	VCCW
FY 1993 average population	499	661
FY 1993 health care appropriation	$614,997	$ 797,552
FY 1993 health care expenditures	$506,010	$2,168,607
Difference in appropriations and expenditures	$108,987	($1,371,055)
FY 1993 appropriation per inmate	$1,232	$1,207
FY 1993 expenditures per inmate	$1,014	$3,281

Source: JLARC staff analysis of FY 1993 *Average Daily Inmate Population*, FY 1993 Appropriation Act, and DOC reported expenditures.

The main explanation for the difference in these institutions' health care expenditures is the variation in service needs. St. Brides houses primarily young males while VCCW houses all female inmates in the State. Young male inmates are typically healthier than other inmate age groups and females generally have unique health care needs. In addition, because VCCW receives all women in the State DOC system, it houses inmates who are pregnant, HIV positive, need kidney dialysis, or have other chronic or acute problems. Furthermore, much of the care provided for women is provided off-site, and due to the comparative size of the female inmate population, there is less opportunity to achieve economies of scale.

Recommendation (15). **The Department of Corrections should adjust each facility's health care budget based on inmate health needs and types of services provided at the facility.**

Expenditures for the medical care component of health care far exceed the expenditures for the other two components of health care services, dental and mental health. However, DOC does not separate medical expenditures from other health care expenditures. Therefore, JLARC staff took steps to separate and report these expenditures. According to this analysis, medical expenditures accounted for approximately 82 percent of DOC's total health care expenditures in FY 1992 and 86 percent of total health care expenditures in FY 1993. According to JLARC estimates, in FY 1992, DOC spent $28.1 million for medical care. These expenditures grew to $31.7 million in FY 1993.

To assess medical costs, JLARC staff also attempted to identify the components of DOC's medical expenditures by analyzing vendor payments for DOC health care programs for the last two fiscal years. This analysis indicates that personnel services accounted for a higher proportion of medical care expenditures than any other expenditure component. However, significant portions of DOC expenditures for medical care go to delivering medical care services at Greensville and providing hospital services. JLARC staff have identified problems with DOC's ability to effectively manage medical costs in these two areas.

JLARC Analysis of Medical Expenditures

As mentioned earlier, medical expenditures and services are not consistently classified and tracked. Medical expenditures are not separated from dental and mental health expenditures. In addition, expenditures are not uniformly classified throughout the decentralized correctional system, making it difficult to disaggregate medically-related goods and services purchased by the department. To overcome the data shortcomings, JLARC staff obtained summaries of DOC medical expenditures for FY 1992 and FY 1993 from the Commonwealth Accounting and Reporting System . Based on vendor names and object code classifications, JLARC staff developed expenditure categories to ascertain the general components of DOC medical expenditures.

Expenditures were categorized into ten types of services, after dental and mental health services were subtracted from the total. These categories, along with a brief explanation, include:

- DOC personnel services — salaries and benefits paid to full-time and part-time State personnel with responsibilities directly related to the delivery or administration of medical care

- equipment and supplies — payments for durable medical equipment, consumable supplies, and prostheses

- Greensville contract — expenditures made to the contractors delivering health care at Greensville

- hospital services — payments made to hospitals for inpatient, outpatient or emergency room care which typically include services such as laboratory, radiology, and pharmacy provided in the hospital setting

- laboratory and X-ray services — expenditures for drawing and analysis of laboratory specimens and radiology photographing and processing

- optometry services — expenditures for eyeglasses and examinations by optometrists

- pharmacy services — payments for prescription drugs and other pharmaceutical products

- physician services — payments made to contract physicians, physician practices, or physician services rendered in a hospital setting for medical care such as consultations, evaluations, or interpretations

- temporary nursing services — expenditures for services provided by contracted temporary agency nurses

- other goods and services — medically-related expenditures including medical reference materials, uniforms, office supplies, employee travel and training, special OHS contracts and services, and disposal of infectious waste.

Summaries of each institution's medical expenditures based on these categories are listed in Appendix F.

Medical Care Cost Components

Payroll expenditures for DOC medical personnel comprised the largest expenditure category of DOC's medical expenditures, accounting for almost a quarter of the expenditures (Figure 5). Personnel expenditures are typically the largest line item in the budget of any health services delivery organization. However, the percentage of medical care expenditures going to DOC personnel has declined from 27 percent in FY 1992 to 23 percent in FY 1993. This appears to reflect the continuing trend of declining DOC health care personnel expenditures each year. Frozen State salaries, high use of contract physicians and temporary nurses, and the Greensville contract appear to account for this change.

The next largest category of expenditures was the payments made to the contractors at Greensville. These payments accounted for 19 percent of DOC medical expenditures in FY 1993 and totaled about $5.2 million and $6.1 million in FY 1992 and FY 1993 respectively. However, it is important to note that these figures are based on the fiscal year during which the expenditures were paid and do not exactly match the cost for the services provided during that fiscal year. (For example, services performed at the end of FY 1993 would be paid in FY 1994.) More details on Greensville expenditures are

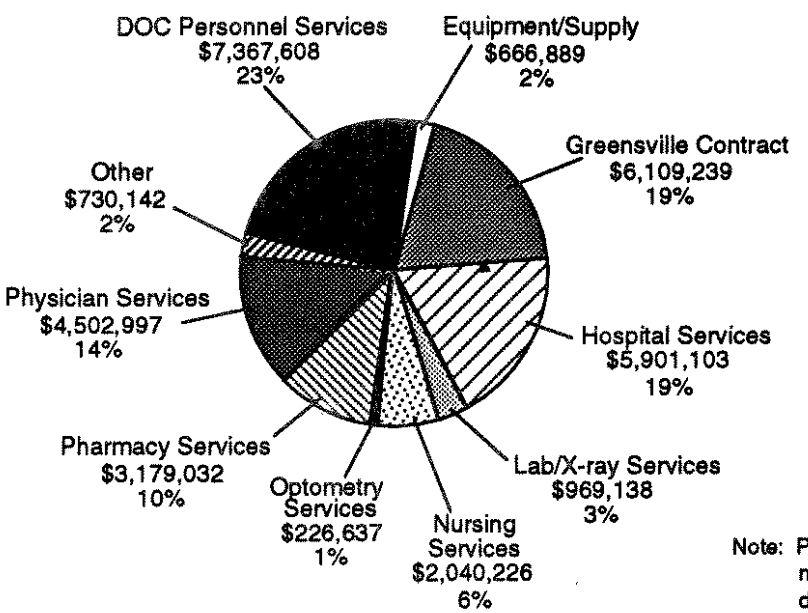
provided in Chapter V using an accrual accounting methodology which accounts for the costs for all services provided in FY 1993.

The next largest cost components in FY 1993 were hospital services (19 percent) and physician services (14 percent). If these expenditures mirror trends in other medical care delivery systems, systematic and effective management will be needed to restrain rapid growth in these costs. DOC management needs to take action to control temporary

Figure 5

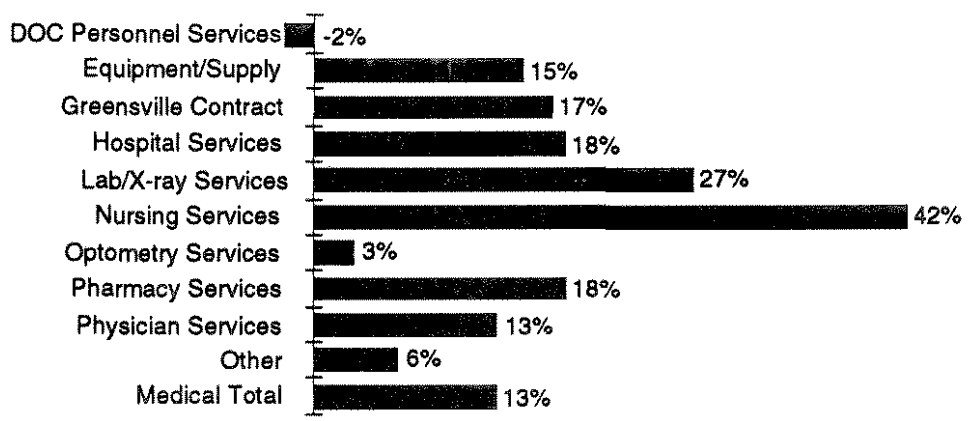
DOC Medical Expenditures by Category, FY 1993

TOTAL EXPENDITURES: $31,693,011



Note: Percentages do not add to 100 due to rounding.

CHANGE FROM FY 1992 TO FY 1993



Source: JLARC staff analysis of FY 1992 and FY 1993 Department of Corrections expenditures obtained from Commonwealth Accounting and Reporting System.

nursing, pursue negotiated rates with hospitals and physicians, expand utilization review, and promote on-site services and greater use of existing DOC infirmaries. These initiatives could provide the department with cost saving opportunities.

COST SAVING OPPORTUNITIES

The lack of good financial management of the DOC health care program inhibits opportunities for additional cost savings. The declining State personnel expenditures and increasing portion of dollars spent on hospital, physician, and nursing services suggest that DOC is not taking advantage of opportunities to restrain medical costs. Despite efforts by some individual institutions to manage inmate medical costs, DOC lacks a system to actively manage inmate medical care costs. As a result, DOC is paying higher costs to provide medical services to inmates. If the department utilized several basic cost management techniques for medical services, the department could save an estimated $2.3 million.

The department needs to take several steps to make better use of State resources for medical care services. The high use and cost of temporary nursing and contract physicians needs to be examined by the department. In addition, DOC should vigorously pursue negotiated rates with medical providers and implement reimbursement policies to ensure that the department pays no more than necessary for medical care services. This could be accomplished with the assistance of other State agency staff who have expertise in medical care financing and service delivery. A stronger utilization review process should be established that ensures that providers are paid for appropriate, medically necessary services within established reimbursement guidelines. DOC's use of a contractor to review medical procedures and bills has not been employed to its fullest extent.

In addition, DOC needs to better use some existing medical infirmaries to provide regional medical services on-site at DOC institutions and field units. This would result in reduced medical care, security, and transportation costs associated with the provision of off-site medical care. Finally, some policy alternatives could be explored for their feasibility in restraining the growth of inmate medical costs in the future while ensuring inmate access to and quality of care.

Expenditures for Temporary Nurses and Contract Physicians Are Increasing

While the percentage of health care expenditures going to DOC personnel services declined from FY 1988 to FY 1993, DOC's spending on contract physicians and temporary nursing has increased. DOC expenditures for State-employed health care personnel dropped from 49 percent of total health care expenditures in FY 1988 to 30 percent in FY 1993. DOC's transition from State employees to contract and temporary labor to fill physician and nursing positions explains part of the rise in inmate health care costs.

State Salary Freeze Imposed an External Cost Constraint. Due to the State budget difficulties in the 1990-1992 biennium, State employees' salaries were frozen. This had the effect of imposing an external cost constraint on DOC's medical expenditures. Because salaries account for nearly one-quarter of DOC's medical expenditures, the growth in inmate medical care costs would have been even larger if State employees had received cost of living or merit pay raises.

Use of Contract Physicians Has Increased Medical Care Costs. DOC has been using salary dollars for physician positions established under the State personnel system for the purpose of hiring contract physicians. The contract physicians have been hired at significantly higher hourly rates than the cost of State-employed physicians. JLARC staff's review identified five major institutions where primary physician care was provided by a contract physician or physicians during FY 1993. These institutions had a total of five physician positions established in the State personnel system in FY 1993. Each position was classified as an "institutional physician," which is a grade 20 in the State personnel system. Assuming the maximum salary for these positions (grade 20, step 20) and applicable benefits, the maximum salary and benefit costs for each position would be $105,829. The maximum annual cost of the salaries and benefits for five full-time State institutional physicians would be $529,145.

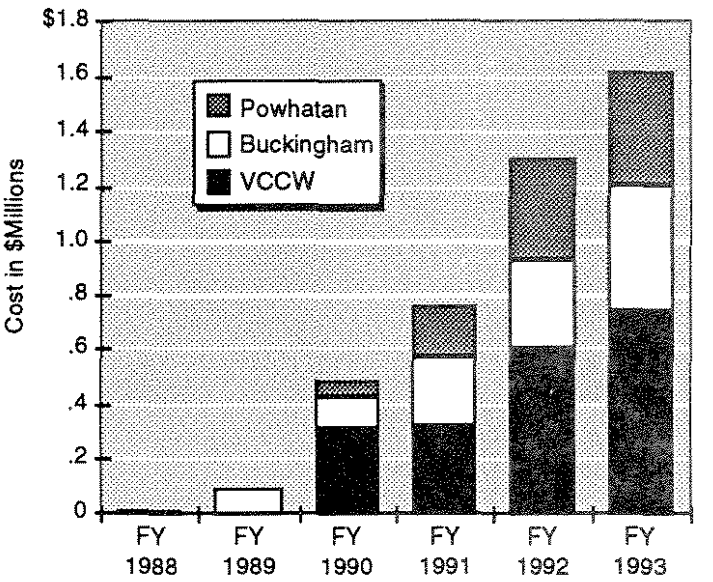
These five institutions spent almost $840,000 on physician primary care in FY 1993, averaging approximately $168,000 per full-time contract physician. This amounts to about 58 percent more in compensation than for a State-employed physician. While in some cases, recruiting difficulties may make contract physicians the only viable alternative to providing access to care, this approach is not as cost effective as the use of full-time State personnel. DOC should ensure that each physician contract arrangement it enters into is the most cost effective viable alternative.

Contract Nursing Increases Costs and Decreases Quality of Care. JLARC staff analyzed temporary nursing expenditures at three major institutions that accounted for the majority of DOC's temporary nursing expenditures in FY 1992 and FY 1993 (90 percent and 79 percent respectively). The use of temporary nursing at these institutions increased dramatically from FY 1988 to FY 1993, as illustrated in Figure 6.

This dramatic increase in the use of temporary nurses at just three institutions over the past five years is a disturbing trend, because of two disadvantages associated with these services. First, temporary nurses cost significantly more per hour than permanent employees. Temporary nurses employed by DOC facilities are typically licensed practical nurses (LPNs), and cost between $19 and $21 per hour. State-employed LPNs are in pay grade 7, with a median salary and benefit cost of $13.76 an hour, or 31 percent lower than the hourly cost of temporary agency LPNs. DOC spent more than $1.6 million in FY 1993 to fill nursing vacancies at Buckingham, Powhatan, and VCCW with temporary agency nurses. These three institutions had three registered nurse and 17 LPN vacancies in FY 1993, with total salary and benefit costs of $605,580, if all 20 positions were filled using State employees. Therefore, it appears that DOC spent approximately $1 million more than the cost for State employees to cover these 20 vacancies using temporary nursing agencies.

Figure 6

Cost of Temporary Nursing Services



Source: JLARC staff analysis of Powhatan, Buckingham, and VCCW CARS 1414 reports of expenditure detail for fiscal years 1988 through 1993.

Second, temporary LPNs cost as much per hour as State-employed registered nurses ($19.09 per hour at the median step for a grade 11 with benefits), but have a much lower level of training and much more narrow scope of clinical practice. By using temporary nurses, DOC is purchasing a lower level of care at a substantially higher cost. Inconsistencies in the classification of temporary nursing costs at major institutions, and DOC's failure to make reduction of temporary nursing services a management priority, have prevented DOC from recognizing this growing problem.

DOC needs to make use of several incentives available to State agencies for recruiting and retaining health care professionals such as shift differentials, flexible schedules, tuition reimbursement, and on-call pay. The $1 million used to pay for temporary nursing services could be used to fund some incentives for nurses. For example, DOC estimates it would cost $250,000 to provide a $1 per hour evening shift differential and a $2 per hour night and weekend shift differential for nurses within DOC.

Recommendation (16). **The Department of Corrections should develop a plan to reduce its use of temporary nursing. The plan should include details on how DOC could use some of the savings from reducing temporary nursing expenditures to fund nurse recruitment and retention incentives. A report on this plan should be made to the Senate Finance and House Appropriation Committees before the next session of the General Assembly.**

Deficient Rate and Reimbursement Policies Result in High Medical Care Costs

System-wide, DOC lacks two major components to manage medical care costs which are commonly used by most other third party payers: (1) cost effective negotiated payment rates and (2) medical reimbursement policies. DOC has negotiated payment rates for some medical services. However, DOC lacks cost effective negotiated rates across the system for inpatient and outpatient hospital care, clinic care, physician specialty services, radiological services, and other medical services. As a result, the State is paying 100 percent of medical provider charges with few exceptions. DOC should adopt lower reimbursement payment rates like most third party payers do. If DOC had implemented a payment rate based on 80 percent of charges (used by some health insurance organizations) during FY 1993, DOC would have saved almost $1.1 million.

In addition, because the department lacks fundamental reimbursement policies, no clear process exists to dispute billed services that appear medically unnecessary. If unnecessary medical services are identified, DOC is unable to deny inappropriate payments after services have been rendered because DOC has no reimbursement policies in effect nor do current agreements with providers allow for this. The lack of reimbursement policies has precluded the establishment of a uniform process to verify that services billed were actually performed and services are paid for only once.

DOC Negotiated Rates for Some Services Are Not Cost Effective. The department uses negotiated rates to obtain a number of medical goods and services. Primarily, these include:

- medical services and goods on State procurement contracts such as pharmaceuticals, temporary nursing services, laboratory services, and medical supplies
- Medical College of Virginia (MCV) Hospitals inpatient acute and intensive care services for male inmates
- primary care physician services at institutions and field units.

In addition, the department has experimented with contracting out a comprehensive set of medical services at Greensville Correctional Center.

With the exception of State procurement contracts which all agencies must use under prescribed State guidelines, negotiated rates contracted by the department may not be cost effective. Negotiated rates with MCV do not cover all services provided to DOC inmates. Rates for primary care services are largely dictated by physicians. And as the following chapter on the Greensville contract indicates, the State is paying a premium for care yet is receiving substantially less in services than outlined in the contract.

During the mid-1980s, the DOC health services administrator and MCV comptroller reached an agreement that DOC would pay $545 per day for inpatient acute care services for male inmates hospitalized in the secure wards at MCV Hospitals. This rate was based on the Medicaid hospital inpatient per diem rate at the time. Effective

July 1, 1992, a new agreement was reached to raise the MCV inpatient acute care rate to $833 per day, which is the current rate for these services for male inmates in the secure unit at MCV. According to staff at MCV, this rate was based on MCV's cost to provide these services.

While this per diem rate results in lower costs for DOC than if charged 100 percent of charges for services, it does not cover all inpatient services provided by MCV. As Table 6 indicates, DOC pays more than the negotiated per diem rate for inpatient care for female inmate inpatient stays. In addition, the department pays MCV 100 percent of charges for all outpatient services, including emergency room services. DOC also pays a higher per diem rate for care rendered in the intensive care unit, however, this may be justified because this type of care is more expensive.

Table 6

DOC Reimbursement Rates for MCV Services FY 1992 - FY 1993

MCV Service	FY 1992 Rate	FY 1993 Rate
Acute inpatient care for male inmates	$545	$833
Acute inpatient care for female inmates	100% of charges	100% of charges
Intensive care unit services	$930	$1,865
Outpatient and emergency services	100% of charges	100% of charges

Source: JLARC staff analysis of letters to DOC Office of Health Services from MCV Director of Finance, dated May 29, 1991 and February 17, 1993; and Medical Society of Virginia Review Organization cost audit for patient billed for ICU charges in FY 1992.

Many third party payers negotiate payment rates for hospital services at less than 100 percent of hospital charges. Generally hospital charges do not reflect the actual cost for the hospital to provide the service. DOC is paying 100 percent of hospital charges for all but male inpatient care provided on the MCV secure unit and for intensive care. This type of payment arrangement for DOC does not result in the most cost effective payment for inpatient services. If DOC had negotiated even an 80 percent payment rate for female inpatient care and all outpatient clinics at MCV, almost $265,000 in inmate health care costs could have been saved in FY 1993.

DOC is also planning to fund capital improvements to the MCV inpatient secure ward. MCV staff have stated that the purpose of the improvements is for MCV to comply with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards on plant, technology, and safety management. In addition, the capital improvements will result in the modification of one ward to accommodate four inpatient beds for female inmates.

