

# Key Points of Report

## An Audit Report on Managed Health Care at the Texas Department of Criminal Justice

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January 1998

### Overall Conclusion

The implementation of a managed health care system, completed in fiscal year 1995, achieved the overall objective of controlling the increasing costs of providing health care to the inmates at the Texas Department of Criminal Justice (Department). As a result, the cost per inmate per day (capitation rate) has decreased from \$5.99 in fiscal year 1993 to \$5.23 in fiscal year 1997.

Opportunities now exist to improve management controls in several areas of the managed health care system, including the system's governance and organizational structure, the capitation rate, and performance evaluation and monitoring.

### Key Facts and Findings

- In fiscal year 1997, \$238.7 million was spent to provide managed health care to an average daily inmate population of 125,110 at the Department.
- University members of the Correctional Managed Health Care Advisory Committee (Committee), the governing board for the managed health care system, may be placed in a position of conflicting loyalties by negotiating service contracts with their employers.
- The Department does not directly contract with The University of Texas Medical Branch at Galveston and Texas Tech University Health Sciences Center (university providers) to provide health care to its inmates. Instead, it contracts with the Committee, which in turn contracts with the university providers.
- Before the capitation rate for the next biennium is set, allowable and unallowable cost components of the managed health care appropriation should be considered. The appropriation is in excess of the university providers' costs. At the end of fiscal year 1996 the university providers realized a net profit of \$25.3 million (10.47 percent of revenues) after returning \$12 million to the State's general revenue fund.
- As reported by our correctional health care consultant, the correctional managed health care system has achieved some efficiencies since it was implemented in September 1994. Accomplishments were noted in areas such as utilization management, decreased pharmacy costs, and use of telemedicine.

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*This audit was conducted in accordance with Government Code, Sections 321.0132 and .0133.*

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## Executive Summary

The implementation of a managed health care system, completed in fiscal year 1995, achieved the overall objective of controlling the increasing costs of providing health care to the inmates at the Texas Department of Criminal Justice (Department). As a result, the cost per inmate per day (capitation rate) has decreased from \$5.99 in fiscal year 1993 to \$5.23 in fiscal year 1997.

Opportunities now exist to improve management controls in several areas of the managed health care system:

- University members of the governing body may be placed in a position of conflicting loyalties by negotiating service contracts with their employers.
- The capitation rate should be reevaluated with consideration given to defining, identifying, and quantifying allowable costs to provide reasonable and necessary health care to the inmates.
- Management controls such as cost allocation systems and performance monitoring and evaluation need to be improved.
- Strengthening of contract provisions would provide some compensating controls and increase accountability of all parties.

As reported by our correctional health care consultant, the correctional managed health care program has achieved some efficiencies since it was fully implemented in September 1994. Accomplishments were noted in the areas such as utilization management, decreased pharmacy costs, and use of telemedicine. See Appendix 5 for the consultant's report.

## The Governance Structure of the Managed Health Care System Is Atypical

The Correctional Managed Health Care Advisory Committee (Committee) was legislatively mandated to create and oversee the implementation of a managed health care delivery system at the Department. The existence of this separate governing body, outside of the Department, has resulted in an organizational structure comprised of a series of contractual relationships.

Instead of contracting directly with the inmates' health care providers, the Department has a contract with the Committee, which in turn contracts with The University of Texas Medical Branch at Galveston (UTMB) and Texas Tech University Health Sciences Center (TTUHSC) to provide health care to the inmates. UTMB and TTUHSC (university providers) also have a number of subcontractors that participate in the health care delivery system.

This organizational structure has several unique characteristics:

- The governance structure of the managed health care system creates the potential for conflicting loyalties. The Committee is comprised of six members: two each from UTMB, TTUHSC, and the Department. The Committee, which is responsible for implementation and oversight of the correctional managed health care system, negotiates the contracts between itself and its medical care providers, UTMB and TTUHSC. Since two-thirds of the Committee members are employed by the universities that provide the health care, this close relationship may not ensure the

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objectivity of the health care procurement process.

- Oversight roles and responsibilities of all parties are not obvious. These roles and responsibilities are defined by various contracts.

The many levels of contracting tend to blur the lines of responsibility and accountability by the various parties. Because the health care system's framework is structured through contracting, it is essential that all contractual agreements clearly define each party's performance standards and monitoring responsibilities.

- The Committee's funding is contained within the legislative managed health care appropriation for the Department. As a result, the Committee cannot be held directly accountable for its financial and operational decisions by the Legislature.
- Although the funding is appropriated to the Department, the Committee has the authority to decide disputes between the Department and the university providers, who represent a majority on the Committee.