DOC officials stated in an interview that they would request funding in their 1994 budget addenda to pay for these capital improvements which will amount to approximately $210,000. DOC estimates that 75 to 80 percent of this amount will be paid for MCV capital improvements related to JCAHO standards compliance and 20 to 25 percent will fund renovations to accommodate female inmates in the unit. Payment by DOC for the total capital improvements does not appear to be sound financial management for DOC.

Both DOC and MCV have stated repeatedly throughout the course of this review that both are somewhat dissatisfied with current hospital service arrangements at MCV. In FY 1992, DOC attempted to contract with another hospital to provide inpatient services for inmates. If DOC terminates its agreement with MCV to provide inpatient services, MCV will continue to benefit from capital improvements to the secure unit. MCV officials have indicated that DOC could obtain more cost effective care at hospitals located within the immediate vicinity of its institutions.

Therefore, if MCV sees renovation of this unit as an immediate necessity to obtain accreditation, then the funding for the renovation should be part of the MCV budget addenda. Arrangements could then be negotiated between MCV and DOC for an interim rate adjustment for a specified time period to pay for a portion of the capital improvements associated with the renovations.

In addition to the MCV negotiated rates, DOC institutions and field units sometimes negotiate payment rates with primary care and some specialty care physicians. However, it is important to note that contracts for primary care physicians at major institutions arise because of recruitment problems associated with hiring physicians as full-time State employees. Further, some areas of the State have acute shortages of primary care physicians. This means that often DOC has little room to negotiate in setting the price of the contract. For example:

> *Located in Southwest Virginia, Keen Mountain Correctional Center has had difficulty hiring a full-time State-employed physician for the institution. To obtain physician services, the department agreed to a contract for a physician at $150 per hour. The department considered the hourly rate excessive but needed the physician to ensure inmates had access to medical care.*

DOC is likely to face difficulties like this in the future. However, where possible, DOC should pursue negotiations to establish cost effective rates with physicians.

Recommendation (17). **The Secretaries of Public Safety and Education should direct the Department of Corrections and the Medical College of Virginia to renegotiate payment arrangements for inmates receiving care at the Medical College of Virginia Hospitals. The negotiated payment rate should reflect the actual cost to provide care and apply to all medical services provided by MCV to DOC inmates.**

Recommendation (18). **The General Assembly may wish to alter the Department of Corrections and the Medical College of Virginia Hospitals budget addenda so renovations to the secure ward are funded by MCV Hospitals. The Department of Corrections and the Medical College of Virginia Hospitals should negotiate an interim rate to reflect a portion of capital costs to renovate the inpatient secure unit. The interim rate should be effective for a specific time period.**

DOC Lacks Negotiated Rates for Many Costly Medical Services. Negotiated payment rates for many medical services are lacking system-wide. Other than MCV and a handful of specialty physicians, DOC lacks cost effective rates for inpatient and outpatient hospital services, specialty physician services, and other ancillary medical care services. These expenditures accounted for nearly 28 percent of total DOC medical spending by institutions and field units in FY 1993.

To some extent, the absence of negotiated rates with individual medical providers is understandable given the history of medical care in correctional settings and the decentralized organization and management structure of DOC. In the past, medical services have not figured prominently in many institutional and field unit budgets in terms of overall expenditures. As a by-product, correctional institutions have not developed expertise in managing medical payments. However, because of the lack of negotiated reimbursement rates for other hospitals and physician services, DOC may have foregone about $811,000 in FY 1993, assuming DOC used the 80 percent rate used by other health insurers.

The establishment of additional negotiated rates has been hindered by the lack of cost and service data. Medical service needs and costs have not been tracked or quantified in a meaningful way, making it difficult to determine the frequency and intensity of medical services purchased by correctional facilities. Consequently while many third party payers promise volume to offset price discounts for medical care services, DOC has lacked the expertise and data to leverage discounted payment rates with community providers. Powhatan Correctional Center appears to be the exception to this.

Powhatan has been successful in obtaining negotiated, cost effective payment rates for on-site specialty medical care providers. Powhatan has the only medical administrator, officially classified as a correctional institution operations officer, employed at the institutional level with full responsibility for the operation of an infirmary. This has aided the medical department in negotiating cost effective payment rates with a handful of physicians with specialties in orthopedics, urology, and dermatology. As a major infirmary, Powhatan has been able to assure inmate volume to negotiate discounted rates. Additional indirect costs are saved because many of these clinic services and associated outpatient surgery can be provided on-site, thereby reducing costs associated with transportation and security needed in transports. DOC is attempting to establish Greensville as a regional facility like Powhatan. However, DOC has been less successful at managing the costs of care effectively at Greensville for a number of reasons. Details on Greensville are discussed in the following chapter.

As the inmate population, their need for medical services, and related medical care costs increase, DOC will need to pay more attention to payment issues and seek to maximize scarce resources by obtaining competitive rates for medical care services. There will be a continued and growing need for community providers to fill the medical care needs of inmates located in remote, rural areas of Virginia. It is not practical that MCV meet the total medical care needs of inmates in the State DOC system. With its location in Richmond and its teaching mission, MCV may not be the most cost effective provider for many hospital services.

Given the current administration of medical care services in the department, it is unlikely that DOC has the capability needed to negotiate with community medical providers for services. However, there are several options that DOC could pursue to maximize its medical care dollars. One alternative is to develop regional purchasing pools for medical services. In addition, DOC could use existing State expertise available in other State agencies to assist in the negotiation of medical payment rates.

Currently, the State plays a major role in the delivery and financing of health care services through the State employee health benefit program administered by the Department of Personnel and Training; the Medicaid program administered by the Department of Medical Assistance Services; the State Health Department; the Department of Mental Health, Mental Retardation and Substance Abuse Services; State teaching hospitals; and through other smaller residential programs which must provide medical care services. As a major purchaser of medical care services, the State could exercise its leverage by assisting DOC in purchasing more cost effective medical care services for inmates. In addition, State health care expertise could be used to help the department develop needed reimbursement policies as indicated below.

Recommendation (19). **The Secretary of Public Safety should establish a task force to assist the Department of Corrections in developing more cost effective mechanisms for purchasing medical care services. This task force should be comprised of representatives from the Department of Personnel and Training; the Department of Medical Assistance Services; the Virginia Health Department; the Department of Mental Health, Mental Retardation and Substance Abuse Services; and the State teaching hospitals. DOC should also explore developing regional purchasing pools to maximize inmate health care funding in conjunction with the task force. Progress of the task force should be reported to the Joint Commission on Health Care by September 1, 1994.**

Reimbursement Policies Need To Be Established for Medical Care Services. Reimbursement policies are often established by third party payers of medical care services. These policies set the payment guidelines for medical care providers to discourage inefficient, costly, and questionable billing practices. Currently, the department has no policies in place to address issues regarding how medical care providers will be reimbursed. Throughout the institutions and regions, medical bills are paid without methodically determining the accuracy or appropriateness of the services being billed. Consequently, the department may be making duplicate payments to medical providers which are costly for the State. For example:

JLARC staff reviewed DOC financial payments to one large physician practice. This practice regularly sees DOC inmates and was paid $1.3 million for services in FY 1993. The review raised concerns about the process and content of medical billings and payments. Duplicate payments for services provided to inmates were noted. In addition, often DOC did not receive some bills until six to 12 months after the services were rendered. Because DOC facilities do not methodically track medical bills for services, often late bills made it difficult for these facilities to meet their payment obligations within a specific fiscal year. Furthermore, medical staff at some institutions complained about receiving bills from several physicians in the group for similar procedures performed for the same patient on the same date. Efforts to challenge these bills have been hampered by the volume of billings received, lack of staff, lack of expertise by institutional accounting staff in processing these bills, and the need to meet State prompt payment guidelines.

* * *

At JLARC request, a registered nurse who specializes in reviewing medical bills examined several outpatient hospital invoices for one major institution for FY 1993. The nurse identified several billed items that could be disputable. These included: (1) unbundling of laboratory services to charge separate rates for those services which are normally tested from one specimen and bundled together into one charge, (2) charges for professional reading of radiological services for which the physician also billed, (3) charges for radiological services which include multiple views which should be part of the charge for the overall service, (4) charges for services that should be included in the price of the clinic visit, (5) charges for multiple nursing observations in the emergency room, and (6) duplicate charges for the same service.

Based on the above review, the cost of potentially disputable billed items amounted to approximately 16 percent of the total charges. Total payments by DOC facilities to this hospital for outpatient and emergency services and the physician group that provides physician services amounted to almost $2.1 million in FY 1993. If reimbursement policies had been in place and even ten percent of the costs had been successfully disputed, it is possible that DOC could have saved up to $205,000.

If reimbursement policies and procedures were developed, bills could be checked for accuracy and appropriateness before they are paid to prevent excessive payments. Notifying hospitals and physicians that payments will be made according to established reimbursement guidelines may also discourage providers from billing services that could be disputed. In addition to disputing payments for services, controls are not in place to prevent DOC from making duplicate payments to vendors. In FY 1993, more than $34,000 was returned by vendors for duplicate payments made by two institutions with large medical expenditures. Most returned payments appear to be initiated by responsible vendors and not through DOC efforts.

To prevent inappropriate and duplicate payments for medical services, most other third party payers have instituted reimbursement policies. For example, the State Medicaid agency has a number of reimbursement policies that cover allowable charges for medical services. Medical care providers must bill within one year of the date of the service or risk denial of payment. If a specialist bills for a limited surgical visit, the specialist cannot bill a separate charge for removing sutures. The Medicaid program will not pay for nursing observations rendered as part of an emergency room visit, unbundled lab services if they can be billed as a group, or for technical readings of X-rays and electrocardiograms if billed by both the hospital and physician. Moreover, the Medicaid agency has controls in place to ensure that it does not pay for the same medical invoice more than once. DOC should consider adopting some of the Medicaid program's reimbursement policies for use in the correctional system.

Recommendation (20). **The Department of Corrections should develop and implement system-wide reimbursement policies for medical care services immediately. The policies could be modeled after State policies which already exist for the Medicaid program and for the State Employee Health Benefits Program. The detail of the policies could be developed with assistance from the task force noted in the previous recommendation. Reimbursement policies should be communicated to medical care providers as soon as available.**

Cost Management through Utilization Review Needs to Be Emphasized

Utilization review mechanisms provide a tool to ensure that only appropriate, medically necessary care is provided to patients. Often these reviews supplement established reimbursement policies developed by third party payers. It is possible that some medical charges could be disputed and costs recovered if DOC implemented a full range of utilization review activities along with reimbursement policies.

Utilization review involves monitoring the use of medical services to determine medical necessity of services, assess the appropriateness of medical care, and prevent excessive payments to providers for services rendered. Utilization review mechanisms for assuring quality medical care have been pursued only in a limited manner with the Medical Society of Virginia Review Organization (MSVRO). In FY 1990, DOC initiated a contract with MSVRO to provide:

- concurrent and prospective utilization review of all adult inmate admissions to MCV with length of stay certified as medically necessary
- retrospective quality review of institutional ambulatory care at one major institution on a quarterly basis
- outpatient pre-certification
- second opinion review of elective procedures and consultations by board certified physicians in cases denied by the DOC chief physician.

DOC also requested MSVRO to conduct ten cost audits in FY 1992. Cost audits are retrospective reviews of inpatient bills to identify inappropriate billing of services not rendered.

DOC has never fully implemented utilization review activities on a system-wide basis as part of an overall cost management strategy. Utilization review for the department has been restricted to inpatient concurrent reviews, outpatient pre-certification, second opinion reviews, retrospective reviews, and a few cost audits. DOC could obtain additional costs savings by better utilizing its contract with MSVRO in three ways. First, DOC could use information obtained in retrospective hospital utilization reviews to deny medically unnecessary services which have been provided. Second, DOC could expand the number of cost audits conducted to identify inappropriate payments made to hospitals for services and expand the number of hospitals reviewed. Third, DOC could increase the number of concurrent and second opinion reviews conducted by the utilization review contractor.

DOC Could Make Better Use of Retrospective Reviews. DOC's utilization review contractor conducts retrospective reviews of DOC inmate inpatient stays at MCV when a patient has been discharged from the hospital before the utilization review analyst can examine the care provided to the inmate. Staff at MSVRO indicated in an interview that they believe that retrospective reviews could result in potential cost savings for DOC by identifying unnecessary hospitalizations. For example, MSVRO could recommend denial of payment for an inmate who stays in the hospital over a weekend when the inmate could and should have been discharged on Friday. However, MSVRO officials stated that DOC should implement agreements with medical providers so that providers are informed of DOC's utilization review procedures. This would ensure that providers do not challenge DOC payment denials resulting from the retrospective reviews.

DOC Should Increase the Number of Cost Audits Conducted to Achieve Potential Savings. More widespread use of cost audits could also ensure that DOC payments to hospitals are cost effective. MSVRO conducted cost audits for ten inmate inpatient stays in FY 1992. These audits resulted in the identification of about $15,000 in inappropriate charges, which average $1,500 in savings from each cost audit conducted. However, the department did not request any of these audits in FY 1993. Cost audits appear to be a means of ensuring that DOC payments for inpatient services are accurate and appropriate. Expanding the number of cost audits conducted appears to be cost effective.

DOC Should Increase the Number of Concurrent and Second Opinion Reviews Conducted. The department does not use the utilization review contract to regularly review inpatient services at any of the other hospitals the department uses. Furthermore, use of the contract to conduct second opinion reviews is limited. Payments to hospitals for inpatient services other than MCV represented 31 percent of all inpatient hospital payments in FY 1993 and amounted to more than $1 million. By limiting the number of concurrent and retrospective reviews to one hospital, the department is missing an opportunity for cost savings.

Second opinion reviews are conducted on all decisions in which the DOC chief physician has denied the request of the facility physician for off-site medical care for inmates, such as elective surgery, clinic visits, tests, and other services. In FY 1993, the chief physician received a total of 2,478 requests for off-site care for inmates. Of these, the chief physician approved 2,389 requests and denied 89 requests. These 89 cases were referred to the utilization review contractor for a physician's second opinion of the medical necessity for the service.

Staff at MSVRO stated in an interview that, on average, 80 percent of the second opinion reviews conducted by their physician reviewers support the DOC chief physician's decision to deny the off-site care. According to MSVRO data from calendar year 1992, this assertion appears accurate. Currently, the chief physician appears to deny only about 3.5 percent of all requests for off-site care (89 of 2,478 total requests for off-site care). This suggests that either all requests for off-site care are absolutely medically necessary or that the chief physician is only referring the most extreme cases to MSVRO for review. It is possible that DOC could expand its use of second opinion reviews to additional cases for which the necessity for the off-site care is questionable. This could result in additional cost savings for the department.

Recommendation (21). **The Department of Corrections should implement a plan to conduct a full range of utilization review activities for medical services. Utilization review should include hospital preadmission reviews, concurrent reviews, retrospective reviews of services, and cost audits. The department should consider expanding these reviews to cover all hospital inpatient services and outpatient and emergency room services.**

Recommendation (22). **The Department of Corrections should establish agreements with hospitals notifying them of utilization review activities which could result in payment denials. The department should increase its use of those utilization review activities at all hospitals regularly used which could result in cost efficiencies, such as retrospective reviews and cost audits. Once agreements are in place, the department should take steps to recover payments that have been inappropriately made based on utilization review activities.**

Better Utilization of DOC Infirmaries and On-Site Services Could Result in Savings

During the period of this review, DOC had ten institutions with medical infirmaries located throughout the State. In addition, during FY 1994, three new institutions will become operational with medical infirmaries. Currently, only two institutions are "designated" as major infirmaries to serve other correctional institutions and field units — Powhatan and Greensville. However, these infirmaries are not being used equally. In addition, other existing infirmaries could be better utilized to serve more DOC inmates and provide a more comprehensive set of services on-site. Delivery of on-site services would be more cost effective, because it would reduce security and transportation costs associated with off-site care. Furthermore, provision of services on-site lessens the escape risk associated with transportation of an inmate off-site.

While both Powhatan and Greensville have major regional infirmaries, the use of these infirmaries is disparate. For example:

> *During FY 1993, more than 4,650 inmates were seen at on-site clinics that were held at Powhatan. For the same period, about 3,000 inmates were seen on-site for similar clinics at Greensville. In addition, the operating room at Powhatan was used for outpatient procedures on 417 inmates while the Greensville operating room served 320 inmates.*
>
> *Furthermore, for the same year, Powhatan provided medical services for inmates from 30 other DOC facilities which totaled approximately $114,000. Greensville provided medical services for inmates from 22 other DOC facilities which totaled $55,000.*

These statistics suggest that, while Greensville has larger and newer medical facilities compared to Powhatan, DOC is not utilizing the Greensville infirmary as the system-wide resource it was intended to be.

DOC has begun to explore providing more services on-site at infirmaries other than Powhatan and Greensville. For example, DOC has attempted to provide a more comprehensive set of on-site services for female inmates at VCCW. However, the lack of space and antiquated condition of the VCCW's facilities have impeded these efforts. Currently, DOC is conducting minimal renovations at VCCW to provide additional clinic space in the basement of the building housing the infirmary. In addition, VCCW hopes to contract for on-site dialysis services as well as mammograms provided by a mobile radiological service.

Nevertheless, DOC could expand its capacity by more fully utilizing other infirmaries located throughout the State. Infirmaries have varying capacity and equipment to provide services. Adding services on-site at some of these infirmaries may require additional specialty personnel, upgraded equipment, and/or service volume. However, in some cases, poor utilization may be due to the fact that the availability of medical services and the capacity of some infirmaries are not widely known within the DOC system. In fact, the health services administrator could not provide JLARC staff with an accurate count of available medical beds in the DOC system.

Some infirmaries appear to be ideally suited for better utilization of needed on-site medical services. For example:

> *Bland Correctional Center has an infirmary which contains the following: two exam rooms; one treatment room; a physical therapy room with two whirlpools, one sitz bath chair, and oxygen; a pill room from which medications are dispensed; a nine-bed ward for ill inmates; four isolation cells for ill inmates who need to be segregated from other ill inmates; a small lab area; a room which contains X-ray equipment; an exam room for optometry services; a dental operatory and X-ray room; and a room for medical records. In addition, it has a common room where inmates wait to be seen.*

Review of the infirmary's average daily census for a three-month period in FY 1993 indicated that, on average, only three beds were occupied in the ward and only one of the isolation / segregation cells was occupied. This may be due, in part, to the fact that most inmates requiring infirmary care are sent to Powhatan and Greensville. However, Bland has numerous medical assets that could be used more productively.

Bland appears to have relatively good physician coverage. Bland makes extensive use of community providers. Bland has been successful in establishing a good working relationship with a community hospital in Radford to provide inpatient and outpatient services. The community hospital also has a semi-private secure inpatient room which is available to Bland, as well as the local police and sheriff departments, for inpatient care. Radford is located about 30 minutes from the Bland Correctional Center.

In addition, a quality assurance review conducted by staff in OHS saw potential for greater use of the facilities at Bland.

The chief nurse noted that "it appears that the present 13-bed infirmary could be enlarged and this will be explored by central office staff. They have and use equipment that could benefit a number of inmates with chronic medical problems."

As of August 1993, DOC still had not taken steps to make use of this potential.

At other institutions with infirmaries, better utilization could occur as DOC addresses problems with nurse recruitment and compensation, physician shortages, and antiquated equipment. For example, Buckingham Correctional Center, located in Dillwyn (one hour west of Richmond), has a five-bed ward and one isolation/segregation cell. JLARC staff review of infirmary census data indicated that occupancy rates were even less than those at Bland. While Buckingham has an X-ray room, a dental operatory, exam rooms, a treatment room, and medication dispensary, physician coverage has been a problem as well as vacant nursing positions. In addition, some equipment at Buckingham needs to be upgraded. A new facility located next to Buckingham — Dillwyn — also has four infirmary beds and two respiratory isolation cells and is handicapped accessible. It is possible that Buckingham and Dillwyn could be used in a complimentary way to attract medical providers and provide additional medical services on-site.

Recommendation (23). **The Office of Health Services should conduct a comprehensive survey of medical services available, medical equipment, and medical capacity at each Department of Corrections institution to determine if existing DOC infirmaries could be better used to provide medical care services. Survey results should be made available to all medical care staff at institutions and field units. In addition, based on the survey information, plans should be made on a regional basis to determine how existing infirmaries can be better utilized to provide needed medical services to DOC inmates.**

Cost Containment Policy Options to Explore

In addition to implementing several management actions to save costs, there are some medical cost containment policy options that DOC should explore or continue to monitor on an ongoing basis for their feasibility in Virginia. Correctional systems in other states have implemented some of these options but their cost saving outcomes are not clear. This review identified three options to be evaluated by the department. They are:

- mandatory HIV testing of inmates
- alternative housing arrangements for inmates with HIV and AIDS.
- offering parole eligibility based on an extreme medical condition.

Mandatory HIV Testing of Inmates. Inmates who are HIV positive have special health needs. However, medical personnel need to be aware of those inmates who are HIV positive in order to provide appropriate medical case management and adequately meet their health care needs. Mandatory testing would provide medical staff with necessary information to better treat these inmates. In addition, aggregate data on the number of inmates with HIV could be used to develop plans concerning the education, medical care, and treatment of inmates. This information could assist the department in developing sound alternatives for providing cost effective and humane treatment and housing for inmates who are HIV positive.

However, the Joint Subcommittee Studying Acquired Immunodeficiency Syndrome reached a consensus that widespread mandatory testing would not be cost effective or good public policy for several reasons. First, mandatory testing has raised concerns about confidentiality concerning the privacy of tested individuals. Second, the HIV test does not always identify individuals who are indeed HIV positive. Finally, the Subcommittee estimated the cost of HIV testing to be about $30 per tested individual. Experts who testified to the Subcommittee stated it was unclear what value mandatory HIV testing of the prison population would have. Annually testing the current population of about 17,000 inmates would cost $510,000 a year. However, DOC should continue to monitor issues related to mandatory HIV testing for inmates because it is an issue subject to ongoing changes.

Alternative Housing Arrangement for Inmates with HIV and AIDS. While DOC data are not available to estimate the actual costs, HIV positive inmates and inmates with AIDS account for a significant portion of medical care costs. One DOC physician estimated it costs $10,000 a year to treat an inmate with HIV. Furthermore, the DOC central pharmacy spent more than $200,000 in FY 1993 on drugs to treat AIDS and HIV positive inmates.

The federal Agency for Health Care Policy and Research estimated the cost of treating someone with HIV averages $50,174 from initial infection until a diagnosis with AIDS. The estimated average cost of treatment for a person diagnosed with AIDS is $69,100 based on an average survival time of 29 months from the time of an AIDS diagnosis to death. Therefore, the estimated average lifetime cost to treat someone with HIV from the time of infection to death is about $119,000.

Special housing for seriously ill AIDS inmates is one option to potentially restrain medical costs for these inmates and better manage their medical care needs. Virginia currently cares for a number of inmates with AIDS requiring more intensive medical care at the Powhatan infirmary. Currently, there are at least 38 inmates with a diagnosis of AIDS in the Virginia correctional system, of which 15 are located at the Powhatan infirmary. The remaining inmates with AIDS are located throughout the DOC system.

One state is designating a medical facility as its AIDS infirmary. As such, it will have the capability of providing medical and hospice-type care to its inmates with AIDS. Florida's AIDS facility will hold 150 of the most seriously ill AIDS inmates. Centralizing medical and hospice care for AIDS inmates in one facility is an improvement over using infirmary beds scattered throughout the system for three reasons. First, management of AIDS cases requires special knowledge and treatment that is different from traditional infirmary medical care. Centralizing these cases in one facility could enhance their medical care and treatment. Second, a hospice-type environment could provide psycho-social services and comfort care for inmates that are dying of AIDS. Third, centralizing the care of AIDS inmates may save the system money because it would open infirmary beds for other sick inmates needing medical care and allow special social programs geared to AIDS inmates to be conducted at one place.

Another option to restrain costs related to HIV and AIDS is to separate those inmates from all other inmates. National studies document that the number of inmates with HIV is rising. The numbers are rising because: (1) before incarceration, many inmates engaged in high-risk activities such as drug use, and (2) despite regulations against sexual relations within prisons, such relations do take place in prison and can spread the virus. For example:

> *In Virginia, a DOC physician related the story of an inmate who had been incarcerated for more than 30 years. Upon a self-requested test, the inmate was found to be HIV positive. The inmate could not have contracted the virus before entering prison because HIV was not a concern when the inmate was incarcerated. Furthermore, the inmate acknowledged having sexual relations with another inmate who subsequently died of AIDS. The inmate who died of AIDS also had relations with other inmates.*

To contain the costs of treating inmates infected with HIV, Alabama conducts mandatory HIV testing and has centralized housing for these inmates. This prevents HIV infected inmates from having relations with other uninfected inmates. Discrimination issues related to this separate housing have been legally resolved for the most part. Furthermore, Alabama believes they are saving costs by providing care for inmates at one institution instead of several.

DOC does not maintain sufficient data to identify trends related to HIV infected inmates. However, the rising number of national AIDS cases and the attendant cost of care necessitate that options to treat these inmates be explored. DOC needs to monitor the outcomes of mandatory HIV testing and alternative housing arrangements for HIV

positive inmates in other states to determine their feasibility as an option to restrain the growth of HIV infected inmates in the DOC system and to reduce costs of their medical treatment. If deemed feasible, the Department of Corrections should prepare a plan to implement them in Virginia and recommend any needed legislation to authorize the changes in procedures and care.

Special Parole Eligibility for Debilitated Inmates. Compassionate medical parole eligibility for terminally ill, chronically ill, or severely handicapped inmates is another option to contain costs. Inmates who are debilitated pose less of a threat to the public and they account for a large portion of DOC medical expenditures. Since parolees must provide their own medical care, placing these inmates on parole may enable them to qualify for Medicaid as a disabled beneficiary. To do this, legislation may be needed to create a special parole eligibility based on medical condition.

Nationally, the literature indicates that several states have provisions for compassionate release of debilitated inmates, however, there is limited information on how often these programs are used. The Governor's Office developed a compassionate release policy at the beginning of 1992. However, this fairly rigid policy pertains to only terminally ill inmates and to date, only two inmates have been released through this action. Greater flexibility in the compassionate release policy through the parole process may provide an avenue for reducing medical costs.

The policy for compassionate release is based on the Governor's Constitutional power to grant executive clemency. After receiving a request for clemency, the Secretary of Public Safety forwards the request to the director of DOC. The policy requires that a DOC committee solicit independent medical opinions about the condition of the inmate to assess whether the inmate has an illness which will likely result in death within ten to 12 months. The committee, which includes the chief physician and an institutional warden, then determines whether the inmate will not benefit from further incarceration and whether the inmate would pose a threat to public safety. A recommendation is made to the parole board which makes a recommendation to the Governor.

Parole eligibility would have to be changed to allow debilitated inmates to be released on parole. Currently, at the earliest, an inmate can be eligible for parole after one-quarter or 12 years of his term is served, whichever is less. Since some debilitated inmates may be ineligible for parole for a long time, legislation could be passed to create a special medical parole eligibility that would allow an inmate to be considered for parole earlier than his normal eligibility date. This would provide a means to release a debilitated inmate before his actual parole eligibility begins. Legislation would allow the director of DOC to specifically recommend debilitated inmates who do not appear to pose a threat to society for parole based on their poor medical condition. Once eligibility is reached, the Parole Board could then make the final determination of whether the parole should be granted using normal procedures. DOC currently has several terminally ill, chronically ill, or severely handicapped inmates that might qualify for this earlier parole eligibility.

Recommendation (24). **The Department of Corrections should continue to monitor issues related to mandatory HIV testing and alternative**

treatment and housing options for inmates diagnosed with HIV and AIDS. If options become viable, the department should develop a plan for implementation and recommend changes to existing legislation if necessary.

Recommendation (25). **The Department of Corrections should explore alternatives for medical parole eligibility. This option should be evaluated for its legality, feasibility, and medical cost saving potential. A report on this evaluation and potential implementation should be made to the Senate Finance Committee and the House Appropriations Committee.**

Part Two: DOC Management of Health Services

V. Privatization at Greensville: An Example of DOC's Health Care Management Problems

Chapters III and IV of this report, as well as the JLARC reports on inmate dental and mental health care, have documented several of the problems that Department of Corrections (DOC) has system-wide in managing inmate health care. The two key areas of concern system-wide are that: (1) DOC does not have sufficient control over the provision of services to ensure access to care and (2) DOC does not have adequate financial controls in place to contain costs.

In addition to the system-wide findings, the issue of DOC's management of health care was examined in detail for the provision of health services at the Greensville Correctional Center (Greensville). Greensville was given substantial attention during the course of the JLARC series on inmate health care because the method of delivering inmate health services at Greensville, privatization, has been cited by some DOC officials as a potential direction for the future. DOC's pilot project for privatization at Greensville involves the provision of most health care services through a contract with a private vendor rather than through State personnel.

DOC entered into the first contract arrangement at Greensville in 1990. The initial vendor terminated the contract after 22 months. In July 1992, DOC entered into a new contract with Correctional Medical Systems (CMS). With nearly two years of experience from the first contract, it might be expected that DOC would be in a position to successfully manage the new contract and monitor the provision of services. However, findings from the JLARC dental, mental health, and medical studies indicate that the arrangement at Greensville has actually resulted in some of the most severe consequences that can be observed from DOC's shortcomings in managing health care.

JLARC staff analysis of inmate access to care and quality of care indicates that DOC has been unable to ensure that adequate access is provided. Problems in the provision of services are not addressed promptly. DOC has also been unable to ensure that the contractor complies with all provisions of the contract.

Costs of the contract for services at Greensville have significantly exceeded appropriations. For FY 1993, Greensville incurred expenditures of approximately $2.9 million more than appropriations (a 61 percent cost overrun). This was the largest overrun, in terms of total amount and percentage of expenditures exceeding appropriation, among male institutions for FY 1993. Greensville also incurred the largest total amount and percentage of expenditures in excess of appropriations among male institutions for FY 1992.

DOC has not developed an effective approach for monitoring the contract and the costs of providing care at Greensville. Faulty medical care management practices have, on occasion, threatened the health of inmates and DOC employees. If DOC is unable to obtain contract compliance by CMS, JLARC staff estimate that the department

could save an estimated $816,000 by terminating the contract and administering health care services using State employees at Greensville.

PROVISION OF CARE PROBLEMS AT GREENSVILLE

Although DOC has contracted with a vendor to provide services at Greensville, DOC still has the ultimate responsibility to ensure that inmates have adequate access to care. Therefore, DOC has a responsibility to monitor the provision of services at Greensville and to ensure that: (1) inmates have access to care, (2) documentation is available to prove that services were rendered, and (3) the contractor provides adequate care that minimizes the State's legal liability.

Analysis of the provision of services at Greensville indicates that there are substantial problems. The documentation of medical and mental health care services is poor. Physician coverage has been uneven. Problems with respiratory isolation rooms and X-ray equipment that was not fully functional were not addressed in a timely manner. Further, the contractor has not complied with contract requirements for implementing quality improvement activities. It appears that a more aggressive and effective DOC health care management presence could have remedied some of the problems.

CMS Has Poor Documentation of Health Care Provided

Appropriate documentation is one criterion for a quality correctional health care program, according to federal court decisions. Its absence can have a negative effect on the quality of care delivered and on the State's ability to protect itself from legal liability. The DOC contract for Greensville requires that CMS document health care in accordance with National Commission on Correctional Health Care (NCCHC) or Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) standards for health care documentation. JLARC staff found problems with the contractor's documentation at Greensville for mental health and medical care services.

The JLARC report on inmate mental health care noted that Greensville, like several other DOC facilities, lacked adequate records pertaining to the provision of mental health services. Mental health treatment plans were too general for use in planning or monitoring treatment, there were no identified goals and objectives for group therapy, and treatment notes were inadequate to document the care provided. An assessment of documentation at Greensville for this review of medical care indicates that CMS has not complied with the contract's requirement that it maintain appropriate inmate medical records and records of inmates' access to care such as sick call logs. Also, CMS failed to appropriately document and follow-up on tuberculosis (TB) tests.

Problems with Medical Records Documentation. A Board of Corrections standards compliance review conducted of Greensville in November 1992 observed that "review of medical records revealed incomplete organization and maintenance of docu-

ments pertaining to services rendered." In addition, a January 1993 Office of Health Services (OHS) quality assurance review of medical records at Greensville recommended that "medical records be maintained as stipulated in DOC/CMS contract 714." For this study, JLARC staff randomly selected and reviewed 42 medical records at Greensville. Problems were also identified with a lack of documentation of care, including important episodes of care. For example:

> *One inmate's medical record contained a refusal of treatment form noting that the inmate had discontinued renal dialysis treatments, which would be potentially fatal for an inmate with end stage renal disease. There was no documentation in the inmate's chart as to why the inmate wished to discontinue the treatment, whether the treatment had in fact been discontinued, or whether medical staff had counseled the inmate on the consequences of discontinuing treatment.*

Problems with Sick Call Logs. The Board of Corrections standards compliance review conducted by DOC also noted problems with sick call logs at Greensville. The OHS quality assurance review in January 1993 noted that "at the time of the visit, each housing unit had a different methodology/system regarding sick call and inmate screening." JLARC's review of sick call logs revealed that it was impossible to determine, from examining many of the sick call logs, which inmates had been seen at all and whether they had been seen by the nurse, physician's assistant, or physician. For example:

> *In one Greensville housing unit visited by JLARC staff, the list of inmates that had been seen, or were to be seen, for sick call was kept on a day calendar. For some time periods, the calendar had no entries, making it impossible to tell if any inmates had been seen. Where the calendar contained entries, these entries consistently included the inmate name and number. However, information was inconsistently available on who the inmate was to be seen by (physician, physician's assistant, nurse, or psychologist), and whether the inmate had in fact been seen. Some of the inmate names on the calendar were highlighted, and other names were not. When asked about this, the nurse on the unit stated that sometimes they begin to highlight who they have actually seen and other times they do not finish the highlighting. These records make it impossible to determine whether inmates in this housing unit have adequate access to care during sick call.*

Problems with TB Testing Documentation and Follow-up. JLARC staff also found substantial problems with the contractor's documentation of TB testing of inmates at Greensville. According to staff at the Virginia Department of Health (VDH) Bureau of Tuberculosis Control, TB testing should be documented in the medical record, individuals with past false positives should not be retested using a skin test, and positive TB test results should be immediately followed up by using more conclusive tests. The implementation of TB skin testing at Greensville during May 1993 by CMS was conducted in a manner that is inconsistent with these public health principles. During a site visit in July 1993, JLARC staff found the following with regard to tests administered to Greensville inmates in May:

- Inmate medical records had not been reviewed by CMS staff prior to administering the skin tests, so inmates with past false positives from skin tests were not identified.

- Unit nursing staff were not all informed that the test had been administered, and became aware of the testing only when inmates came to them for follow-up during sick call.

- Approximately two months after the test had been administered, inmate medical records still had not been updated to document that a TB test had been administered or to reflect the test result (although some records on the test were kept in a computer printout).

- Apparently due to poor record-keeping and communication problems, as of two months after the test, CMS had not completed follow-up testing of the inmates with positive test results.

Poor documentation of tests and test results, along with inadequate follow-up due to a lack of effective communication among nursing staff, has serious consequences. First, it has the potential to endanger the health of inmates and DOC employees. Second, it may have exposed the State to potential liability if an inmate with active TB infects other inmates or institutional staff. Given the current breakdown in testing procedures and follow-up at Greensville, an infected inmate could potentially remain in the general population for months without being detected. For example, review of inmate medical records by JLARC staff noted the following:

> *A CMS physician ordered a TB test for an inmate, who appeared to display TB symptoms, in March 1993. This was documented in the inmate's medical record and confirmed by the head nurse in his housing unit. This inmate had not been tested for TB as of JLARC's last site visit on July 15, 1993. The housing unit's nursing staff had no explanation for the failure to test this inmate, other than a breakdown in communication.*
>
> * * *
>
> *In one housing unit JLARC staff randomly selected and reviewed ten medical records of inmates who had been tested for TB according to the CMS computer printout. None of the ten charts reviewed contained any documentation of the TB test. Three of these inmates, according to CMS testing records, required follow-up testing. There was no record of any follow-up testing having been performed.*

Recommendation (26). **The Department of Corrections should require CMS to improve its medical documentation to meet DOC standards.**

Recommendation (27). **The Department of Corrections should require CMS to conform with public health standards regarding testing and necessary follow-up testing of inmates at Greensville Correctional Center for tuberculosis, and ensure that CMS staff follow these requirements.**

Physician Coverage Has Been Uneven

Medical care problems related to inconsistent physician coverage were also noted at Greensville. In particular, one general housing unit and an isolation/segregation unit at Greensville had difficulty obtaining adequate physician coverage. This violated contract provisions on physician coverage. For example:

> *The unit at Greensville housing protective custody inmates and isolation / segregation inmates had no physician coverage for several weeks from late March to early June 1993. The contract administrator for CMS states that inmates in this unit had access to physician care in an emergency, but the contract for services at Greensville states that the unit should have physician coverage for eight hours per week and physician extender coverage for 20 hours per week. In fact, review by JLARC staff indicated that the unit had only physician extender coverage for several weeks and that this coverage amounted to only about eight hours per week. For some weeks during this period, the unit had neither physician extender coverage nor physician coverage.*

In other areas, despite the contract's requirement that CMS provide physician coverage daily, a quality assurance review conducted by DOC's chief pharmacist in March 1993 found that CMS did not have a physician on-site on Mondays. This led to delays in having medication orders filled. One of the general population units, which houses approximately 750 inmates, did not have a physician assigned to it on a permanent basis from September 1992 until June 1993. This caused periodic problems with inmates access to primary care. For example:

> *While on-site at Greensville during July 1993, JLARC staff found evidence that one general population unit did not have access to either a physician or a physician extender. During that week, more than 300 inmate sick call requests were disregarded as a result of this lack of coverage. In order to be seen the following week at sick call, the inmates would have needed to resubmit a sick call request.*

These gaps in physician access created potential problems with continuity of care. Further, they clearly violated language in the contract requiring that inmates have access on all week days to a physician or physician extender. The Board of Corrections standards compliance review conducted by DOC also noted the problems with physician coverage at Greensville, observing that "routine inmate medical problems may take a week to a month to resolve." Minutes from a meeting between DOC and CMS representatives on February 23, 1993 noted a Greensville deputy warden's "concern

about lack of physician coverage." JLARC interviews with DOC administrative staff and with CMS nursing staff at Greensville continued to note concerns with physician coverage at Greensville through mid-July 1993.

Recommendation (28). **The Department of Corrections should require CMS to comply with contract requirements regarding physician access for inmates.**

DOC Provision of Support Services Has Been Inadequate

Although the State has contracted for the direct delivery of health care services, it remains responsible for a variety of support services at Greensville that potentially affect quality of care, access to care, and cost effectiveness of care. DOC has experienced difficulty in performing its support role at Greensville. DOC is responsible for maintenance of the medical facilities and for most of the medical equipment at Greensville, and has experienced problems in both of these areas. For example:

- the respiratory isolation rooms to house tuberculosis patients did not work properly for more than two years of the facility's operations

- the X-ray equipment, the infirmary's most expensive piece of equipment, did not function properly until more than two years after the facility's opening.

Respiratory Isolation Rooms Found to Be Non-Functional. Greensville was designed as the respiratory isolation facility for the Department of Corrections, and, as such, was to act as a statewide resource for the isolation of inmates with active or suspected tuberculosis. Greensville's ten bed respiratory isolation ward was reviewed in March 1993 and was found to lack sufficient negative pressure to completely refresh the rooms' air supply six times per hour. Since Greensville's opening, there had been little review of the respiratory isolation rooms by DOC officials, who assumed that the negative pressure was functioning properly.