### **Reevaluate the Managed Health Care Capitation Rate (Cost per Inmate per Day)**

Although the system of health care delivery changed under managed health care, the process used to calculate the appropriate allocation to fund the services did not change. The appropriation for correctional managed health care was based on prior period expenditures, not on estimates of reasonable costs to provide managed health care to the inmates. As a result, the current cost per

inmate to provide health care may not be set at the appropriate level.

All cost components for providing direct health care have not been identified. For example, there is no fee or charge back for indirect support services provided by the universities to managed health care. Furthermore, allocation of staff workload among both university providers' managed health care initiatives (for the Department and others) is based upon estimations, which may yield an inaccurate cost designation.

Each university provider has set aside a catastrophic reserve fund; however, there has been no actuarial analysis to determine what the reserve fund balances should be. Because the providers have realized excess revenues over expenses since implementing managed care, once the appropriate fund balance is obtained, the capitation rate should be adjusted downward.

The margin of revenues over expenses has increased since managed health care was implemented in September 1994. The combined net profit realized by the university providers at the end of fiscal year 1996 was \$37.3 million out of \$241.8 million total revenue. The providers refunded \$12 million to the State's general revenue fund in September 1996, leaving a balance of over \$25 million; they plan to carry forward another \$12 million in excess revenue toward funding the Department's managed health care strategy in the current biennium.

### **Correctional Managed Health Care Lacks a Comprehensive Monitoring System**

Although a number of processes exist to evaluate and/or monitor aspects of performance, these processes do no interface

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or link with each other to provide a comprehensive monitoring and evaluation system. Because the basis of several of the monitoring processes is self-monitoring, review of operations by another party becomes even more necessary.

Although managers at all levels of the managed health care system receive reports from the evaluation and monitoring processes, many complained that they cannot easily integrate the multiple reports or use them to plan for improving performance. Establishment of a comprehensive, standardized monitoring system that integrates the various information and monitoring systems already in place would enhance current processes.

### Summary of Management's Response

The parties of correctional managed health care generally agreed with most of the report recommendations. A management response from the Committee, summarizing the responses of the Department, TTUHSC, and UTMB follows each recommendation. A summary letter from the Committee as well as the parties' detailed responses, are included in the "Managements' Responses" section of this report, beginning on page 49.

### Summary of Objective and Scope

The objective of this audit was to evaluate key controls over the Department's managed health care system. The correctional health care consultant compared prior and current periods in the areas of process quality and scope of services.

The scope of our audit included the review of management control systems such as governance, performance evaluation and monitoring processes, and information management. We reviewed contract provisions in the contracts between the Department, the Committee, UTMB, TTUHSC, and subcontractors. We evaluated expenditures and cost allocation systems related to the managed health care appropriation. Changes implemented under the managed health care system related to service delivery were reviewed. Mental Health Services was not included in our evaluation because of the newness of the program to a managed health care environment.

The Department's managed health care strategy was appropriated \$260,040,472 in fiscal year 1997. This amount represented over 9 percent of the State's total appropriation for Public Safety and Criminal Justice.

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## Overall Conclusion

The implementation of a managed health care system, completed in fiscal year 1995, achieved the overall objective of controlling the increasing costs of providing health care to the inmates at the Texas Department of Criminal Justice (Department). As a result, the cost per inmate per day (capitation rate) has decreased from \$5.99 in fiscal year 1993 to \$5.23 in fiscal year 1997.

Opportunities now exist to improve management controls in several areas of the managed health care system. University members of the governing body may be placed in a position of conflicting loyalties by negotiating service contracts with their employers. Management controls such as cost allocation systems and performance monitoring and evaluation need to be improved. Strengthening of contract provisions would provide some compensating controls and increase accountability of all parties. The capitation rate should be reevaluated with consideration given to:

- Defining allowable costs to provide "reasonable and necessary" health care
- Identifying and quantifying all allowable costs
- Determining a sufficient fund balance for a catastrophic reserve fund, if one is deemed appropriate

As reported by our correctional health care consultant, the correctional managed health care program has achieved some efficiencies since it was fully implemented in September 1994. Accomplishments include:

- Utilization management resulting in more on-site primary care and decreased number of specialty visits and emergency trips.
- Pharmacy cost savings achieved through use of clinical pharmacists, formulary management, and disease management guidelines.
- Deployment of telemedicine sites at various locations around the State, resulting in reduced inmate travel to specialists and reduced security risks.

See Appendix 5 for the consultant's report.

## The Governance Structure of the Managed Health Care System Is Atypical

**Creation of the Correctional Managed Health Care Advisory Committee**

The 73rd Legislature established the Correctional Managed Health Care Advisory Committee (Committee) through the provisions of Section 501.059 of the Texas Government Code. The Committee is composed of six members: two from The University of Texas Medical Branch at Galveston; two from the Texas Tech University Health Sciences Center; and two from the Texas Department of Criminal Justice. One member from each entity must be a physician.