VDH officials brought potential problems with the ventilation system for the respiratory isolation rooms to the attention of staff within OHS in 1991. However, in March 1991, DOC staff advised VDH that the ventilation system was working properly. This apparently was not the case, as a long-standing problem with the isolation cells was confirmed in March 1993, approximately two years after the facility's opening. CMS initiated a review of the negative pressure rooms after another VDH review in January 1993 noted apparent problems (an inmate was observed smoking in one of the isolation rooms and the smoke was not being filtered out of the room). Because of difficulties moving patients housed in the respiratory isolation ward to other institutions, the negative pressure rooms were not retrofitted until July 1993. The cost of the repairs was borne by DOC and amounted to $10,859. Figure 7 illustrates the sequence of events related to this problem.

In addition to having problems with determining whether the respiratory isolation rooms were working properly, DOC has experienced difficulty in managing

Figure 7

Sequence of Events Related to Respiratory Isolation Rooms

JANUARY 1991	*Greensville infirmary opens*
FEBRUARY 1991	*Inmate with multi-drug resistant tuberculosis sent to Greensville, VDH staff question if respiratory isolation rooms are functional*
MARCH 1991	*DOC staff state respiratory isolation rooms are functioning adequately*
JANUARY 1993	*VDH site visit raises further questions about respiratory isolation rooms*
MARCH 1993	*Negative pressure found to be non-functional*
JULY 1993	*Matter resolved according to Department of Corrections*

Source: JLARC staff analysis of interviews with VDH and DOC staff, memorandum dated March 1991 from chief physician to DOC staff, and memorandum from DOC Planning and Engineering to Office of Health Services dated March 1991.

patients with active or suspected TB housed in the respiratory isolation ward. These problems threatened the health of both staff and inmates. For example:

> *VDH staff reviewed the respiratory isolation ward at Greensville in January 1993. During this visit, VDH staff noted that correctional officers and inmates were not taking necessary precautions such as always using masks and that, when used, masks were improperly fitted. In addition, VDH staff recommended that DOC: ensure regular TB testing of staff working in the isolation area, implement an improved form of TB testing for HIV positive inmates, institute procedures for confining inmate movement in the isolation area to prevent the spread of TB, conduct training regarding the transmission of TB, and annually check the negative air pressure of the isolation rooms and inspect the ventilation equipment. Despite repeated requests by JLARC staff, DOC officials were unable to document that they had completed follow-up on these recommendations.*

According to DOC officials, the department intends to request additional funds during the 1994 General Assembly session to construct a more advanced respiratory isolation ward for Greensville. Each inmate room in this ward would be equipped with an anteroom, showers, and negative pressure in both rooms. The existing respiratory isolation ward would be used to house inmates with post-operative wound infections or with behavioral problems. The expected cost of this project is approximately $2.1 million.

It is not clear whether additional respiratory isolation cells are needed at the present time. There does not appear to be a consensus among DOC Office of Health Services staff about this issue. The DOC health services administrator stated that additional respiratory isolation cells are needed because the present respiratory isolation rooms, even after being retrofitted, do not function adequately. The DOC chief physician stated that the present respiratory isolation rooms are sufficient and conform to standards set by the U.S. Centers for Disease Control.

In addition, each of DOC's new facilities is equipped with two respiratory isolation rooms. The three new facilities that will become fully operational in FY 1994 will add an additional six respiratory isolation rooms to the existing ten at Greensville. DOC officials have not communicated to JLARC staff the justification for the additional respiratory isolation beds at Greensville.

Recommendation (29). **The General Assembly may wish to defer consideration of funding for additional respiratory isolation beds at Greensville Correctional Center until the Department of Corrections adequately demonstrates: (1) its ability to manage the existing respiratory isolation facility at Greensville and (2) its need for additional respiratory isolation beds at Greensville.**

X-ray Equipment at Greensville Did Not Function Fully for More Than Two Years. In addition to its responsibility for the physical plant, DOC is responsible for maintaining the medical equipment purchased as part of the facility's activation. The department made a major purchase of X-ray equipment in January 1991 at a cost of $258,000. As illustrated in the case example below, this equipment was never fully functional. Nevertheless, DOC delays in resolving issues regarding its repair resulted in the State absorbing the entire costs of the repairs.

> *Greensville's X-ray equipment was never fully functional, according to a memorandum written by a DOC engineer. This meant that inmates had to be sent off-site for some exams, resulting in additional transportation, security, physician, and testing costs. An OHS quality assurance review conducted in January 1993 by the health services administrator and chief nurse noted that "the X-ray equipment reportedly still malfunctions. This equipment has not been fully operational in a satisfactory manner since installation. The equipment has been assessed by a contractor but there is an 8 item list of malfunctions in the equipment that is dated August 12, 1992 that has not been resolved." The X-ray equipment was finally repaired by the vendor in June 1993, more than two years after the facility's opening. DOC absorbed the*

$6,634 cost of these repairs, as the warranty for the equipment had expired.

It is not clear why DOC staff could not resolve problems concerning the repair of the X-ray equipment in a timely manner. Staff at the institutional and central office level have denied responsibility for the matter in interviews with JLARC staff. In addition, these staff could not satisfactorily explain why the equipment had not been repaired or who was responsible for the cost of the repairs.

Quality Improvement Efforts by CMS Have Been Minimal

The contractor at Greensville has not complied with contract requirements for implementing quality improvement activities. The contract requires that "All Medical services shall be provided in accordance with JCAHO or NCCHC standards." The contract further requires that the "Contractor shall institute a quality assurance program consistent with VDOC Medical Quality Assurance Program."

According to the CMS response to the DOC request for proposal for health care services at Greensville, the contractor's goal at Greensville was to achieve accreditation by JCAHO. Achieving JCAHO accreditation would be significant in terms of attracting both staff and contract providers. CMS no longer is considering JCAHO accreditation, according to the contract administrator for CMS. CMS plans to seek accreditation by NCCHC in early 1994 but has made only minimal preparations for doing so. CMS clinical oversight committees meet infrequently and have sparse documentation, and CMS has not performed any monitoring and evaluation of the quality of care. Both properly functioning oversight committees and consistent monitoring and evaluation of care are required by accrediting bodies.

Aside from being required by the contract, quality improvement programs in health care are important because they give managers information on the quality and cost effectiveness of care delivered, and they help reduce legal liability by proactively managing risk. The contractor's lack of activity regarding quality improvement prompted the health services administrator in OHS to file a vendor complaint in May 1993 stating that "Clinical Oversight Committees [are] not established." These oversight committees, according to JCAHO and NCCHC standards, are the basis for a quality improvement program. Most of these clinical oversight committees, which are required by the contract, were not implemented until the period from January to March 1993. Documentation of the clinical oversight committee meetings is sparse and consists largely of a catalogue of staff complaints and grievances.

In addition to the slow implementation and low level functioning of the clinical oversight committees, CMS is currently performing no monitoring and evaluation of quality of care. Monitoring and evaluation of quality of care and the subsequent identification of opportunities to improve care is the basis of quality improvement activities in contemporary health care. Despite this absence of monitoring and evaluation, CMS officials insist that they will be ready for NCCHC accreditation in 1994, having revised their earlier expectation of obtaining the more demanding JCAHO accreditation.

Recommendation (30). **The Department of Corrections DOC should require CMS to specify the type of accreditation that it intends to pursue for its operations at Greensville Correctional Center and should set a firm deadline for CMS to accomplish accreditation. This deadline should not be later than June 30, 1994.**

DOC MANAGEMENT OF CONTRACT COSTS

DOC has experienced problems with the current contractor at Greensville similar to those it experienced with the initial contractor. These problems include costs that significantly exceed appropriations and questionable contract modifications. Greensville incurred the largest costs in excess of appropriations for health care of all DOC male institutions in FY 1992 and in FY 1993. In terms of the percentage of appropriations expended, Greensville also had the largest proportion of overruns in FY 1992 and in FY 1993. DOC needs to establish responsibility for the Greensville contract at the central office level and to clarify responsibilities for contract oversight at the institutional level. If DOC cannot resolve problems with its current contractor regarding the costs of care and the contractor's noncompliance with contract provisions, then DOC should prepare to directly deliver inmate health care at Greensville.

Management of First Greensville Contract Was Problematic

Southside Medical Systems was the initial contractor for providing inmate health care at Greensville. Later Southside Correctional Care was formed and assigned the contract. Costs of care during Southside Correctional Care's tenure exceeded appropriations and appear to have exceeded the contractor's cost estimates. Further, DOC allowed questionable contract modifications that were not fully communicated within the department and may have raised the cost of the contract. The contractor contended that it did not realize the expected level of profit at Greensville and gave notice to terminate the contract at the end of FY 1992.

Contract Exceeded Projected Costs. The contract specified that Southside should be paid on a cost-plus-fixed-fee basis. Under this arrangement, Greensville paid Southside for the costs of pharmaceuticals, supplies, and the amount of the actual salaries of the Southside medical personnel plus a 19 percent fringe benefit cost. Clinic services and inpatient and outpatient hospitalizations were billed to Greensville as a fixed fee per inmate.

At the time the contract was prepared, Southside estimated the cost of providing services would be nearly $3.9 million for its first full operational year of the contract. However, this estimate did not include annual cost projections for off-site care and dialysis. In FY 1992 Southside was paid $5,333,249, and in FY 1993 Southside was paid $839,445 for services rendered in FY 1992. Greensville's medical expenditures in FY 1992 totaled nearly $7 million, including payments to Southside by other correctional facilities and expenditures for associated off-site care. This exceeded DOC's FY 1992 medical appropriation for Greensville of $4.3 million by more than 50 percent.

Although the cost of the contract was clearly greater than estimated, an accurate determination of where overruns occurred cannot be made. Some annual service costs were not estimated, and Southside's billing statements to Greensville lacked specificity as to whether some services were performed on-site or off-site. Nevertheless, DOC attributed these cost overruns to a lack of experience with health care contracting.

Southside terminated the contract effective June 30, 1992 because its profit margin was less than expected. Southside claimed it needed more medical positions than it was allowed, and to attract personnel, it had to compensate them more than the State allowed for the positions. In addition, Southside claims it incurred costs for carrying accounts payable for pharmaceuticals and supplies which were not reimbursed by the State.

Contract Modifications Were Poorly Communicated. Southside also engaged in practices not sanctioned by the contract, according to DOC's interpretation of the contract. An internal audit by DOC revealed that Southside had marked up pharmaceuticals and consumable supplies by ten percent, contrary to contract provisions and Section 11-43 of the *Code of Virginia*. In addition, Southside billed DOC for positions and compensation not specified in the contract. Southside contended that the modifications were agreed to orally by DOC personnel. DOC performed an internal audit of the contract with Southside and while the audit revealed that oral contract modifications had been allowed, several of Southside's practices did violate the contract and the *Code of Virginia*. For example:

> *The DOC audit found that several contract modifications were approved orally or in writing by DOC officials. For example, the health services administrator approved one contract modification in a memo, while others appear to have been approved orally. Modifications to the contract raising the price of the contract have to be approved by DOC's chief deputy director. Because the health services administrator was not authorized to make modifications affecting the cost of the contract and oral modifications violated DOC policy, the internal auditor recommended that contractor bills for inappropriate modifications be denied.*

DOC withheld more than $80,000 from Southside's final payment to offset these inappropriate contract modifications. Southside's noncompliance with the contract and cost overruns during the contract period were exacerbated by the lack of close monitoring. Originally, there was no on-site contract monitor for the Greensville contract. In May 1991, a position classified as a mental hospital administrative services supervisor was made responsible for serving as the on-site contract monitor at Greensville. However, many of the oral modifications to the contract were not documented sufficiently to allow the DOC on-site contract monitor to identify noncompliance on the part of the contractor. In addition, the on-site monitor did not have the authority to rectify billing problems until the last month of Southside's contract. These problems have been repeated during the current contract.

Costs of the CMS Contract Exceed Appropriated Amounts

Although the costs of the current CMS contract at Greensville have significantly exceeded appropriations for FY 1993, DOC does not yet know the final cost of the contract for FY 1993. However, it is expected to exceed the amount set forth in the contract by more than $1.5 million and appropriations by about $2.9 million. DOC cannot adequately monitor the contract's costs because it has not resolved billing problems with the contractor.

Summary of Contract Costs for FY 1993. The CMS contract was designed to be a "fixed fee" contract, where one monthly amount paid to the contractor would substantially defray inmate medical care costs at Greensville. The contract set this monthly fee at $491,000 for the first year of the contract, for an annual payment of $5,892,000. The monthly fee was to cover costs of:

- salaries and benefits for the contractor's employees
- operating expenses for on-site primary and infirmary care for Greensville and non-Greensville inmates
- the medical care pool, an estimated $1.2 million cost for off-site care and on-site specialty care (1/12 of the expected cost of this care for the year was to be paid each month).

In addition, any supplies provided to the contractor by the State and salary costs of vacant positions were to be deducted from the fixed monthly amount.

If specialty care costs could be held to less than the $1.2 million paid as part of the monthly fee for the first year of the contract, the State and the contractor were to split the savings. As for any off-site care expenses exceeding $1.2 million, the first $300,000 in additional expenses were to be split between the contractor and the State, for a total of $1.5 million in shared responsibility. However, any costs beyond the total of $1.5 million were to be absorbed completely by the State.

DOC paid monthly invoices to CMS totaling $5,269,793 in FY 1993. In addition, a bill for the fixed payment for June 1993 of $466,296 was submitted after the end of the fiscal year, for a total of $5,736,089 in monthly fees incurred in FY 1993. Other costs of services at Greensville included repairs of equipment and expenses for State employees assigned to medical care. These totaled $491,244 in FY 1993. Including an estimate of more than $1.3 million as the outstanding liability for the medical care pool, the total estimated cost of medical care provided in FY 1993 at Greensville is $7.6 million. These costs are detailed in Table 7.

A comparison of Greensville's appropriations for medical care and estimated costs incurred for FY 1992 and FY 1993 shows that the Southside Correctional Care contract and the Correctional Medical Systems contract combined were approximately $5.4 million in excess of appropriated amounts. The 1993 General Assembly approved a $968,300 special appropriation for FY 1994 to cover cost overruns of the Greensville

Table 7

Medical Care Costs Incurred at Greensville Correctional Center FY 1993

Expenditure Type	Amount
Monthly invoices paid to CMS in FY 1993	$5,269,793
June 1993 invoice incurred in FY 1993	466,296
State expenses (salaries and miscellaneous)	491,244
Medical care pool utilized but not paid	1,350,000*
Total	$7,577,333

*Estimated costs according to CMS Regional Controller, July 28, 1993.

Source: JLARC staff analysis of DOC CARS expenditure data for Greensville Correctional Center, FY 1993, and CMS Regional Controller estimate, July 28, 1993.

contract, but JLARC staff estimates suggest that this special appropriation will not be sufficient. Table 8 illustrates the appropriations and actual expenses for medical care at Greensville for FY 1992 and FY 1993.

DOC's contract with CMS stipulated that CMS bill DOC monthly. Throughout the first year of the contract, CMS has not been able to produce invoices in a timely manner with adequate information for DOC staff to verify expenditures sufficiently.

Table 8

Comparison of Appropriations and Costs of Contracts for Inmate Health Care at Greensville FY 1992-FY 1993

Fiscal Year	1992	1993	Total
Appropriation	$4,369,911	$4,695,263	$ 9,065,174
Expenditures incurred	$6,917,099	$7,577,333	$14,494,432
Difference in expenditures incurred from appropriations	($2,547,188)	($2,882,070)	($5,429,258)
Expenditures incurred as a percentage of appropriations	158 percent	161 percent	160 percent

Source: JLARC staff analysis of DOC CARS expenditure data for FY 1992 and FY 1993, and 1992 and 1993 Appropriation Acts.

This has made it difficult for DOC to: (1) determine whether charges for services were accurate and appropriate, (2) assess whether costs of the medical care pool were consistent with projected amounts, (3) prepare contingency plans if the costs of the medical care pool were higher than expected, and (4) determine the overall costs of health care at Greensville. As of mid-August, these billing issues had not been resolved.

The two parties met in September 1992 on this issue and apparently DOC staff orally agreed to grant CMS 120 days to address its billing problems. Therefore, DOC did not receive bills for either the medical care pool or the contract base until February 1993, seven months into the contract. At this point it became evident that DOC was facing significant unanticipated charges for medical services at Greensville from the medical care pool.

Medical Care Pool Costs Remain Unclear. As of mid-August 1993, DOC had not determined within $500,000 the final cost of the medical care pool for FY 1993. Estimates of its cost by DOC officials range from under $1 million to $1.5 million. Regardless, the State remains liable for approximately $1 million or more in unanticipated charges incurred in FY 1993.

DOC did not receive the first bill for the medical care pool until February 1993. At that time, the total charge for services billed to the medical care pool was $962,460. DOC officials realized that the costs for services charged to the medical care pool would substantially exceed the expected $1.2 million cost for FY 1993 outlined in the contract. Further, DOC's procurement and budget staff became concerned with the lack of documentation of services charged to the medical care pool. This lack of documentation made it impossible for DOC staff to verify expenditures sufficiently to obligate State funds. Representatives from DOC and CMS met on February 23, 1993 to address billing issues with the medical care pool and CMS officials promised to rectify the situation.

The situation had not been resolved by May 1993 when the health services administrator filed a vendor complaint regarding incomplete and untimely billing. The contractor's regional manager, who responded to the complaint, attributed these problems to delays in implementing an automated accounting system. DOC staff on-site at Greensville devised an *ad hoc* system for reviewing bills that did not become operational until early June 1993, less than a month before the end of the fiscal year.

At the end of the fiscal year, the amount of the State's liability for the medical care pool remained unclear. DOC does not expect to finalize the amount of the medical care pool until September 1993. Review by JLARC staff suggests that the outstanding liability may be between $1.35 million (the amount suggested by the contractor's regional controller and documented by bills submitted to date) and $1.5 million (the amount suggested by DOC's chief of operations for programs). The total amount is expected to be higher than $1.35 million, because some bills for services in FY 1993 have not yet been received. However, JLARC staff used the $1.35 million amount in calculating the costs of care at Greensville in order to provide a conservative cost estimate. As DOC has already paid $1.2 million for the medical care pool as part of the contract's fixed monthly fee, the final total cost of the medical care pool is estimated to be between $2.5 million and $2.7 million.

The CMS contract administrator attributed the high costs of the medical care pool to costs associated with providing care to DOC inmates housed at other institutions and field units. However, review by JLARC staff indicated that this care amounted to slightly more than $55,000, roughly four percent of the expected total cost of the medical care pool. The regional controller for CMS indicated that DOC agreed to allow the $55,000 cost of caring for non-Greensville inmates to be billed separately from the medical care pool. JLARC staff, in developing cost estimates, have included this cost in the total outstanding for the medical care pool.

The CMS contract administrator and the CMS medical director at Greensville also indicated that DOC has been "dumping" older and sicker inmates on Greensville but offered only anecdotal information to support this claim. DOC's lack of a patient-level data base makes it difficult to verify. However, the workload comparison in Chapter IV between Powhatan Correctional Center and Greensville suggests that Greensville is not receiving a disproportionate share of medical workload.

Interviews with DOC's budget and procurement directors in July 1993 indicated that they attributed the unexpectedly high costs of the medical care pool to: (1) the contractor's "steep learning curve" at the beginning of the contract and (2) DOC's initial refusal to allow the contractor to bill other institutions for the cost of providing care to their inmates at Greensville. DOC's rationale was that funds from the medical budgets of each institution in the system were reallocated in order to fund the medical care pool initially. Allowing CMS to bill the other institutions would essentially charge these institutions twice for the care provided. DOC officials are exploring the possibility of allowing CMS to charge other institutions for inpatient stays of greater than 24 hours in the Greensville infirmary in FY 1994, but have not made a final decision on this issue.

Recommendation (31). **The Department of Corrections should immediately clarify the costs of the medical care pool for FY 1993 and report to the House Appropriations and Senate Finance Committees before the next session of the General Assembly on these costs, as well as on expected costs for care provided in FY 1994.**

CMS Slow to Implement Utilization Review. CMS has not complied with contract requirements to perform utilization review of all outside medical care provided to Greensville inmates. This may have contributed to the high cost of the medical care pool, as utilization review is performed to limit outside care to that which is medically necessary and appropriate. As Chapter IV illustrates, utilization review can result in significant cost savings. According to interviews with the contract administrator and medical director at Greensville, CMS has a three stage utilization review process: (1) the unit physician writes a request for off-site care or infirmary care to the medical director, (2) the medical director approves or disapproves the request, and (3) if the procedure requested is part of the contractor's "prior approval list," then the request is forwarded to CMS headquarters for review by utilization review staff. These staff make the final decision on approval or disapproval.

However, CMS did not implement its utilization review process at Greensville until May 1993, ten months into the contract. This slow implementation of utilization

review prompted a vendor complaint in May by the health services administrator in OHS. This vendor complaint suggested that the delay in implementing utilization review was responsible for the unexpected costs of the medical care pool outlined earlier in this chapter. CMS blamed delay in implementation on the shortage of physicians, which required the CMS medical director to act as a unit physician.

In addition to its late implementation of utilization review, CMS appears to be experiencing problems in communicating its utilization review process to its staff. CMS nursing staff have complained about inadequate training in utilization review and delays in the scheduling of needed appointments. CMS officials indicate that nursing staff are trained in utilization review as part of orientation and do not need additional training, suggesting a communication problem between staff and management. This communication problem may result in problems with the quality of care provided if not addressed promptly.

Recommendation (32). **The Department of Corrections should closely monitor and evaluate Correctional Medical System's performance of utilization review activities to ensure that the State pays only for medically necessary, appropriate medical care.**

Problems with CMS Contract Reflect DOC's Ineffective Contract Management

With regard to contract modification issues, DOC continues to have problems with internal communications between the central office health services personnel, central office procurement personnel, and DOC staff at Greensville. As with the previous contract at Greensville, the costs of the current contract with Correctional Medical Systems significantly exceed appropriated amounts. DOC has not ensured that the contractor prepare timely and appropriate invoices for the department to review. In addition, DOC has not yet received clarification from the contractor of the contract's total liability for care provided at Greensville in FY 1993. The total cost of this care is known to be higher than appropriated, partially due to the contractor's failure to implement utilization review in a timely fashion. In view of these problems, DOC needs clearer accountability for the management of the Greensville contract at both the institutional and central office level.

DOC Has Not Clearly Communicated Contract Modifications to the Current Contract. DOC officials appear to have communication problems regarding modifications to the Greensville contract. As with the Southside contract, central office officials and Greensville's institutional management do not appear to be communicating effectively regarding the status of contract modifications. These problems involve communications between the institution's warden, the Office of Health Services, and DOC central office procurement staff regarding contract modifications. For example:

> *DOC's health services administrator stated that the original contract price did not take into account the salaries of the operating room staff (approximately $60,000). The administrator indicated that DOC had allowed CMS to bill these costs against the amount of the contract set*

aside to fund outside care for inmates. DOC procurement staff stated that they had no knowledge of this contract modification, and stated that any such modification, would need to be approved by the department's chief deputy director if it raised the price of the overall contract. Review of the CMS response to DOC's request for proposal indicates that no operating room staff are provided for in the "Suggested Staffing Pattern." CMS provided JLARC with documentation that the health services administrator had approved adding the operating room staff to the medical care pool, after DOC had been unable to provide this documentation. JLARC staff review of FY 1993 invoices submitted by CMS for the medical care pool show that CMS has been billing the cost of the operating room staff to the amount f outside medical care provided for inmates.

* * *

CMS requested additional licensed practical nurse (LPN) and clerical coverage for each dispensing unit on September 26, 1992. This request totaled 3.1 positions (1.5 clerks and 1.6 LPNs) at an estimated cost of $72,000. DOC's on-site contract monitor and the contract administrator for CMS both stated that this request had been sent to DOC central office for approval. DOC central office staff, including the health services administrator and the director of procurement, stated that they have never seen this request. Greensville's chief warden approved payment for two full-time clerk positions on a temporary basis in October 1992 until the request for a contract modification could be acted on by DOC central office. These positions were filled on November 1, 1992 and have been paid for monthly at an average cost of about $2,200. In January, the chief warden at Greensville approved these positions indefinitely. The chief warden also approved additional LPN coverage for weekends on an indefinite basis in October 1992. These positions have been billed monthly at an average monthly cost of about $2,000 per month. The request for a permanent modification of the contract is still marked as pending according to CMS records. DOC central office apparently remains unaware of a contract modification for which the State has paid approximately $35,000 as of mid-August 1993. Greensville's warden also granted permission to bill costs of "essential position vacancies." These have cost, for both clerical and nursing staffing, approximately $4,000 per month.

* * *

The contract between CMS and DOC does not require CMS to provide staffing on legal holidays. Since Greensville must have medical coverage on legal holidays, DOC has been paying CMS extra for providing staffing on each legal holiday. DOC has not provided any documentation of this contract modification, which appears to have

been approved orally. The cost for staffing each legal holiday is approximately $4,500, or an annual cost of about $50,000 for 11 legal holidays.

Table 9 summarizes the approximate cost of these contract modifications. DOC has allowed contract modifications potentially totaling almost $200,000 annually without clearly communicating these modifications among health services, procurement and institutional staff. In some cases these contract modifications appear to have been made without following DOC's own procedures and the contract's procedures for contract modification.

Table 9

Approximate Costs of Contract Modification At Greensville, FY 1993

Contract Modification	Annual Cost
Addition of operating room staff	$60,000
Additional clerical staffing	44,000
Additional licensed practical nurses	44,000
Holiday compensation	50,000
Total	$198,000

Source: JLARC staff analysis of documentation provided by CMS on August 11, 1993, and documentation provided by DOC on July 30, 1993; and JLARC interviews with DOC staff within the Office of Health Services, the procurement office, and Greensville Correctional Center.

Recommendation (33). **The Department of Corrections should improve its internal communication regarding contract modifications to the Greensville contract. The director of the Department of Corrections should ensure that DOC follows its internal policies, State contracting guidelines, and contract provisions for contract modifications of the contract for inmate health services at Greensville Correctional Center.**

Responsibility for Greensville Contract Remains Diffused. Responsibility for the Greensville contract is delegated to the institutional level. DOC central office officials are involved in discussions regarding the contract. However, there is no single accountable official or organizational unit in DOC's central office responsible for monitoring the contract and ensuring the contractor's compliance with its provisions. DOC's deputy director for adult institutions, the directors of procurement and budget, the health services administrator, and the chief of operations for programs have been actively involved in meetings and discussions on the Greensville contract. However, formal responsibility for management of the Greensville contract rests with the on-site

contract monitor, who is officially classified as a mental hospital administrative services supervisor (grade 13).

Currently, the on-site contract monitor reports directly to Greensville's chief deputy warden, not to DOC central office staff. The Greensville contract for inmate health care is supposed to be a pilot project for assessing privatization of inmate health care in the Virginia correctional system, but there is no central office official clearly responsible for monitoring this pilot project. Central office budget, procurement, and health services staff seem aware of the problems regarding contract delivery of medical care at Greensville, but appear to lack formal authority and responsibility to resolve these issues.

In particular, the DOC health services administrator needs a formalized role in contract monitoring at Greensville. The health services administrator performed a quality audit of Greensville in January 1993, and noted many of the problems outlined earlier in this chapter regarding quality of care and access to care. The health services administrator has been involved in contract modifications to the Greensville contract, filed DOC's vendor complaints regarding CMS contract violations, and is, according to the chief of operations for programs, informally responsible for monitoring it at the central office level. DOC needs to formalize this responsibility.

Recommendation (34). **The Department of Corrections should designate the health services administrator in the Office of Heath Services as the central office official responsible and accountable for: (1) effective monitoring of the contract for medical care at Greensville Correctional Center and (2) DOC's effective performance of its support role in the delivery of health services at Greensville.**

Contract Compliance Issues Remain Unresolved. At the conclusion of this study, DOC had not resolved concerns about the timeliness and accuracy of the contractor's billings, the amount of the medical care pool, or the contractor's implementation of utilization review. In early July 1993, DOC and CMS officials met to address these issues. According to a memo circulated prior to the meeting, the purpose of the meeting was to express DOC's "acute level of dissatisfaction" with the contractor over billing issues, the medical care pool, and utilization review. Despite DOC staff's memo to the DOC controller expressing satisfaction at the meeting's outcome, the amount of the medical care pool remained unsettled. Further, no system was established for effective, efficient review of bills for either the contract base or the medical care pool. DOC appears to be relying on the contractor's good faith, despite a similar commitment by CMS in February 1993 which did not result in any improvement in the billing, resolution of the medical care pool, or full implementation of utilization review. Exhibit 4 summarizes the contract provisions with which CMS has been noncompliant. Most of these contract noncompliance issues have also been noted by DOC and nearly all of them are unresolved.

Exhibit 4

Summary of Contract Compliance Problems With CMS

Noncompliance Issue	Noted By DOC	Noted By JLARC	Resolved?
Timeliness of Billing	●	●	No
Accuracy of Billing	●	●	No
Medical Care Pool Costs	●	●	No
Utilization Review	●	●	No
Improper Contract Modifications	●	●	No
Tuberculosis Testing Procedures		●	No
Accreditation		●	No
Quality Improvement Committees	●	●	Partially
Physician Access	●	●	Partially

Source: JLARC staff analysis of DOC Board of Corrections standards compliance audit at Greensville, November 9, 1992; OHS quality assurance review of Greensville, February 12, 1993; JLARC interviews with DOC and CMS staff; and DOC vendor complaints to CMS, May 6, 1993.

According to interviews with the directors of budget and procurement and the chief of operations for programs, DOC must rely on the contractor's good faith, because they have few viable alternatives for providing continuity of medical care to inmates at Greensville. While the DOC procurement director admits that CMS is in technical default of the contract, DOC is not in a position to discontinue the contract for non-performance, because DOC is not prepared to deliver medical care services at Greensville itself.

Potential Cost Savings of State Delivery of Health Services at Greensville

DOC should prepare a plan to deliver inmate health care directly at Greensville Correctional Center, in the event that the contractor does not comply with all contract requirements. The plan should include provisions to recruit needed staff and make other arrangements for provision of care, should DOC need to take over the provision of health care at Greensville. DOC could potentially save about 13 percent or approximately $816,000 of the contract's costs by directly delivering care at Greensville.

JLARC staff developed an estimate of cost savings if the State provided inmate health care at Greensville directly by using the following assumptions:

- The staffing complement would remain the same, with the exception of deleting the contract administrator and on-site contract monitor, and adding a medical facility director (grade 15). This would result in a salary savings of approximately $58,000 a year if the medical facility director were hired at the median step within the grade. These salary savings could be used as nursing

recruitment incentives and would provide approximately $1,400 annually per nursing position for these incentives.

- The State would pay at least the same salary level as CMS for each position and might need to provide nursing recruitment incentives as discussed above.

- The State would pay approximately the same cost of care as CMS for outside care, an estimated $2.7 million in FY 1993. This assumption is given only for purposes of developing a conservative estimate and does not preclude DOC from realizing significant savings by implementing utilization review, better cost management, and effective reimbursement policies.

- The State would realize savings from not having to pay an estimated 13 percent profit margin on the delivery of inmate health care. The base cost of the Greensville contract for FY 1994 is $6,274,980. Of this amount, $815,747 represents the estimated profit margin. As the State would not need to realize a profit on the delivery of inmate health care at Greensville, it would not need to pay this markup if it delivered inmate health care directly.

DOC has not yet assessed whether privatization is a desirable alternative in terms of providing quality, cost effective health care for inmates. JLARC review of the Greensville contract suggests that DOC's experience with privatization has been problematic in terms of both quality of care and cost effectiveness of care. DOC needs to assess whether it could provide better quality care or realize cost savings if the State directly delivered inmate health care at Greensville. DOC also needs to carefully assess its experience with the Greensville contract before committing to any other major privatization efforts.

Recommendation (35). **The Department of Corrections should require Correctional Medical Systems to immediately comply with all provisions of the contract for medical care at Greensville Correctional Center. DOC should prepare a plan to deliver inmate health care directly in the event that the contractor does not immediately comply with all provisions of the contract. The Department of Corrections should report to the next session of the General Assembly on the status of this recommendation.**

Recommendation (36). **The General Assembly may wish to restrict the Department of Corrections from entering into additional major contracts for direct delivery of substantially all inmate health care at major institutions until the department: (1) satisfactorily addresses the findings and recommendations of this report concerning the contract for inmate health care at Greensville and (2) demonstrates that privatization is more cost effective and provides at least the same quality of care as inmate health services directly delivered by the State.**

VI. Improving Health Care Management in the Department of Corrections

The JLARC series of reports on inmate health care has identified Department of Corrections (DOC) management problems which limit the department's ability to efficiently and effectively manage inmate health care services. These problems affect four broad areas: (1) ensuring access to care, (2) effective contract management and oversight, (3) cost management and cost containment, and (4) quality improvement systems. The department's ability to effectively address these problems is hampered by two factors:

- the department has failed to assign management responsibility and accountability for these problems to a single individual or organizational unit at the central office level

- in areas for which the department has assigned responsibility to the Office of Health Services (OHS), the office has not successfully carried out these responsibilities.

Exhibit 5 summarizes management problems identified by the JLARC series of reports on inmate health care and indicates which factor appears to be related to them.

Improving DOC's management and oversight of inmate health care will require revising the mission, role, and structure of the Office of Health Services. In doing so, DOC should strongly consider centralizing both funding and direct supervision of health care. It is of equal importance, however, that DOC ensure that its central office health care staff have appropriate qualifications to perform the duties and responsibilities to which they are assigned in light of the growing complexity and expense of the health care program. It is especially important that the health services administrator be properly qualified for the duties and responsibilities assigned to that position. Further, DOC needs to clearly assign responsibility for the areas noted in Exhibit 5 and to implement needed management systems in these areas. The Secretary of Public Safety and the Board of Corrections need to hold DOC accountable for meeting its present responsibilities and for implementing the needed management systems in these areas.

ORGANIZING DOC HEALTH CARE SERVICES

DOC should seriously consider implementing stronger central office oversight of inmate health care to ensure that needed management systems are developed and OHS adequately performs its assigned responsibilities. Centralization appears necessary to maximize cost savings and to minimize legal liability. At present, OHS is the only organizational unit with health care management responsibilities. However, OHS has not been assigned clear responsibility for a number of management systems needed to improve the administration of inmate health care.

Exhibit 5

Factors Related to DOC Health Care Management Problems

Problems Identified	Lack of Clearly Assigned Responsibility in DOC	OHS Performance Problems
Access to Care		
Documentation		✘
Medical Transfers	✘	
Nurse Recruiting	✘	
Physician Recruiting	✘	
Use of Clinical Personnel	✘	
Contract Oversight		
Contract Compliance	✘	
Contract Costs	✘	
Cost Management		
Collection of Patient Data		✘
Reimbursement Policies	✘	
Tracking Expenditures	✘	
Temporary Nursing	✘	
Utilization Review		✘
Quality Improvement		
Infection Control		✘
Risk Management		✘
Quality Assurance Review Follow-up		✘

Source: JLARC staff analysis of inmate dental, mental health, and medical care in the Department of Corrections, 1992 and 1993.

OHS lacks a defined mission with clearly articulated goals and objectives for health services delivery and OHS lacks authority to enforce DOC policies and procedures related to inmate health care. DOC needs to: (1) establish a mission with goals, objectives, and a clearly defined role for OHS; (2) develop the structure needed for OHS to reach its goals and objectives; and (3) ensure that OHS staff are adequately qualified to perform the duties assigned to them.

OHS Needs a Clearly Defined Mission and Role

DOC's mission statement for inmate health care needs to be improved to include a statement of the Office of Health Services' specific goals and priorities, as well as the office's role in oversight of the provision of inmate health care. DOC's general health services mission is stated in department operating procedure (DOP) 701:

> *It is the medical mission of the Department of Corrections to provide health services for inmates within the correctional system that are equal in quantity and quality to that received by the general public. To carry out its mission, the Department promotes standards and guidelines for a health care delivery system in which health care professionals coordinate the distribution of health care resources. The Department assigns high priority to health care in the correctional environment.*

DOP 701 does not address the specific role OHS should have in assisting the department to provide health care services "equal in quantity and quality to that received by the general public." Nor does this DOP establish concrete goals and priorities for OHS.

According to department operating procedures, OHS is responsible for coordinating the delivery of health care in DOC. A review of management literature suggests that coordinating agencies or organizational units are seldom effective unless they are given a more specific goal beyond coordination. OHS has been implicitly or explicitly assigned numerous tasks, such as developing policies and procedures and conducting quality assurance reviews, but these tasks have not been linked to broader goals. A statement of goals provides a context in which a particular task becomes important. Otherwise, performing certain activities can become the goal rather than the means to attaining a larger goal. For example:

> *OHS is responsible for conducting quality assurance reviews, but this is not formally connected to any mission statement or policy regarding the goals or objectives for conducting quality assurance reviews. For example, one goal for quality assurance reviews could be to improve the quality of health care provided and thereby minimize the State's legal liability. OHS staff are conducting quality assurance reviews of the medical care, but state they lack needed authority to enforce recommendations for improving care.*

* * *

> *OHS is responsible for tracking morbidity data, but this task is not linked to the broader goal of identifying workload and utilization trends to allow for budget planning and to identify areas for cost containment. As a result, OHS has collected data on inmate health services for the past eight years, but has not ensured that the data are reliable or useful. Therefore, OHS has not been able to use the data in any meaningful way.*

* * *

OHS develops policies and procedures for health care delivery, typically in the form of department operating procedures. DOC has not explicitly connected the development of policies and procedures with the broader goal for accomplishing this task: developing uniform standards for the provision of health care to ensure consistent quality of care. Most policies and procedures have not been updated since early 1990, because there has been no clearly established reason for OHS staff to assign a high priority to updating these policies and procedures.

In addition, DOC needs to establish clear priorities for OHS. The complexity of modern health care creates a daily set of demands that makes it easy for health care administrators to respond to the demands of the moment, rather than focusing on long-term management objectives. For example:

One OHS staff member reported spending nearly 60 percent of the work day responding to problems with inmate transfers and jail intakes. This meant that the staff member had not been able to work on needed policies and procedures for several months.

Priorities will flow naturally from the goals set for OHS. If DOC makes reducing costs a goal, then the tasks that relate to that goal will become correspondingly more important.

In addition to not setting clear goals and priorities for OHS, DOC has not determined what role OHS should play in managing the delivery of inmate health care. A role is the approach used to carry out the goals of a particular organizational unit. OHS has an ambiguous role with elements of both a coordinating responsibility and direct authority. In some senses OHS is simply a coordinating office, because it does not exercise direct supervisory authority over medical and dental staff. At the same time, OHS has clinical supervisory responsibility for medical and dental staff, suggesting a greater responsibility than simply coordination.

Recommendation (37). **The Department of Corrections should clearly and specifically state the goals and objectives to be accomplished by the Office of Health Services, as well as the relative priority of these goals and objectives. DOC should hold OHS staff accountable for meeting these goals.**

Recommendation (38). **The Department of Corrections should clarify the role of the Office of Health Services for inmate health care. The department should articulate the role of the office in directly supervising facility health care staff.**

DOC Needs to Redefine the Structure of Health Services Management

DOC needs to redefine the structure of health services management in the department to be consistent with the mission and role it sets for OHS. The structure should be modified to integrate dental, mental health, and medical care services within

the office and streamline the Office of Health Services' reporting relationship within DOC, oversee health care funding in the system, and enforce health care policies and procedures. This could be accomplished by centralizing health services within OHS and providing the office with the resources necessary to implement needed management systems.

DOC Needs to Assign Responsibility for Development of a System of Care for Dental, Mental Health, and Medical Care Services. The department has not clearly assigned responsibilities to any one unit to develop a systematic approach to providing inmate health care. Currently, the Office of Health Services has some responsibilities for developing policies and procedures for medical care services. The chief dentist, located at Powhatan Correctional Center, has dual responsibilities for system-wide dental policies and procedures, and directly providing dental services to inmates at Powhatan. And, while the mental health program director is located in proximity to OHS staff, this position is not considered a part of OHS. DOC should consider combining the supervision of dental, mental health, and medical care into one office.