The Committee was charged with developing a managed health care plan to include “the establishment of a managed care network of physicians and hospitals . . .” and “to the extent possible the committee shall integrate the managed health care provider network with the public medical schools of this state.”

Although the legislation creating the Committee and mandating a managed health care system was passed in the summer of 1993, the new delivery system was not fully implemented until September 1, 1994. The Committee, with support from its administrative staff, is responsible for the general statewide oversight, both fiscally and operationally, of the managed health care system.

The organizational structure of the Texas Department of Criminal Justice’s (Department) managed health care system consists of a series of contractual relationships. Instead of contracting directly with The University of Texas Medical Branch at Galveston (UTMB) and Texas Tech University Health Sciences Center (TTUHSC), the Department contracts with the Correctional Managed Health Care Advisory Committee (Committee). The Committee in turn contracts with UTMB and TTUHSC (university providers) to provide health care to Department inmates. Both university providers also have a number of subcontractors that participate in the health care delivery system.

This structure creates an environment in which the university providers could have conflicting loyalties, and it places some health care staff in conflicting roles. Strengthening the contracts between the various parties could reduce the opportunity for miscommunication and ensure managerial and monitoring decisions are made independently and objectively.

Figure 1

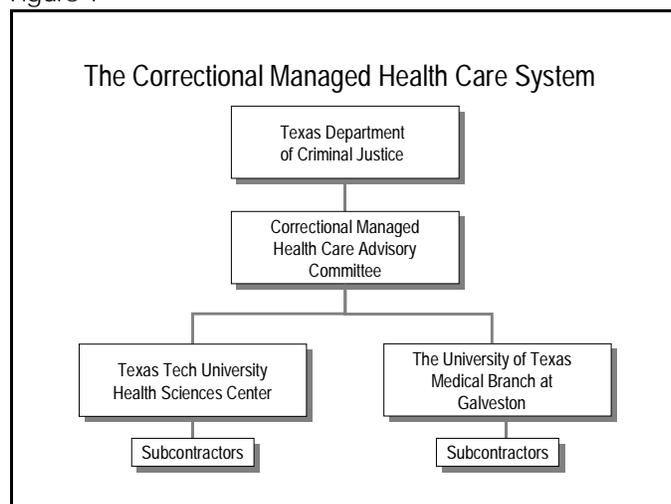


Figure 1 shows the organizational structure and contractual relationship of the correctional managed health care system.

The organizational structure creates several unique circumstances:

- The Department does not directly contract with the university providers for health care services to its inmates; the Committee contracts for the services.

- Oversight roles and responsibilities of all parties are not obvious. These roles are defined by the various contracts.
- The Committee's funding is contained within the legislative managed health care appropriation for the Department. As a result, the Committee cannot be held directly accountable for its financial and operational decisions by the Legislature.
- Although the funding for the health care system is appropriated to the Department, the Committee has the authority to decide disputes between Department and the university providers, who represent a majority on the Committee.
- The Committee is in the unique position of being in a contractual relationship as the "vendor" with the Department, and the "purchaser" with the university providers.

Whereas an entity separate from the Department may have been necessary to create and oversee implementation of a new health care delivery system, the existence of a separate governing board such as the Committee may no longer be critical to the continuation of the managed care system.

The following discussion is not intended to diminish the substantial endeavor undertaken by the Committee to implement a managed health care system. Nor does it challenge the obvious benefits to both the Department and the university providers by using the State's medical schools to provide health care to the inmates.

Section 1-A:

### **The Potential Exists for the University Members of the Committee to Have Conflicting Loyalties to Two Entities**

The current relationship between the Committee and the university providers does not ensure the objectivity of the procurement process. The Committee, with two-thirds of its members employed by the university providers, negotiates the contracts between the Committee and the university providers. Good contract administration practices generally prohibit parties who can influence procurement decisions in contract awards from being in a position to gain advantage from those decisions and awards. An arm's length contractual relationship to oversee compliance and administer the health care system would prevent questions about conflicting loyalties and add integrity to the organizational structure.

While we did not find any evidence of bias in contracting decisions, the close relationship between the Committee's medical school members and their employers (the university providers) may hamper competition by discouraging other potential providers from pursuing service contracts. Currently, no other state medical schools participate in the Department's managed health care system. The Committee's enabling

legislation envisioned, "to the extent possible," the integration of Texas' public medical schools into the managed care provider network. As previously discussed, the Committee, the contractee for health services, is composed of members who are employed by the university providers, the contractors who provide the health care. This type of relationship, in the private sector, would raise questions over conflicting loyalties between the parties.

Any sizeable managed health care system, especially one as large as the Department's system, requires two essential functions: system administration and a medical advisory board. The administrative function provides for the centralized operation of the health care system. An advisory board provides a forum to make decisions about health care standards, to create policy and procedures, and to ensure consistency of correctional health care throughout the State. While these two important functions are currently part of the Committee, this structure is not the only one that could accommodate system administration and a medical advisory board. For example, the Texas Youth Commission contracts directly with both UTMB and TTUHSC to provide medical care to the youth at its numerous facilities around the State. These interagency agreements do not include an intermediate entity such as the Committee.

While the providers of medical care should be represented on the medical advisory board to decide medical treatment and policy issues, they should not necessarily be in a position to make decisions about the financial aspects of the system. Currently, the three physicians and the three financial officer committee members make all operational and financial decisions. The Committee meets quarterly, in open session. Any sensitive or confidential issues must be discussed by the Committee in closed (executive) session.

Staff from the Texas Sunset Advisory Commission are currently reviewing the Committee's function. The Commission will receive a self-evaluation report from the Committee, conduct public hearings, and ultimately prepare a report to the 76th Legislature recommending continuation, abolishment, or statutory changes for the Committee.

Section 1-B:

### **Some Health Care Staff Are Placed in Potentially Conflicting Roles**

Apart from the contractual relationships which may cause conflicting loyalties for certain Committee members, the current organizational structure contains some areas in which health care staff and management are placed in conflicting roles. As a result, managerial and monitoring decisions may not be made independently and could be suspect if a challenge arose.

**The Medical Director of the Health Services Division is a full-time employee of UTMB who provides his services to the Department.** As Medical Director of the Health Services Division, this doctor is in a position to approve or veto the Health Services Division's monitoring actions and policies, which could be taken against his

full-time employer. The Department has been actively trying to hire a full-time Health Services Division director who would not be an employee of either university provider.

### ***Ruiz v. Estelle***

In 1972, David Ruiz, an inmate of the Department, filed a petition in U.S. district court claiming that prison conditions were unconstitutional. In 1980, federal district judge William Wayne Justice ruled in favor of the plaintiff, saying that the totality of the conditions in Texas prisons constitutes cruel and unusual punishment. In 1992, the State entered into a final judgement in the *Ruiz* case, which contained some general and specific requirements. In 1996, the Attorney General filed a motion to terminate the *Ruiz* Final Judgement; the federal district court had not ruled on the motion by the end of December 1997.

Major reforms resulting from the *Ruiz* case include:

- Improvements in health care and care of special-needs inmates
- Standards for the use of force
- Standards for prison construction
- Caps on prison population
- Reforms in work safety and hygiene
- Procedures for administrative segregation

The salaries of the Department doctors who hold management positions in the Health Services Division are paid through UTMB's payroll system. When the payment agreement between the Department and UTMB was created in 1988, the Department was having trouble hiring and retaining qualified physicians while under the specter of the *Ruiz* case's federal court supervision. Circumstances are changed now: the university providers are the direct employers of the prison unit physicians and the Department is operating under limited orders from the federal court. The only Department physicians still paid by UTMB who are not *bona fide* UTMB employees (with the exception of the current Health Services Medical Director) are the doctors in the Department's Health Services Division. Because this division contains staff and functions that oversee the health care services and providers, it is inappropriate for staff members to be paid by the party they monitor.

According to a recent Department internal audit report, some medical school dental and mental health staff members are borrowed by the Health Services Division to participate in the operational review process. The operational review process provides an evaluation of prison health clinic operations, independent of the service providers. Since this review is a major part of the Department's monitoring effort, use of medical school staff to monitor units staffed and operated by the university providers presents a potential conflict of interest. This problem was noted in the Department's *Internal Audit Report on Operational Review*.

Section 1-C:

### **The Contracts Between the Various Parties Could Be Strengthened**

The many levels of contracting tend to blur the lines of responsibility and accountability for processes and performance. Because the health care system's framework is structured through contracting, it is essential that all contractual agreements clearly define each party's roles and responsibilities, especially concerning performance standards and monitoring. Furthermore, frequent and open communication between the various parties is critical. Lack of clear definition or adequate communication can lead to finger-pointing and inaction in a time of crisis.

**Contracts at all levels of the organization would benefit from more specific provisions related to performance expectations, financial controls, and monitoring.** The contract between the Department and the Committee does not include provisions for:

- Sanctioning for poor performance
- Establishing guidelines for monitoring of subcontractors
- Ensuring all costs are reasonable and necessary (due to the nature of unit-cost contracts)
- Verifying that comparable costs are charged for comparable services
- Monitoring operational results to determine overall performance and or compliance

The contracts between the Committee and the university providers mirror the contract between the Committee and the Department; therefore, the provisions listed above are lacking from the university providers' contracts as well.