DOC has failed to recognize the importance of integrating inmate health care services. National experts have noted that many inmates have a combination of medical and mental health problems which need to be addressed during incarceration. Interdisciplinary treatment approaches would help to address these problems.

DOC could also achieve efficiencies in its current administration of inmate health care if it were approached as a total system of care. Program resources could be shared to ensure adequate support staff, and problems affecting the provision of care could be addressed by a single organizational unit. For example, personnel recruitment of clinical staff could be streamlined if one unit were responsible for this function.

Recommendation (39). **The Department of Corrections should integrate the functions for dental, mental health, and medical care within one organizational unit.**

DOC Should Consider a Revised Reporting Relationship for OHS. As mentioned earlier, all functions for inmate health care should be placed within the Office of Health Services. At the same time, DOC should consider having OHS report to the department's director or deputy director for adult institutions, in order to improve the office's accountability and to facilitate top management oversight of health services delivery. Currently, OHS is located three levels of management down in DOC's organization, reporting to the chief of operations for programs. The chief of operations for programs reports to the deputy director for adult institutions, who in turn reports to the department's director. This reporting relationship does not facilitate close oversight of health care management or a quick response to problems in health care management by DOC's top management.

Currently, 25 states have the health services director report directly to the director or deputy director of their corrections agency. This reporting relationship would

increase the visibility and status of the health services function in the department. Health services needs enhanced visibility and status in DOC because of the increasing cost and complexity of health care, the importance of services, the legal liabilities, and the extent of the problems that DOC currently has managing this care. Just as DOC needs to strengthen OHS's mission, it also needs to incorporate health services into the department's overall mission. Having OHS report to the department's director or deputy director for adult institutions would send a clear signal to all concerned that health services is an important part of the department's operating mission.

Recommendation (40). **The Department of Corrections should revise the reporting relationship of the Office of Health Services to report directly to the department's director or to the deputy director for adult institutions.**

DOC Should Consider a Revised Funding Mechanism for Health Services. The current method of funding inmate health care does not encourage cost containment and does not efficiently allocate resources to institutions and field units based on their medical needs. These problems are outlined in Chapter IV of this report. Consideration should be given to providing central office health care oversight staff direct control over the health services budget and, as already recommended in Chapter IV, revising the method of budgeting for inmate health care.

At present, cost overruns in medical care are funded by shifting money from other programs of the Division of Adult Institutions, such as food services or maintenance. Medical staff have little incentive to contain costs for two reasons. First, costs will be covered from other accounts, so there is not a significant amount of meaning attached to the appropriations for medical care. Second, medical appropriations for the different institutions do not accurately reflect the medical expenditures that will be incurred by the facility. As the comparison between St. Brides Correctional Center and the Virginia Correctional Center for Women indicated in Chapter IV, institutions of similar inmate populations may have very different health care funding needs, depending on the population incarcerated there.

Granting a central office of health services control of medical funding would allow the allocation of medical funds to be adjusted to reflect different institution's needs based on the characteristics of their inmate populations. There would also be an incentive for cost containment, because overspending in medical care could not so easily be balanced by shifting funds from other program accounts within the Division of Adult Institutions. Control of funding would also give the central office of health services a mechanism to ensure compliance with its policies and procedures.

Recommendation (41). **The Department of Corrections should consider placing control of funding for inmate health care in a central office unit responsible for health care oversight.**

OHS Needs Enforcement Authority. OHS currently lacks any mechanism to enforce compliance with departmental medical policies and procedures. Any problems noted at the institutional level by OHS are addressed to the relevant warden or superintendent. OHS lacks independent authority to enforce compliance.

Giving OHS control of funding for health care would result in the office having a strong compliance mechanism. This should be coupled with granting OHS staff direct supervisory authority over health care staff at the institutional level. Further, this centralization of funding responsibility and supervisory authority would improve standardization of care, which would help reduce the State's legal liability. Centralization would also improve tracking of medical care costs, because these costs would now be managed by one organizational unit in the central office, instead of by individual wardens and administrators in the regional offices.

Currently, OHS has responsibility, but not authority, for clinical supervision of medical and dental staff in the field. Similarly, the mental health program director is responsible for clinical supervision but lacks the authority to make this supervision meaningful. Granting central office staff direct supervisory authority over health care staff at the institutional level would make clinical supervision a reality, by linking this supervision to more traditional supervisory control devices such as performance appraisals. Centralization would likely improve the cost effective utilization of health care staff, because these staff would now be supervised by persons trained in health care and conversant with the appropriate tasks and duties of different levels of providers. Moreover, the centralization of health care funding would give health care administrators an incentive to contain costs, as discussed above.

Centralization of health care management would also provide a single organizational unit, with appropriate funding and enforcement authority, to be responsible for correcting management problems identified in the JLARC series of reports on inmate health care. DOC has not assigned organizational responsibility for problems such as recruiting and retention of nurses and physicians, ensuring access for special inmate populations, tracking of inmate medical costs, control of temporary nursing costs, developing more cost effective reimbursement policies, and management of the contract for health services at Greensville Correctional Center.

Recommendation (42). **The Department of Corrections should strongly consider granting central office health care staff direct supervisory authority over health care staff at major institutions and field units. DOC should report to the next session of the General Assembly on its plan to remedy management deficiencies identified in JLARC reports on inmate dental, mental health, and medical care.**

Resources Required for Centralization of Health Care Management. At present, the DOC central office has 6.5 positions for the oversight of health care. These are a health services administrator, a chief physician, a chief nurse, a chief pharmacist, and a secretary senior, all of whom oversee medical care; the mental health program director; and the chief dentist, who is half time in an administrative capacity. Centralization of inmate health care would require retaining each of these positions, however, the positions would have additional duties and responsibilities.

Centralization of funding might require additional fiscal and clerical support. Centralization of direct supervisory authority over clinical staff might require additional professional staff to provide a workable span of control in supervising institutional health

care staff. These additional staff, if needed, might be located physically in one or more of DOC's existing regional offices, thereby taking advantage of DOC's existing management structure.

Recommendation (43). **The Department of Corrections should assess the resources required to accomplish the mission and role it determines appropriate for the central office oversight of inmate health care.**

Qualifications of Central Office Health Care Staff Should Be Assessed

While DOC needs to pay close attention to improving the mission, role, and structure of OHS, an equally important factor in improving the management of health care is ensuring that capable health services staff are placed in the central office positions responsible for the oversight of health care. The position of health services administrator is an especially critical one. Correctional literature in particular, and public management literature in general, emphasize that the role of the administrator or head of an organizational unit is a critical one.

Corrections literature and JLARC staff review of challenges facing DOC suggest that the health services administrator should have, at a minimum, a masters degree in health services administration, substantial knowledge of budgeting, nurse recruiting, quality improvement, and health care contract oversight. It is desirable that the administrator have a broad-based health administration background, as that individual is potentially responsible for dental, mental health and medical care.

In addition, contract oversight and quality improvement are two areas which have grown in importance since the present structure of the Office of Health Services was created. OHS staff position descriptions written in 1985 and 1986 do not accurately reflect the present responsibilities of the positions. For example:

> *The health services administrator is actively involved in discussions regarding the contract for delivering inmate health care at Greensville, but the position lacks a formal oversight role for the contract at Greensville. Approximately 20 percent of the DOC health care system's resources are devoted to this contract.*

As DOC establishes a mission and role for OHS to reflect needed changes to the health care system, these position descriptions will need to be modified to reflect the changing role of the office.

Because the mission and role of the Office of Health Services will be significantly expanded, DOC will need to carefully reassess the qualifications and skills required of OHS staff, and compare these qualifications and skills to those required of its current OHS staff. This is particularly true if DOC elects to centralize funding and supervision of inmate health care, as this would substantially increase the duties and responsibilities of the present central office positions for health care oversight, especially the health

services administrator. Assuming the duties and/or qualifications of a particular position are substantially revised, DOC will need to readvertise the position.

Recommendation (44). **The Department of Corrections should carefully assess the qualifications required of its central office health care staff. The department should consider enhancing the qualifications required of the position of health services administrator. This position should be readvertised to reflect substantial changes in the position's responsibilities. DOC should consider readvertising for any other position where the duties or qualifications are substantially revised.**

MANAGING DOC HEALTH CARE SERVICES

DOC has not clearly assigned authority, responsibility, and accountability for the oversight activities needed to effectively manage inmate health care. As a result, oversight of these areas has been problematic. DOC needs to develop management systems for these areas of responsibility. Responsibility for developing and maintaining these management systems should be clearly assigned to one organizational unit at the central office level. The Office of Health Services is the logical place to assign this responsibility.

However, DOC has assigned oversight responsibility for a number of important areas of health care management to the Office of Health Services. OHS has not developed needed management systems in these areas. DOC needs improved performance from OHS in its present responsibilities and for OHS to develop needed management systems.

DOC Needs to Assign Responsibility and Develop Management Systems

DOC needs to develop health care management systems at the central office level to address problems identified with the access to care due to staffing problems, contract oversight, and cost containment. These systems are important for providing quality care, controlling costs of medical care, and reducing the State's legal liability in the provision of inmate health care. Logically, OHS should be responsible for these activities.

DOC Needs to Clearly Delineate Responsibility for Ensuring Access to Care through Appropriate Staffing, Recruitment, and Retention. DOC has not assigned responsibility for ensuring access to health care for inmates through cost effective staffing. Chapter III of this report identified problems with physician access created by DOC's reluctance to use physician extenders. The inmate dental report noted problems with inmates' access to cost effective care because of DOC's limited use of dental assistants. The inmate mental health report noted problems with inmates' access to mental health care caused by mental health providers spending significant portions of their time on clerical tasks.

Chapter III of this report also identified problems with access to care created by DOC's difficulties in recruiting and retention of nursing and physician staff. DOC has not assigned any single organizational unit responsibility to explore creative alternatives for recruiting and retaining nursing and physician staff. This has created problems with access and continuity of care and has required DOC to fill nursing and physician vacancies with more expensive temporary nursing agencies and contract physicians.

DOC needs to develop a systematic approach to assessing the health care staffing components appropriate for each facility. DOC then needs to develop a systematic approach for recruiting and retaining these needed staff. Doing so would promote cost effective access to health care for inmates.

DOC Needs to Clearly Delineate Responsibility for Health Care Contract Oversight. DOC has not clearly assigned responsibility at the central office level for monitoring the contract for provision of inmate health care at Greensville Correctional Center. Chapter V describes in detail problems concerning DOC's lack of adequate oversight of the contract at Greensville. Many of the problems which resulted are the direct result of poor contract oversight by DOC. The department has failed to clearly delineate a responsible individual or organizational unit at the central office level for overseeing the contract. Chapter V recommended that the Office of Health Services be given clear responsibility for systematically monitoring and overseeing implementation of the contract.

DOC Needs to Develop Management Systems to Effectively Analyze Health Care Costs and Implement Cost Containment Mechanisms. DOC has not assigned any individual or organizational unit responsibility for analyzing health care costs or making recommendations for systemic improvements to contain these costs. As a result, DOC has not effectively implemented needed cost containment approaches, such as those outlined in Chapter IV of this report. At present, DOC leaves wardens and regional administrators, who do not have expertise in these areas, to devise their own cost containment approaches or to deal with the consequences of uncontrolled health care costs. For example:

> *When asked by JLARC staff how the region responded to significant cost overruns in medical care at two of the region's major institutions, one regional administrator stated that maintenance and other needed expenditures throughout the region were deferred. When asked how much help central office staff were in controlling these medical costs, the regional administrator stated that they meant well, but did not provide much help.*
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> * * *
>
> *One region that is located several hours from the Richmond metropolitan area wanted to explore using a hospital in proximity to the region's facilities for inpatient and outpatient medical care. This would have helped these facilities to reduce costs of security for transporting*

inmates to the Medical College of Virginia (MCV) for services. According to the regional administrator, DOC central office staff did not support this idea and the region continues to expend large sums on transporting inmates and attendant staff.

DOC needs to designate a single individual or organizational unit as responsible for identifying opportunities for cost savings in the provision of inmate health care. Chapter IV outlines several steps DOC could take immediately to contain costs and rechannel funds to better use. DOC should clearly assign this responsibility to OHS and assign priority to identifying cost savings in the provision of inmate health care.

Recommendation (45). **The Department of Corrections should assign responsibility for health care cost tracking and cost containment to the Office of Health Services.**

DOC Should Assign Responsibility for Needed Management Systems to OHS. OHS is the logical organizational unit for DOC to assign responsibility for implementing needed management systems. OHS is the department's only organizational unit for overseeing the delivery of inmate health care, aside from the mental health program director. OHS staff and the mental health program director are also the department's only central office staff with health care backgrounds of any type. OHS, in cooperation with the mental health program director, should be assigned responsibility for ensuring access to care through staffing, recruiting, and retention of health care staff; contract oversight; as well as, cost analysis and cost containment.

OHS, however, will need to significantly improve its performance in order to carry out additional responsibilities. OHS is presently responsible for several important health care management activities. It has not successfully carried out these responsibilities.

Recommendation (46). **The Department of Corrections should assign responsibility for developing needed health care management systems to the Office of Health Services. The department should hold Office of Health Services staff accountable for developing and implementing these management systems.**

OHS Performance Needs Improvement

In the instances in which DOC has assigned responsibility for health care management, it has assigned this responsibility to the Office of Health Services. At present, OHS has not successfully carried out these responsibilities for the oversight of documentation of care, cost containment, or quality improvement. OHS needs to rethink its approach to areas where its performance has been inadequate, and to approach these problems in terms of management systems. In particular, OHS needs management systems to: (1) guide the documentation of care and medical transfers, (2) collect

appropriate health care data for analysis of inmate health care costs and identify opportunities for cost containment through utilization review activities, and (3) follow-up on quality assurance reviews, infection control, and risk management.

OHS Needs Systems for Documenting Inmate Access to Care. OHS has not adequately developed systems to ensure access to quality care and appropriate documentation of medical care. Problems with access and documentation of medical care are discussed in Chapter III. OHS needs to develop management systems to address these issues.

OHS Needs to Improve Performance of Utilization Review and Data Collection. OHS could identify other cost savings by doing a better job of tracking morbidity and patient data to assess the resource requirements of the correctional health care system both now and in the future. Absent more comprehensive data, OHS has been unable to effectively plan for the future. As illustrated in Chapter IV, OHS needs to improve its performance of data collection and utilization review. Both data collection and utilization review are important for identifying and containing costs of health care. OHS has not collected complete, accurate morbidity and patient data; and OHS has not sufficiently analyzed medical care data that have been collected or used the data to identify opportunities for cost savings. Further, OHS has not fully utilized its contract with MSVRO for utilization review. OHS could realize significant cost savings from fully utilizing this contract.

OHS Quality Assurance Reviews Lack Follow-up. OHS has identified management problems in its quality assurance audits but has not followed through on these findings to correct problems noted. The health services administrator's position description states that he is responsible for "institutional evaluations and quality assurance." Currently, this responsibility is discharged by conducting an annual quality assurance audit of each facility, which is typically performed by the chief nurse. JLARC staff reviewed the findings from OHS quality assurance audits conducted in FY 1992 and compared them with findings during JLARC staff's site visits at DOC facilities in April to July 1993. In many cases, OHS findings from the previous year's quality assurance audit had not been corrected at the time of the JLARC site visit. For example:

> *At one major institution, the quality assurance audit conducted in December 1992 noted that the medical secretary reviewed bills for inmate medical services and "found a number of duplications, errors, etc." JLARC staff noted the same problems on their site visit in May 1993. Little action had been taken to correct the problems of duplicate billing since they were noted in December 1992.*
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> * * *
>
> *At a major institution housing handicapped inmates, the OHS audit noted concerns about the handicapped inmates' access to the medical building. The audit, conducted in December 1992, stated that this matter would be discussed with the OHS staff and that recommenda-*

tions would be developed. As of JLARC's site visit in April 1993, no such recommendations had been developed and concerns about handicapped inmates' access to the medical building continued to be expressed by institutional staff and inmates.

Recommendation (47). The Department of Corrections should require the Office of Health Services to develop a system to ensure appropriate, timely follow-up on the findings of quality assurance audits.

OHS Lacks a System for Infectious Disease Management. OHS has not successfully fulfilled its responsibilities for tracking infectious diseases and has not developed adequate policies and procedures for managing infectious diseases. DOP 726 states that "the Office of Health Services should maintain data bases on the incidence and trends of all notifiable diseases." When JLARC staff requested a copy of these data bases, they were provided with statistics on Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) infections only, not other notifiable diseases such as tuberculosis and hepatitis B. JLARC review of mail survey data from major institutions and field units suggests that the existing OHS data base severely understates the number of inmates with HIV and AIDS in the DOC system. For example, in August 1993 the DOC chief physician provided JLARC staff with FY 1993 statistics indicating 83 HIV positive inmates and 38 inmates with AIDS in the entire correctional system. However, JLARC surveys and interviews with DOC medical care staff indicated as many as 154 HIV positive inmates and 48 inmates with AIDS in the system.

DOC signed a memorandum of understanding with the Virginia Department of Health (VDH) in March 1993 to track tuberculosis and to implement tuberculosis testing. VDH provided DOC with $25,000 in federal grant funds to assist in this effort. As of June 1993, however, DOC's chief nurse noted that "we are still not getting 100 percent compliance in reporting" from DOC facilities. JLARC staff's review of the June 1993 report indicated that fewer than 50 percent of DOC facilities reported the requested data to OHS.

Monitoring and reporting of all incidences of reportable communicable diseases is important, because a disease can only be contained if its outbreak is identified. Public health standards require that DOC report information on infectious disease occurrences in the correctional system, because members of the public, such as correctional officers and other staff and visitors come into contact with inmates. An outbreak that starts in a correctional facility could potentially spread into the surrounding community.

In addition, a 1992 Board of Corrections standards compliance review conducted by DOC of Greensville Correctional Center noted that there was "no written department protocol for the management of communicable diseases." DOP 726, the department's only policy on infectious diseases, is not comprehensive. Management of patients with infectious diseases is not covered by the policy and it fails to address specific issues regarding testing. OHS staff state that they are working on updating the policy, but as of mid-July 1993 this had not yet been completed. As Chapter V illustrates, such

a policy is needed, because DOC's management and oversight of infectious disease cases has been problematic, particularly regarding inmate transfers. These problems potentially place the health of DOC employees and inmates in jeopardy.

Recommendation (48). **The Department of Corrections should assign a high priority to improving its monitoring and tracking of infectious diseases in the DOC system. DOC should require the Office of Health Services to immediately develop and promulgate needed policies and procedures on infectious disease management.**

OHS Has Not Implemented Risk Management Effectively. Risk management is designed to reduce legal liability in a health care system by minimizing the sorts of incidents that create liability. The health services administrator, according to the position's description, is responsible for risk management, but there is no health care risk management system in place in DOC. DOC's procurement office is responsible for department-wide risk management such as worker's compensation accidents and tort claims, but not health care risk management. OHS needs to perform this function for it to be carried out effectively.

The absence of a health care risk management system means that there is no follow-up on incidents that create potential liability. DOP 706 states that OHS will review all incidences of "serious illnesses, injury, or death." OHS staff were unable to provide any information regarding improvements made or lessons learned as a result of these reviews or to document these reviews. Moreover, this policy does not address all potential sources of legal liability because it focuses only on incidents where the outcome was serious illness, injury, or death, as opposed to cases which had the potential for these outcomes. For example:

> *At a major institution visited by JLARC staff, an inmate with AIDS experienced an outbreak of genital herpes, which is serious and even potentially fatal for persons with AIDS. Because the institution was on lock down and the case was not deemed an emergency, this inmate was not treated for nearly three weeks. Once the inmate was treated, it took an additional four weeks for the correct diagnosis of the inmate's problem to be made. No corrective action was taken as a result of this case, which resulted in two legal actions against the Commonwealth and its employees.*

OHS staff indicate that they need to revise DOP 706 but have been unable to find the time to do this. OHS needs to assign a high priority to revising this policy to focus on implementing lessons learned from serious incidents and from potentially serious incidents. OHS also needs to document these reviews and the improvements made as a result of them.