The contract between the Department and the Committee does not provide the Department with direct recourse if performance of the contractors is unsatisfactory. The Department lacks the authority to remove a doctor or dentist from direct patient care if sufficient questions are raised about a specific care provider. The current contract states that the Department must formally request that the university provider remove the doctor from patient care, pending review by the university. If the Department does not agree with the decision of the university provider, it can appeal to the Committee, whose decision is binding. The Department does have authority to deny access to the prison unit for security reasons.

There are no contract provisions which would allow the Department to hold the university providers accountable for monitoring their subcontractors' performance. Neither the contract between the Department and the Committee nor the contracts between the Committee and the university providers include a provision which requires subcontractors to be monitored.

In July 1997, state health facility licensing inspectors found serious deficiencies at a prison dialysis unit operated by a subcontractor of UTMB. Although the Department's Executive Director expressed his deep concern over the effectiveness of UTMB's monitoring of its subcontractor, the contractual agreements do not provide the Department with any recourse against UTMB or the subcontractor in question.

**Contracts between university providers and subcontractors should be enhanced.** Both UTMB and TTUHSC employ a number of subcontractors to provide various medical services for the inmate population. In the western sector of the State, TTUHSC subcontracts about 80 percent of its medical services to local providers. The university providers have subcontracts with:

- Local providers for off-site emergency care
- Local providers for on-site care at the prison units

- Individual health care specialists
- Health care providers for miscellaneous services such as ambulance transportation, laboratory services, radiology services, and other ancillary care

In general, the contracts between the university providers and subcontractors lack (1) clearly defined performance standards and measurable outcomes and (2) a clear statement of how contractor performance is evaluated. The contracts cite general standards such as those from the National Commission on Correctional Health Care, the Department's Comprehensive Care Plan, and applicable court mandates; however, specific rules, such as licensing or state health laws which might apply to the subcontractor, are not referenced. The contracts also lack specific reporting requirements; however, subcontractors for on-site services must comply with reporting Quality Improvement Program results.

Contract provisions specifying performance standards for subcontractors would give the university providers a means of holding their subcontractors accountable for specific performance. In the example above of the subcontracted dialysis unit, the contract between UTMB and the subcontractor does not reference the specific performance standards by which the State inspects dialysis units. Without this provision, UTMB lost an enforcement tool.

Overall, the subcontracts do contain:

- Termination provisions
- Audit clauses that allow access to subcontractors' records by oversight entities
- A clear statement of expected services

**Roles and responsibilities of all parties need to be more clearly defined.** This is especially important because the levels of contracting may hamper communication between involved parties. For example, state health inspectors made a courtesy visit to a prison dialysis unit in December 1995, before proposed licensing regulations became effective. The purpose of the visit was to point out possible deficiencies at the dialysis unit based on current rules in effect for licensing private dialysis facilities. (These rules were considered a prototype for rules proposed for state entities.) Although inspectors provided a summary report of potential deficiencies to the unit health administrator (a UTMB employee) and spoke with the subcontractor (which provided dialysis services for the unit), the report was not shared with anyone from the Department.

The failure to provide feedback to the Department is especially surprising in light of the fact that the Department is the official applicant for the dialysis unit's license and is responsible for the physical plant. By not sharing the courtesy licensing survey results with Department, the Department was denied the opportunity to address a problem that contributed to a serious deficiency report a year and a half later.

A situation in which a clear understanding of each party's responsibility was critical occurred in July 1997, when a team of state health facility licensing inspectors found

serious deficiencies at the prison dialysis unit cited above. The deficiencies were both in the operation of the dialysis center and the physical plant. The Department is responsible for any problems with or changes to the physical plant itself. UTMB employs the staff of the prison's health clinic, including the physician responsible for the dialysis center. A subcontractor for UTMB is responsible for the dialysis operation, and the subcontractor employs yet another subcontractor to maintain the water treatment system at the dialysis unit. Before deficiencies cited by the health inspector could be addressed, even in a corrective action plan, all parties—the Department, UTMB, and the subcontractors—had to communicate with one another and jointly determine responsibilities and a course of action. Lack of cooperation on anyone's part would jeopardize corrective action and potentially the inmates' health and safety.

**The organizational structure lacks sufficient processes to fully monitor managed health care's programmatic and financial operations.** It is not obvious from the organizational structure where the monitoring responsibilities lie; all parties bear some risks and thus should oversee operations. As mentioned previously, the various contracts do not necessarily assign all monitoring responsibility. However, as the party legally responsible for the inmates, the Department must assume a major monitoring role.

As a unique entity whose funding comes entirely from the Department's managed health care strategy, the Committee is not directly monitored by either the Department or the Legislature. Provisions defining specific monitoring processes would ensure the Department that both the Committee and the university providers could be held accountable for specified performance standards. Similarly, specific monitoring provisions in the contracts between the Committee and the university providers would also strengthen the accountability of the health care providers.

**Unless a monitoring process was specifically denoted in the contract provisions, no party to the contract could reasonably be held accountable for its execution.** The contract between the Committee and the Department for fiscal years 1996 and 1997 contained only the broad monitoring provision that the Committee and the Department had the right to monitor provision of services under the contract and to inspect all records, charges, billings, and supporting documentation. The contracts between the Committee and the university providers for fiscal years 1996 and 1997 contained only the above provision and two others related to monitoring:

- The university providers were responsible for developing and maintaining an ongoing quality improvement plan and providing semi-annual reports to the Committee and the Department.
- Staff members of the university providers' and Department's internal audit departments were to meet and jointly develop a plan outlining auditing responsibilities. The contract provision indicates that each internal audit department will be responsible for reviewing operations at its respective agency.

Neither the Committee nor the university providers developed a statewide quality improvement plan. The quality improvement/quality management (QI/QM) process resides in the Department's Health Services Division, and essentially remains unchanged since the implementation of managed health care in September 1994. See further discussion of the quality improvement process at Section 4-A.

Although the contract called for staff members of the internal audit departments to meet and jointly create an auditing plan, this provision was not fully implemented. The provision acknowledging the roles of the internal audit departments did not contain a mechanism to ensure that the university providers resolved weaknesses noted in any audit reports. The staff members of the three agencies met jointly two times in the two-year period and never developed an overall auditing plan for managed health care. The auditors agreed to each review managed health care operations within their respective agencies. Moreover, few audits of the new health care system occurred. Given the newness of the managed health care system and the sizeable resources devoted to it, this should be considered a high-risk area. Audits that were completed include:

- A UTMB internal audit of the pharmacy year-end inventory in November 1996
- A TTUHSC internal audit to test billings from private vendors in September 1996
- A Department internal audit of the Health Services Division's Operational Review process in May 1997

The newly signed contracts for fiscal years 1998 and 1999 do not contain a similar provision acknowledging the roles of the respective internal audit departments.

As noted in a recent Department Internal Audit Division report, no Department division is responsible for monitoring the Committee's and university providers' compliance with contract provisions. The Department's internal audit report cites contract provisions which should receive regular monitoring but currently do not. These provisions include the Committee's reporting of required studies such as cost containment, care case management, and utilization management. To address monitoring deficiencies identified by the Department's internal audit report in May 1997, the Department proposed a plan to hire additional staff in the Health Services Division. The additional staff will be responsible for monitoring medical operations of the correctional managed health care contracts.

Since the contracts between the university providers and their subcontractors mirror the contracts between the university providers and the Committee, these contracts would also benefit from specific monitoring provisions. As noted in Section 4, managed health care lacks a comprehensive, integrated monitoring and evaluation process. Adding specific contract provisions that assign and clarify monitoring responsibility to all contractual agreements should promote accountability throughout the organizational

structure. A better defined, integrated evaluation process will provide managers at all levels with the information needed to adjust operations to achieve stated objectives.

Recommendation: The Department is encouraged to pay its Health Services Division physicians through its own payroll system.

Committee's Response: *TDCJ concurs.*

Recommendation: The Department is encouraged to continue its efforts to hire an independent Health Services Division Medical Director, who is independent of the contracted health care providers.

Committee's Response: *TDCJ concurs and has an action plan in process.*

Recommendation: The Health Services Division should secure sufficient staff to perform all aspects of the Operation Review audits, eliminating reliance on staff from the university providers to assist in the audits.

Committee's Response: *TDCJ concurs and has an action plan in process. The university providers note that the utilization of peer practitioners in reviewing the clinical aspects of health care delivery is an established and traditional medical model recognized by both state law and industry practice. The university providers will continue to offer and make available their assistance to the TDCJ Health Services Division. Should TDCJ elect to adopt this recommendation, the fiscal implications resulting from increased staffing should be considered. Given the historical difficulty experienced by TDCJ to recruit and retain health care practitioners and the likely expense involved in hiring full-time clinical staff to perform non-patient care duties, the feasibility of contracting for such services should be examined.*

Recommendation: Consider an amendment to the current contracts between the Department and the Committee and the Committee and the university providers which enables the Department to hold the university providers accountable for monitoring their subcontractors' performance.