Recommendation (49). **The Department of Corrections should require the Office of Health Services to implement a proactive risk management ~~proMedical Care Services for Female and Handicapped Inmates~~.**

Appendixes

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Appendix A

Item 15-A, 1992 Appropriation Act

The Joint Legislative Audit and Review Commission shall examine the increasing costs of inmate health care in the state correctional system. The objective of this study shall be to determine the appropriate level of inmate health care while developing mechanisms for restraining the growth of costs. The Commission shall report on its progress to the 1993 General Assembly and to each succeeding session until its work is completed. In carrying out this review, Virginia Commonwealth University, the Departments of Corrections, Health, Medical Assistance Services, and Mental Health, Mental Retardation and Substance Abuse Services, and the Auditor of Public Accounts shall cooperate as requested and make available all records, information and resources necessary for the completion of the work of the Commission and its staff.

Appendix B

Agency Responses

As part of an extensive data validation process, the major State agencies involved in a JLARC assessment effort are given an opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from the written comments have been made in this version of the report. Page references in the agency responses relate to an earlier exposure draft and may not correspond to page numbers in this version of the report.

This appendix contains the responses of:

- the Secretary of Public Safety
- the Department of Corrections
- the Medical College of Virginia Hospitals

COMMONWEALTH of VIRGINIA

O. Randolph Rollins
Secretary of Public Safety

Office of the Governor
Richmond 23219

(804) 786-5351
TDD (804) 786-7765

September 10, 1993

Mr. Philip A. Leone
Director
Joint Legislative Audit and Review Commission
Suite 1100
General Assembly Building
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

I have received the copies of the exposure draft of your report, Review of Inmate Medical Care and DOC Management of Health Services and your request for comments from this office.

This office has reservations concerning several recommendations in the report. Specifically, recommendation 24, which would require the Secretary of Public Safety to explore mandatory HIV testing, HIV segregation, and medical parole eligibility, entails a policy decision. Separation of inmates based upon a non-contagious medical condition has been and continues to be the subject of litigation in many states and may create charges of discrimination and subject the Commonwealth to challenges on constitutional grounds.

Recommendation 25, to require that inmates pay for medical services, if implemented may be discriminatory. A large segment of the inmate population is indigent. Charging inmates for medical services would create a disparity of medical treatment within the institutions.

Recommendation 36, that the General Assembly restrict the Department's ability to contract for medical services, would seriously impair the ability of the Department of Corrections (DOC) to operate. In many areas of the state, DOC's ability to contract for medical services is the only option available to provide service.

This office has reviewed the response by DOC and concurs with many of the comments made by the Department during the meeting with you and members of your staff.

Sincerely,

Theophlise L. Twitty
Deputy Secretary of Public Safety

TLT/aka-p

cc: The Honorable O. Randolph Rollins
Mr. Edward Murray

COMMONWEALTH of VIRGINIA

EDWARD W. MURRAY
DIRECTOR

Department of Corrections

P. O. BOX 26963
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September 10, 1993

Mr. Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

Enclosed are attachments 1 & 2 from the Department of Corrections' technical review of your exposure draft of August 27, 1993, "Review of Inmate Medical Care and DOC Management of Health Services".

While many of the recommendations require additional study, it is apparent that additional personnel and other resources will be needed to execute any plan in consonance with the recommendations. I would welcome your support in developing appropriate plans and budget addenda to address these needs.

Sincerely,

for EWM

E. W. Murray

Enclosure

EWM/cfg

Attachment 1

Department of Corrections Comments to Exposure Draft of August 27, 1993

JLARC REPORT

Page 7, Paragraph last

JLARC Comment: DOC's consultants contract was for $60,000.

DOC Response: The contract cost was $45,000.

Page 15, Paragraph 1
Page 61, Paragraph 2

JLARC Comment: Infirmary beds are not available at Deep Meadow if inmates require acute care.

DOC Response: Infirmary beds are available at Powhatan, which is less than 1 mile away.

Page 22, Paragraph 3

JLARC Comment: DOC pays 100% of inpatient charges for female inmates.

DOC Response: It is the DOC's understanding that the negotiated rate of $833.25 per diem applies equally for male & female inpatients at MCV since July 1, 1992. This is less than 100% of the inpatient charges.

Page 31, Paragraph last

JLARC Comment: Role of the chief nurse.

DOC Response: The chief nurse also spends substantial time arranging jail inmates' intakes into the Department for medical reasons.

Page 38, Paragraph 1

JLARC Comment: OHS is responsible for assessing medical staff needs....little has been done to address these problems.

DOC Response: Staffing is the number one DOC budget priority. OHS has historically requested additional FTE through addendum budget procedures. The General Assembly approved funding for 15 nurse positions as of FY 93 and 3 as of FY 94.

Page 42, Paragraph 3
Page 43, Table 2

Page 49, Paragraph 3

JLARC Comment: DOC major institutions reported average waiting periods to see a physician of between four and five days.

DOC Response: Inmates are triaged by nursing staff and are referred to a physician the same day if necessary. A system is available for emergency off-site care. After-hours institutional physician coverage is not clinically efficient or cost effective inasmuch as the physician has no access to on-site laboratory or radiology diagnostic support, specialty consultants, and staff to support him/her. Physicians are on call at DOC infirmaries.

Page 52, Paragraph 2

JLARC Comment: DOC does not employ nurse practitioners.

DOC Response: DOC is considering the use of physician extenders at VCCW & MCTC. However, it appears that nurse practitioners may be as difficult to hire as MD's.

Page 52, Paragraph 3

JLARC Comment: DOC considers a correctional health assistant equivalent to a nurse practitioner.

DOC Response: DOC does not consider these positions to be equivalent in terms of experience, knowledge, skills, or ability.

Page 54, Paragraph 2

JLARC Comment: The use of contract physicians is not as cost effective as the employment of state institutional physicians.

DOC Response: Many institutions are located in medically underserved areas which, because of physician unavailability, precludes the hiring of full-time physicians. Consequently, DOC's only option is contract physician coverage. Also, there are many situations such as field units where full time state physicians would not be cost effective.

Page 59, Paragraph 1

JLARC Comment: Additional clinic space at VCCW is not comparable with infirmaries for male inmates.

DOC Response: Environmental and space deficiencies at the VCCW medical facility have been previously documented by the DOC. The plans for the new women's facility will contain necessary medical and mental health treatment unit and will serve as the women's primary medical facility. There is a need to renovate and expand clinic space at VCCW and DOC is currently assessing options for corrective actions.

Page 70, Paragraph 2
Page 77, Paragraph 1
Page 146, Paragraph 3

JLARC Comment: DOC lacks detailed data on health care expenditures and services provided.

DOC Response: Data regarding work-load and morbidity has been revised and will be analyzed through spreadsheet formats in conjunction with staffing and financial data. This combination of information will assist in substantiating subsequent budget requests. Enhanced morbidity data collection commenced on July 1, 1993.

Page 71, Table 3

JLARC Comment: Off-setting temporary nursing charges with improved recruiting.

DOC Response: Dependence on temporary nursing charges is substantially a result of insufficient staffing, particularly in medically underserved areas. The savings identified in Table 3 are hypothetical, and are based on uncertain assumptions.

Page 77, Paragraph 2

JLARC Comment: There are no staffing standards for medical personnel.

DOC Response: Surveys on many states and inquirires to the American Correctional Association and the National Commission on Correctional Health Care, have indicated that nationally no staffing standards exist for nurses in correctional facilities. However, OHS staff is attempting to establish staffing standards based upon acuity of illness, population, chronic illness, and handicapped conditions, and to some extent, geographic location of the institution.

Page 86, Paragrah 3

JLARC Comment: Good financial management.

DOC Response: The reference to a lack of good financial management is not an accurate statement. As the Department improves its capture of health services information, opportunities for cost savings will improve.

Page 87, Paragraph 2
Page 91, Paragraph 2

JLARC Comment: DOC's use of a contractor to review medical procedures has not been employed to its fullest extent.

DOC Response: During contract renewal discussions, the Medical Society of Virginia Review Organization was requested to perform retrospective review as well as other initiatives to identify savings to DOC. The contract renewal became effective August 1, 1993. All hospitals providing inpatient services for DOC will be informed of this utilization review initiative. DOC will continue to review the cost effectives of utilization reviews.

Page 90, Paragraph 1

JLARC Comment: It appears that DOC spent over $1 million more than the cost of state employees to cover vacancies.

DOC Response: DOC has had to rely on agency nurses to cover vacancies and to supplment expanded needs.

Page 92, Paragraph 2

JLARC Comment: 100% payment for female inpatient care.

DOC Response: It is DOC's understanding that the per diem rate for men and women is the same. The $833.25 negotiated rate is less than 100% of charges.

Page 95, Paragraph 2

JLARC Comment: Lack of negotiated reimbursement rates for other hospitals and physician services DOC may have forgone as much as $745,000 in FY 93.

DOC Response: Based upon DOC's experience, it may be difficult to gain meaningful savings because of the low patient volume outside the Richmond area. The DOC agrees with Recommendation #17 to renegotiate rates with MCV.

Page 100, Paragraph 3
Page 101, Paragraph 3
Page 158, Paragraph 3

JLARC Comment: DOC could use information obtained in retrospective hospital utilization review to deny medically unnecessary services.

DOC Response: During contract renewal discussions, the Medical Society of Virginia Review Organization was requested to perform retrospective review as well as other initiatives to identify savings to DOC. The contract renewal became effective August 1, 1993. All hospitals providing inpatient services for DOC will be informed of this utilization review initiative. DOC will continue to review the cost effectives of utilization reviews.

Page 104, Paragraph 3

JLARC Comment: The Health Services Administrator could not provide JLARC staff with an accurate count of available medical beds in the DOC system.

DOC Response: Medical beds are reflected on the daily bed utilization report. JLARC was provided this report.

Page 106, Paragraph last
Page 108, Paragraph 1

JLARC Comment: An option is to implement mandatory testing and separation of these inmates from general population inmates.

DOC Response: DOC does not consider separation of HIV infected inmates to be an economic, clinical, or administratively viable option in light of contemporary standards. HIV testing would have to be conducted quarterly on all inmates because of the window of infection probability extending beyond several years. Cost data is significant in terms of 17,000 inmates who are currently incarcerated. There is no definitive data available that reflects any cost savings associated with separating HIV infected inmates.

Page 114, Paragraph 3

JLARC Comment: DOC could save $816,000 by terminating the contract and use state employees.

DOC Response: JLARC contends that by canceling the CMS contract at Greensville and delivering health care ourselves, that the DOC could save about $800,000 per year. This assertion is based on the assumption that CMS is realizing approximately 13% profit, an amount the DOC would not pay on its own operations. However, there is no evidence to indicate whether CMS is achieving any profit at Greensville.

There may be other reasons to contract apart from saving money. In many instances, the expertise required to operate complicated medical facilities in remote areas can only be obtained on a contract basis.

Page 117, Paragraph 2

JLARC Comment: Greensville had problems with TB testing and follow-up.

DOC Response: CMS has corrected its TB testing and documentation procedures and retesting will be completed by October 1, 1993.

Page 120, Paragraph 2

JLARC Comment: Since opening there has been little review of the respiratory isolation rooms. DOC officials assured that the negative pressure was functioning properly.

DOC Response: Improvements were completed in July 1993 and the rooms meet CDC standards.

Pages 140, Paragraph 3

DOC Response: Cancelling Greensville contract.

JLARC Response: JLARC contends that by canceling the CMS contract at Greensville and delivering health care ourselves, that the DOC could save about $800,000 per year. This assertion is based on the assumption that CMS is realizing approximately 13% profit, an amount the DOC would not pay on its own operations. However, there is no evidence to indicate whether CMS is achieving any profit at Greensville.

There may be other reasons to contract apart from saving money. In many instances, the expertise required to operate complicated medical facilities in remote areas can only be obtained on a contract basis.

Page 156, Paragraph 4

JLARC Comment: One region wanted to use a hospital in proximity to the regions facilities...central office staff did not support this idea.

DOC Response: Emergency inpatient care is provided in the geographic area of the institution. Division Operating Procedure 720, paragraph VII, I stipulates that "wherever and whenever feasible medical and dental outpatient consultations should be provided in the geographic area of the institution". This provision is consistently verbally communicated by OHS staff.

Attachment 2

DOC Comments to 8/27/93 JLARC Exposure Draft

JLARC Recommendations/Medical Review

1. The Department of Corrections should ensure that institutions and field unit staff take immediate steps to improve documentation of inmate medical care. The Office of Health Services should: (1) follow-up on problems noted in quality assurance reviews to monitor problems with compliance and the institutional and field unit level, (2) complete the medical records manual for facility medical care staff, and (3) design training on documentation requirements for medical care staff. Additional training on documentation procedures should be provided to all institutional medical care staff with medical record-keeping responsibility.

   DOC Response: Concur

2. The Department of Corrections should implement changes in its nurse recruitment and retention policies and procedures to decrease position vacancy rates and use of temporary nursing to fill these positions. The department should work with the Department of Personnel and Training to implement a full range of methods for improving nurse recruitment and retention.

   DOC Response: Concur

3. The Department of Corrections should assess physician coverage in major institutions. At institutions which are experiencing problems with adequate physician coverage, DOC should consider alternatives for providing physician coverage such as the use of physician extenders or enhance physician recruitment efforts.

   DOC Response: Concur

4. The Department of Corrections should expand its use of physician extenders as a cost mechanism for delivery of primary care at institutions which it determines requires additional physician coverage. The Department should consider providing existing staff with additional education and training to enhance the number of physician extenders at its facilities.

   DOC Response: Concur

5. The Department of Corrections should begin improving its procedures for recruiting institutional physicians. Improvements should include working with the Department of Personnel and Training to explore physician compensation issues, establishing linkages to State teaching hospital programs for physician primary care, better advertisement of positions, and exploring scholarships for physicians with criminal justice training.

DOC Response: Concur

6. The Department of Corrections should take immediate steps to begin addressing problems in delivering on-site care at the medical infirmary at VCCW.

DOC Response: Concur

7. The Department of Corrections should track the number and acuity levels of handicapped inmates in the correctional system to better plan future facilities for handicapped inmates. Once these data are collected, the department should develop a plan to address the full range of housing and medical care needs of handicapped inmates within the system.

DOC Response: Concur

8. The Department of Corrections should evaluate the current staffing patterns at Deep Meadow Correctional Center to determine if current levels are adequate to address the medical care needs of inmates housed at the facility. The assessment should include consideration of acuity levels of handicapped inmates housed at the facility.

DOC Response: Concur

9. The Department of Corrections should revise policies and procedures for inmate medical transfers to (1) provide for adequate and appropriate notification of and input from institutional physicians concerning inmate transfers, (2) emphasize the need for appropriate precautions in transporting inmates with active or suspected infectious diseases (3) specify conditions under which medical staff should accompany the inmate and what provisions to make for an inmate's access to food, fluids, and bathroom facilities while in transit,

and (4) implement training for medical and correctional officers on revised procedures.

DOC Response: Concur

10. The Department of Corrections should use the element option to distinguish medical, dental, and mental health expenditures when processing financial vouchers for the Commonwealth Accounting and Reporting System to supplement the program and subprogram designation for non-inpatient health services (379-10).

DOC Response: The DOC recognizes the importance of being able to distinguish medical, dental and mental health expenses. With the support of JLARC, the Department would like to request DPB to introduce new and revised subprograms in program 379 that would separate the three areas of expenditures for the 1994-96 biennium.

11. The Department of Corrections should issue a department operating procedure to institutional and regional office accounting personnel to ensure there is a system-wide uniform classification of health care expenditures. Compliance with these standards should be incorporated into the Board of Corrections standards audit.

DOC Response: Concur.

12. The Department of Corrections should ensure that morbidity data are routinely collected, summarized, and analyzed. The department should use these data to evaluate the cost effectiveness of care and develop workload standards.

DOC Response: Concur.

13. The Department of Corrections should develop and implement a systematic method of tracking inmates with special health care needs. Summaries of these data should be used to compile the cost of care for inmates with special needs, forecast trends, and justify health budget requests.

DOC Response: Concur

14. When submitting its budget proposal for health care, the department should include statistics showing inmate health care trends and costs associated with those tends. Statistics should include, but not be limited to, the number of inmates with chronic conditions such as AIDS and end stage renal disease and other conditions such as the number of pregnancies.

DOC Response: Concur

15. The department should adjust each facility's health care budget based on inmate health needs and types of services provided at the facility.

DOC Response: The DOC has examined the medical missions of its institutions and has introduced a two-tier budgeting system for medical Direct Inmate Costs in FY1994. Institutions with major infirmaries (Powhatan and Greensville) and those dealing with women's medical needs (VCCW) are funded at a higher rate than others. These institutions also benefit from higher staffing levels.

16. The DOC should develop a plan to reduce its usage of temporary nursing. The report should be made to the Senate Finance and House Appropriation Committees before the next session of the General Assembly.

DOC Response: Concur

17. The Secretaries of Public Safety and Education should direct the Department of Corrections and the Medical College of Virginia to re-negotiate payment arrangements for inmates receiving care at the Medical College of Virginia Hospitals. The negotiated payment should reflect the actual cost to provide care and apply to all medical services provided by MCV to DOC inmates.

DOC Response: Concur

18. The General Assembly may wish to alter the Department of Corrections and the Medical College of Virginia hospitals budget addenda so renovations to the secure

ward are funded by MCV. The Department of Corrections and the Medical College of Virginia Hospitals should negotiate an interim rate to reflect increased operating costs of the inpatient secure ward. The interim rate should be effective for a specific time period.

DOC Response: Concur. If MCV is authorized to expend its own funds for capital improvements for the DOC security ward and imposes a temporary rate increase on DOC to recover its expenditure, DOC will require an appropriation to cover the temporary interim rate increase.

19. The Secretary of Public Safety should establish a task force to assist the Department of Corrections in developing more cost effective mechanisms for purchasing medical care services. This task force should be comprised of representatives from the Department of Personnel and Training, the Department of Medical Assistance Services, the Virginia Health Department, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, and the State teaching hospitals. DOC should also explore developing regional purchasing pools to maximize inmate health care funding in conjunction with the task force. Progress of the task force should be reported to the Joint Commission on Health Care by September 1, 1994.

DOC Response: Concur

20. The Department of Corrections should develop and implement system-wide reimbursement policies for medical care services immediately. The policies could be modeled after State policies which already exist for the Medicaid program and for the State Employee Health Benefits Program. The detail of the policies could be developed with assistance from the task force noted in the previous recommendation. Reimbursement policies should be communicated to medical care providers as soon as available.

DOC Response: Concur

21. The Department of Corrections should implement a plan to conduct a full range of utilization review activities for medical services. Utilization review should include hospital pre-admission reviews, concurrent reviews, retrospective reviews of services, and cost audits. The department should consider expanding these reviews to cover all hospital inpatient services and outpatient and emergency room services.

DOC Response: The contract with the Medical Society of Virginia Review Organization, renewed August 1, 1993, stipulates retrospective review. DOC will consider the cost benefit of expanding the MSVRO role to include ambulatory care and emergency care.

22. The Department of Corrections should establish agreements with hospitals notifying them of utilization review activities which could result in payment denials. The department should increase its use of these utilization review activities at all hospitals regularly used which could result in cost efficiencies, such as retrospective reviews and cost audits. Once agreements are in place, the department should take steps to recover payments that have been inappropriately made based on utilization review activities.

DOC Response: Concur

23. The Office of Health Services should conduct a comprehensive survey of medical services available, medical equipment, and medical capacity at each DOC institution to determine if existing DOC infirmaries could be better used to provide medical care services. Survey results should be made available to all medical care staff at institutions and field units. In addition, based on the survey information, plans should be made on a regional basis to determine how existing infirmaries can be better utilized to provide needed medical services to DOC inmates.

DOC Response: Concur

24. The Secretary of Public Safety should explore mandatory HIV testing and HIV segregation and medical parole eligibility. These options should be evaluated for their legality, feasibility, and medical cost saving potential. A report on this evaluation and potential implementation should be made to the Senate Finance Committee and the House Appropriations Committee.