Committee's Response: *The university providers disagree with this recommendation. Under current law, they contract with the CMHCAC and not the TDCJ and are therefore accountable to the CMHCAC for contract compliance. Amending the contracts as recommended would essentially bring another party "TDCJ" into the agreement, would change the character of the contract substantially and ignore the current statutory arrangement. TDCJ concurs with the recommendation and*

*has proposed that such an amendment be incorporated into the next biennium contract.*

Recommendation: In all applicable subcontracts, include by reference any relevant state licensing or health regulations for the services being contracted.

Committee's Response: *The CMHCAC partners note that the current contracts contain a number of general references to insure subcontractor compliance, but concur that additional clarifying language would be beneficial. Due to the number of contracts involved, the clarifying amendments will be added during the next biennial contracting process and in any new subcontracts entered into this biennium.*

Recommendation: Roles and responsibilities of all parties should be clearly defined and specifically stated in the contracts.

Committee's Response: *The CMHCAC partners concur that additional role definition would be beneficial and will work to more precisely define roles and responsibilities. Such clarifications will serve as the groundwork for the next biennial contracting process.*

Recommendation: Information relating to potential problems as well as any action affecting managed health care must be shared with all parties within the organization. This includes the Department's executive management and Department Health Services Division management, the Committee, the university providers, their subcontractors, and unit and regional management.

Committee's Response: *The CMHCAC partners concur. While it is believed that the example cited in the report represents an aberration and not the norm, all partners are committed to more effective communication on issues relating to the managed health care program.*

Recommendation: The Department should develop a monitoring function which will be responsible for monitoring all operational and financial aspects of the contract between the Department and the Committee. This function would also oversee the monitoring of the providers by the Committee and have the authority to review all financial and operational records related to the provision of health care to the Department's inmates.

Committee's Response: *TDCJ concurs and has initiated an action plan for operational monitoring. As noted by the university providers in an earlier response above, the utilization of peer practitioners in overseeing the health care delivery system is an established medical model. Should TDCJ elect to adopt adding staff as called for in this recommendation, the university providers suggest that the fiscal implications resulting from increased staffing be considered. Given the likely expense*

*involved and TDCJ's difficulty in recruiting and retaining health professionals, the feasibility of contracting for such services should be examined. As needed, the university providers will continue to offer and make available their assistance to the TDCJ Health Services Division.*

*Perhaps more fundamental to this issue is that the university providers believe that it is the Legislature's prerogative to determine the role of the CMHCAC in monitoring the university providers charged with providing offender health care. The current legislatively established structure vests that authority within the CMHCAC. At the same time, the CMHCAC contract documents already clearly provide TDCJ and the CMHCAC staff with access to "all records, charges, billings and supporting documentation" and to all medical records.*

A summary management letter from the Committee and detailed responses from the Department, TTUHSC, and UTMB are included in the "Managements' Responses" section of this report, beginning on page 49.

## Section 2: CAPITATION RATE

### Reevaluate the Managed Health Care Capitation Rate

Although the system of health care delivery changed under managed care, the process used to calculate the appropriate allocation to fund the services did not. The appropriation for the inmates' managed health care system was based mainly on prior period expenditures, not on estimates of reasonable costs to provide managed health care to inmates. Therefore, the current cost per inmate to provide health care may not be set at the appropriate level.

To calculate an appropriate allocation for providing health care to the inmates, the following steps must occur:

- Allowable costs to provide "reasonable and necessary" health care must be defined.
- All allowable costs must be identified and quantified.
- If a catastrophic reserve fund is deemed appropriate, the methodology for determining a sufficient fund balance must be developed.
- Fixed and variable costs associated with providing health care to the increasing inmate population should be identified and tracked.

The Department's prior health care system was essentially a "fee-for-service" system, which is inherently more costly than a system where the use of specialty care is managed through treatment protocols. In fact, the impetus behind the January 1993

Texas Performance Review recommendation that Texas adopt a managed care system for the inmates was to “effectively control health care costs.” Information reported by the university providers shows that since the implementation of managed health care, efficiencies have been realized in costly areas such as the use of specialists and length of hospital stays. The demonstrated cost savings can be used in the reevaluation of the managed health care appropriation.

Section 2-A:

## Allowable Costs Were Not Clearly Defined

### Capitation Rate

The capitation rate is the price per inmate per day paid to the university providers for inmate health care. The capitation rate is calculated by taking the amount appropriated to provide health care to the inmates and dividing by the average annual inmate population. This annual figure can also be recalculated and stated as a daily or monthly amount.

Currently the university providers are paid for their services based on a “capitated rate,” essentially a unit-cost contract. With this type of contract, the university providers are not held accountable for how the money is spent; that is, there are no restrictions on the use of the funds. The unit-cost contractual agreement emphasizes service delivery and does not state how the dollars are to be spent or define allowable and unallowable costs. As a result, any funds not spent on service delivery are essentially “profit” to the university providers and can be spent however they choose without violating the contract terms.