DOC Response: None

25. The Department of Corrections should explore the legality, feasibility, and medical cost savings potential of charging inmates fees for medical services. If evidence becomes available from other states that inmate fees are practical, legal, and have cost saving benefits that exceed the cost of administration, DOC should report on this issue to the Senate Finance Committee and the House Appropriates Committee.

DOC Response: DOC does not concur. Evidence available from other states does not support that the cost savings benefits would exceed the cost of administration.

26. DOC should require CMS to improve its medical documentation to meet DOC standards.

DOC Response: Concur

27. DOC should require CMS to conform with public health standards regarding testing and necessary follow-up testing of inmates at Greensville Correctional Center for tuberculosis, and ensure that CMS follows these requirements.

DOC Response: Concur

28. DOC should require CMS to comply with contract requirements regarding physician access for inmates.

DOC Response: Concur

29. The General Assembly may wish to defer consideration of funding for additional respiratory isolation beds at Greensville Correctional Center until the Department of Corrections adequately demonstrates: (1) its ability to

manage the existing respiratory isolation facility at Greensville and (2) its need for additional respiratory isolation beds at Greensville.

DOC Response: Do not concur. DOC should replace the existing beds at Greensville and equip medical isolation beds in any new construction to handle infectious respiratory diseases as this is the most cost effective way to add new respiratory isolation beds.

30. DOC should require CMS to specify the type of accreditation that it intends to pursue for its operations at Greensville Correctional Center and should set a firm deadline for CMS to accomplish accreditation. This deadline should not be later than June 30, 1994.

DOC Response: Concur

31. The Department of Corrections should immediately clarify the costs of the medical care pool for FY 1993 and report to the House Appropriations and Senate Finance Committees before the next session of the General Assembly on these costs, as well as on expected costs for care provided in FY 1994.

DOC Response: Concur

32. The Department of Corrections should closely monitor and evaluate Correctional Medical System's performance of utilization review activities to ensure that the State pays only for medically necessary, appropriate medical care.

DOC Response: Concur

33. The Department of Corrections should improve its internal communication regarding contract modifications to the Greensville contract. The director of the Department of Corrections should ensure that DOC follows its internal policies, state contracting guidelines, and contract provisions for contract modifications on the contract for inmate health services at Greensville Correctional Center.

DOC Response: Concur

34. The Department of Corrections should designate the health services administrator in the Office of Health

Services as the central office official responsible and accountable for: (1) effective monitoring of the contract for medical care at Greensville Correctional Center and (2) for DOC's effective performance of its support role in the delivery of health services at Greensville.

DOC Response: Concur

35. The Department of Corrections should require Correctional Medical Systems to immediately comply with all provisions of the contract for medical care at Greensville Correctional Center. DOC should prepare a plan to deliver inmate health care directly in the event that the contractor does not immediately comply with all the provisions of the contract. The Department of Corrections should report to the next session of the General Assembly on the status of this recommendation.

DOC Response: Concur

36. The General Assembly may wish to restrict the Department of Corrections from entering into additional contracts for direct delivery of inmate health care at major institutions until the department (1) satisfactorily addresses the findings and recommendations of this report concerning the contract for inmate health care at Greensville and (2) demonstrates that privatization is more cost effective and provides at least the same quality of care as inmate health services directly delivered by the State.

DOC Response: Do not concur. Restricting this management prerogative seriously compromises the Department's capability to provide medical services to inmates, particularly in medically underserved areas of the Commonwealth. Particular reference is made to our continuing need to provide contract medical specialty services at VCCW. Additionally the ability to satisfactorily address the findings of the report will require additional funding and positions. These additional resources are not entirely within the control of the DOC.

37. The Department of Corrections should clearly and specifically state the goals and objectives to be accomplished by the Office of Health Services, as well as the relative priority of these goals and objectives. DOC should hold OHS staff accountable for meeting these goals.

DOC Response: Concur

38. The Department of Corrections should clarify the role of the Office of Health Services for inmate health care. The department should articulate the role of the office in directly supervising facility health care staff.

DOC Response: Concur

39. The Department of Corrections should integrate the functions for dental, mental health, and medical care within one organizational unit.

DOC Response: The Department will consider this recommendation.

40. The Department of Corrections should revise the reporting relationship of the Office of Health Services to report directly to the department's director.

DOC Response: The Department will consider this recommendtion.

41. The Department of Corrections should consider placing control of funding for inmate health care in a central office unit responsible for health care oversight.

DOC Response: The Department will consider this recommendation.

42. The Department of Corrections should strongly consider granting central office health care staff direct supervisory authority over health care staff at major institutions and field units. DOC should report to the next session of the General Assembly on its plan to remedy management.

DOC Response: Concur

43. The Department of Corrections should assess the resources required to accomplish the mission and role it determines appropriate for the central office oversight of inmate health care.

DOC Response: Concur

44. The Department of Corrections should carefully assess the qualifications required of its central office health care staff. The department should particularly consider increasing the qualifications required of the position of health services administrator. This position should be re-advertised to reflect substantial changes in the position's responsibilities. DOC should consider re-advertising for any other position where the duties or qualifications are substantially revised.

DOC Response: The DOC will consider this recommendation.

45. The Department of Corrections should assign responsibility for health care cost tracking and cost containment to the Office of Health Services.

DOC Response: The DOC will consider this recommendation.

46. The Department of Corrections should assign responsibility for developing needed health care management systems to the Office of Health Services. The department should hold Office of Health Services staff accountable for developing and implementing these management systems.

DOC Response: Concur

47. The Department of Corrections should require the Office of Health Services to develop a system to ensure appropriate, timely follow-up on the findings of quality assurance audits.

DOC Response: Concur

48. The Department of Corrections should assign a high priority to improving its monitoring and tracking of infectious diseases in DOC system. DOC should require the Office of Health Services to immediately develop and promulgate needed policies and procedures on infectious disease management.

DOC Response: Concur

49. The Department of Corrections should require the Office of Health Services to implement a pro-active risk management program to reduce the State's legal liability in the provision of inmate health care.

DOC Response: Concur

Medical College of Virginia Hospitals
Virginia Commonwealth University

September 10, 1993

Mr. Philip A. Leone
Director
Joint Legislative Audit and Review Commission
Commonwealth of Virginia
Suite 1100, General Assembly Building
Capital Square
Richmond, Virginia 23219

RE: Exposure Draft: Review of Inmate Medical Care and DOC Management of Health Services

Dear Mr. Leone:

Thank you for sharing this exposure draft with VCU/MCV Hospitals. The report is very informative, and your staff is to be complimented on the work they have done.

Per your request, my written comments follow:

Page 71: Potential Cost Savings from Management Activities:

VCU/MCV Hospitals has worked closely with the Department of Corrections (DOC) to help ensure the most cost effective management of health care resources. We will continue this close association, and will assist DOC as they more effectively manage their health care expenditures.

VCU/MCVH outpatient hospital services: VCU/MCV Hospitals would agree to accept 80% of charges for outpatient services, beginning in 1995.

Female inpatient hospital stays: VCU/MCV Hospitals differentiated between female and male reimbursement rates because females are not able to be cared for on the secured unit, and are then more costly then males. This required differential will no longer exist when the renovations to the secured unit are complete later this year. VCU/MCV Hospitals has already agreed with DOC to a reimbursement rate that would be equal for male and females in fiscal 1995.

Female inpatient hospital stays: The current arrangement between DOC and VCU/MCV Hospitals is that charges should be paid by DOC for female inpatient stays. During the past year, DOC paid some female stays at the male rate, and VCU/MCV Hospitals has requested that the differential be paid.

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Page 92: DOC pays a higher per diem for care rendered in the intensive care unit (of VCU/MCV Hospitals).

Your report is correct in stating that intensive care is more expensive. For your information, the per diem that DOC pays for intensive care services was calculated so that VCU/MCV Hospitals would not recover more then cost on this service.

Page 92: DOC Reimbursement Rates for MCV Services FY92-FY93:

Your report should note that VCU/MCV Hospitals FY 93 rates to DOC are at cost, and that the FY 92 rates were approximately $(1,500,000) below cost.

Page 93: Rates paid to VCU/MCV Hospitals:

The reimbursement rates established between DOC and VCU/MCV Hospitals were intended to approximate cost, and so DOC should not pay a premium to VCU/MCV Hospitals. The Inpatient male rate and ICU rate was established for 1993, and not updated for 1994, in an attempt to negate any profit on outpatient and female reimbursement.

Page 93: Renovation to the inpatient secure unit:

VCU/MCV Hospitals would contend that the full payment of renovations to the secured unit is only a sound financial management decision if DOC funds the total project. VCU/MCV Hospitals gets no benefit from this renovation since it will be solely used for DOC patients. Immediate renovation to obtain accreditation was necessary only because DOC could not find suitable care in other local hospitals.

As stated previously, VCU/MCV Hospitals has already agreed to an equal reimbursement rate for male and females when the renovation to accommodate females is complete.

Again, thank you for the opportunity to comment on the study, and if additional information or clarification is needed, please contact me.

Sincerely,

Carl R. Fischer
Hospital Executive Director

cc: Dr. Eugene Trani
Dr. John Jones

Appendix C

Department of Corrections Health Care Appropriations and Expenditures
FY 1992 and FY 1993

Facility	FY 1992 Health Care Appropriations	FY 1992 Health Care Expenditures	FY 1992 Expenditures as Percent of Appropriations	FY 1993 Health Care Appropriations	FY 1993 Health Care Expenditures	FY 1993 Expenditures as Percent of Appropriations
Augusta	$1,204,824	$1,206,251	100%	$1,207,939	$1,381,301	114%
Bland	1,341,876	1,322,033	99	1,237,072	1,424,511	115
Brunswick	705,797	1,046,358	148	754,515	1,146,237	152
Buckingham	1,067,095	1,553,263	146	1,061,336	1,577,175	149
Deerfield*	77,476	0	0	0	0	0
Deep Meadow	546,691	697,674	128	728,581	971,139	133
Dillwyn**	0	0	n/a	58,700	12,737	22
Greensville	4,369,911	6,091,310	139	4,695,263	6,643,388	141
Haynesville **	0	0	n/a	0	699	n/a
James River	402,148	509,215	127	446,351	557,044	125
Keen Mountain	753,769	1,309,065	174	905,628	1,277,630	141
Marion	1,371,717	1,559,698	114	1,410,066	1,584,669	112
Mecklenburg	619,313	719,982	116	633,180	848,927	134
Nottoway	1,053,165	1,337,549	127	1,164,523	1,494,270	128
Powhatan	4,200,745	4,078,235	97	3,058,345	4,104,726	134
Powhatan Reception	291,446	556,274	191	323,913	529,349	163
Southampton	716,271	487,487	68	728,013	524,369	72
Southampton ITC	250,359	214,326	86	256,030	197,365	77
Southampton Reception	293,662	332,954	113	288,008	327,194	114
St. Brides	600,157	417,377	70	614,997	506,010	82
Staunton	1,441,123	1,659,803	115	1,505,701	1,825,005	121
VCCW	755,864	1,677,364	222	797,552	2,168,607	272
Central Region Field Units	515,958	643,912	125	727,023	741,833	102
Eastern Region Field Units	375,537	188,558	50	206,741	204,031	99
Northern Region Field Units	925,740	804,330	87	704,542	797,812	113
Western Region Field Units	984,118	1,656,552	168	1,192,515	1,581,219	133
Division of Institutions	4,843,891	4,313,728	89	5,835,012	4,428,069	76
Total Major Institutions	22,063,409	26,776,218	121	21,875,713	29,102,352	133
Total Field Units	2,801,353	3,293,352	118	2,830,821	3,324,895	117
Total for Department	$29,708,653	$34,383,298	116%	$30,541,546	$36,854,616	121%

* Deerfield closed during FY 1992.

** Dillwyn and Haynesville began receiving inmates at the end of FY 1993.

Source: JLARC analysis of 1992 and 1993 Appropriation Acts and Department of Corrections reported health care expenditures.

Appendix D

FY 1992 DOC Medical Care Cost Components by Facility

	FACILITY							
	Augusta	Bland	Brunswick	Buckingham	Deep Meadow	Greensville	James River	Keen Mountain
SERVICE								
DOC Personnel	$385,325	$471,607	$289,177	$208,256	$249,098	$334,362	$210,974	$133,481
Equipment/Supply	13,660	42,596	61,102	23,281	16,466	22,359	5,080	61,494
Greensville Contract	0	0	0	0	0	5,204,085	0	0
Hospital Services	193,588	80,666	104,798	38,761	7,853	11,994	69,295	287,107
Lab/X-ray Services	30,184	81,342	48,045	52,237	26,336	0	6,850	19,914
Nursing Services	16,238	0	0	367,582	8,973	0	0	0
Optometry Services	25,538	18,804	23,965	13,994	2,624	0	2,400	27,042
Pharmacy Services	246,876	151,332	172,309	197,211	3,730	125	49,953	153,029
Physician Services	158,203	205,581	230,829	179,269	82,695	176,654	115,030	385,235
Other	21,591	11,745	16,238	11,551	24,071	16,476	2,121	186,760
Total	**$1,091,204**	**$1,063,673**	**$946,463**	**$1,092,092**	**$421,846**	**$5,766,055**	**$461,704**	**$1,254,062**

	Marion	Mecklenburg	Nottoway	Powhatan	Powhatan R&C	Southampton	Southampton ITC	Southampton R&C
SERVICE								
DOC Personnel	$199,628	$227,680	$368,224	$1,469,195	$85,213	$150,449	$156,796	$163,524
Equipment/Supply	20,930	6,152	32,747	128,622	3,801	8,858	1,242	10,325
Greensville Contract	0	0	0	0	0	0	0	0
Hospital Services	34,393	41,737	147,378	51,425	83,392	37,768	2,790	12,548
Lab/X-ray Services	0	288	39,740	55,411	30,166	18,069	0	2,670
Nursing Services	0	52,072	635	604,479	0	0	0	0
Optometry Services	6,172	1,512	10,814	32,009	1,492	1,793	419	207
Pharmacy Services	6,189	87,524	171,971	309,945	125,241	233,144	1,776	7,583
Physician Services	34,072	163,534	265,212	164,456	192,266	39,460	2,657	37,443
Other	46,265	6,845	15,546	21,525	1,832	4,472	110	1,019
Total	**$347,649**	**$587,344**	**$1,052,267**	**$2,837,067**	**$523,402**	**$494,013**	**$165,789**	**$235,320**

	Staunton	St. Brides	VCCW	Central Region Field Units	Eastern Region Field Units	Northern Region Field Units	Western Region Field Units	Office of Health Services	All Facilities
SERVICE									
DOC Personnel	$555,180	$193,261	$213,546	$207,734	$81,008	$230,691	$386,104	$555,179	$7,525,692
Equipment/Supply	21,499	12,572	25,839	11,136	1,064	19,487	13,145	17,673	581,130
Greensville Contract	0	0	0	0	0	0	0	0	5,204,085
Hospital Services	126,745	26,228	224,493	70,999	12,345	95,863	176,961	3,075,542	5,014,668
Lab/X-ray Services	73,618	10,137	31,268	22,398	6,739	86,818	67,142	52,348	761,720
Nursing Services	460	0	327,680	37	0	0	61,426	0	1,439,582
Optometry Services	5,561	1,546	6,700	6,226	1,289	5,313	24,881	0	220,251
Pharmacy Services	194,996	20,477	208,093	91,932	15,213	66,181	172,652	2,623	2,690,104
Physician Services	191,239	41,404	373,394	124,203	50,878	246,065	485,613	22,923	3,968,315
Other	10,395	5,695	9,647	1,926	1,206	4,447	13,925	256,471	691,881
Total	**$1,179,692**	**$311,321**	**$1,420,661**	**$536,590**	**$169,744**	**$754,863**	**$1,401,848**	**$3,982,758**	**$28,097,428**

FY 1993 DOC Medical Care Cost Components by Facility

	FACILITY							
SERVICE	Augusta	Bland	Brunswick	Buckingham	Deep Meadow	Dillwyn	Greensville	James River
DOC Personnel	$354,228	$426,318	$287,570	$148,625	$280,474	$3,487	$253,689	$199,805
Equipment/Supply	12,219	50,899	23,847	22,387	28,295	0	11,425	16,509
Greensville Contract	0	0	0	0	0	0	6,109,239	0
Hospital Services	254,360	83,338	172,647	78,667	2,804	0	33	63,956
Lab/X-ray Services	43,696	73,338	36,597	16,517	28,935	0	6,692	9,273
Nursing Services	27,752	32,236	0	409,175	118,178	0	0	0
Optometry Services	640	29,464	12,622	17,843	3,359	0	0	2,571
Pharmacy Services	211,886	178,699	250,651	211,186	33,698	0	40	83,810
Physician Services	237,380	245,597	270,725	301,792	145,262	0	32,849	129,270
Other	62,642	25,406	21,665	22,810	16,446	0	32,999	1,455
Total	**$1,204,804**	**$1,145,295**	**$1,076,323**	**$1,229,003**	**$657,451**	**$3,487**	**$6,446,965**	**$506,649**

SERVICE	Keen Mountain	Marion	Mecklenburg	Nottoway	Powhatan	Powhatan R&C	Southampton	Southampton ITC	Southampton R&C
DOC Personnel	$123,462	$229,811	$292,116	$353,972	$1,378,690	$71,267	$171,947	$178,638	$72,993
Equipment/Supply	48,153	22,257	9,376	38,693	116,027	647	4,681	2,929	19,820
Greensville Contract	0	0	0	0	0	0	0	0	0
Hospital Services	146,085	92,664	56,006	215,945	190,004	21,749	53,992	1,502	7,698
Lab/X-ray Services	17,899	5,504	5,648	29,726	91,939	30,521	1,342	5,617	6,473
Nursing Services	125,662	0	26,881	43,958	749,870	0	0	0	0
Optometry Services	30,105	2,331	7,507	23,443	35,854	229	1,638	94	858
Pharmacy Services	128,113	1,659	144,555	264,402	342,528	162,712	60,800	4,392	15,323
Physician Services	406,791	56,964	162,119	296,633	345,288	220,336	84,429	4,943	44,724
Other	17,392	35,121	7,622	25,565	36,491	5,429	5,955	222	6,233
Total	**$1,043,664**	**$446,310**	**$711,829**	**$1,292,337**	**$3,286,692**	**$512,889**	**$384,785**	**$198,337**	**$174,122**

SERVICE	Staunton	St. Brides	VCCW	Central Region Field Units	Eastern Region Field Units	Northern Region Field Units	Western Region Field Units	Office of Health Services	All Facilities
DOC Personnel	$618,407	$189,513	$302,870	$216,098	$74,538	$224,323	$356,514	$558,253	$7,367,608
Equipment/Supply	24,495	24,887	40,285	11,563	2,101	10,373	11,452	113,568	666,889
Greensville Contract	0	0	0	0	0	0	0	0	6,109,239
Hospital Services	129,520	70,722	227,534	54,903	20,253	87,544	213,590	3,655,588	5,901,103
Lab/X-ray Services	81,020	5,924	332,541	5,680	12,323	60,446	61,487	0	969,138
Nursing Services	0	0	459,413	0	0	0	47,101	0	2,040,226
Optometry Services	5,542	2,190	8,090	8,246	1,968	3,814	28,229	0	226,637
Pharmacy Services	260,850	52,670	267,325	137,674	26,547	143,322	196,190	0	3,179,032
Physician Services	278,910	64,512	296,273	156,167	48,438	265,078	407,232	1,287	4,502,997
Other	10,850	7,368	16,383	4,845	1,260	5,699	33,345	326,939	730,142
Total	**$1,409,594**	**$417,785**	**$1,950,713**	**$595,176**	**$187,427**	**$800,599**	**$1,355,141**	**$4,655,635**	**$31,693,011**

Note: Service component amounts may not sum to totals due to rounding.
Source: JLARC staff analysis of FY 1992 and FY 1993 expenditures obtained from Commonwealth Accounting and Reporting System.

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