**Without analyzing prior health care cost components or defining allowable and unallowable costs for managed**

**health care, it is difficult to assess the reasonableness of the capitation rate.**

When the managed health care concept was adopted and funded by the Legislature, there was no effort to identify essential cost factors for providing health care to the inmates. Allowable and unallowable costs for managed health care were not clearly defined before the capitation rate was initially set. In fact, the initial appropriation to fund the inmates’ health care was set at a level consistent with the expenditures in the prior period. Even the funding for the Department’s hospital on the UTMB campus remained at the same level.

While the cost of providing direct medical services to inmates would certainly be considered an allowable expenditure, other expenditures related to the health care system have not been categorized as allowable or unallowable. In our review of expenditures by the university providers, we identified some items, budgeted by UTMB for fiscal year 1997, which did not involve direct delivery of health care to Department inmates. These expenses included:

- \$400,000 to establish performance outcome measures for correctional health care
- \$200,000 to start up a correctional health care residency training program
- \$1,000,000 for physician incentive bonuses; \$668,000 in bonuses was actually paid to physicians and dentists in August 1997.

Neither the contracts to provide medical services nor the legislative appropriation address the appropriateness of expenditures related to health care. Because the capitation rate does not have guidelines for allowable expenditures, charges of this nature are legitimate uses of managed health care funds. We did not find similar expenditures when reviewing TTUHSC records.

Expenditures such as these raise the question of whether the university providers are receiving more funding than is “reasonable and necessary” to cover the costs of providing medical care to the inmates. The capitation rate is currently set higher than the actual cost of providing health care to Department inmates. This is evidenced by the \$12,000,000 in excess revenues over expenses returned to the State at the beginning of fiscal year 1997 and the existence of catastrophic reserve funds being held by the university providers. The difference between the actual cost (the expenditures by the university providers directly related to health care) and revenues based on the capitation rate is the margin of profit to the providers.

As shown in Table 1 below, the combined net profit realized by the two university providers in fiscal year 1996 was \$25,325,283, or 10.47 percent excess revenue over expenses. From this amount, the university providers set aside a total of \$9 million as catastrophic reserve funds. For further discussion of the catastrophic reserve funds, see Section 2-C.

Continued excess revenues over expenses in fiscal year 1997 (not shown) resulted in a carry forward of \$12,000,000 to reduce the appropriation needed for the 1998-1999 biennium. If managed care efficiencies continue to be realized, further capitation rate reductions may be possible.

Table 1

Reported TTUHSC and UTMB Combined Summary Revenues and Expenses Unaudited Fiscal Years 1995 and 1996				
	Amount		Percentage	
	1995	1996	1995	1996
Average Daily Population	100,508	121,601		
Revenues	\$181,968,770	\$241,845,627	100.00%	100.00%
Expenses	\$181,890,952	\$204,520,344	99.96%	84.57%
Revenues Over Expenses	\$77,818	\$37,325,283	0.04%	15.43%
Refund	0	(\$12,000,000)	0.00%	(4.96%)
Net Balance	\$77,818	\$25,325,283	0.04%	10.47%

Source: Correctional Managed Health Care Advisory Committee

As the immediate purchaser of health care services from the university providers, the Committee is responsible for monitoring the university providers' expenditures. However, since a majority of the Committee's members are employees of the university providers, this relationship is awkward and lacks the distance necessary to ensure an independent appraisal.

The question of whether the university providers should be accumulating excess revenues by providing medical care to the inmates and if so, how much the excess should be, is a policy matter that only the Legislature can address. A solution involves full identification and reporting of all expenditures by the university providers, which would allow the Legislature to revisit the capitation rate based on more complete expenditure information.

Section 2-B:

### **All Cost Components for Providing Direct Health Care Have Not Been Identified**

The inability to identify all managed health care cost factors prevents the university providers from completely calculating the total costs associated with the managed health care system. Two areas where cost are not clearly identified include (1) the indirect support services provided by the university providers to the Department's managed care and (2) the cost of a portion of the reclaimed drugs.

**There is no fee or charge back for indirect support services provided by the universities to the Department's managed care.** Discussions with managed health care administrators at both UTMB and TTUHSC reveal that costs for the following support services provided by the universities are not charged to the Department's managed care:

- At UTMB, the Department's managed care is not charged for administrative support services provided by the fiscal office or the payroll, accounting, and legal divisions.
- At TTUHSC, indirect support services such as risk management, legal, contracting, payroll, data processing, and university administrative overhead have never been charged to the Department's correctional care accounts. Building use at the TTUHSC main campus is provided at no charge to the Department's managed care program.

At TTUHSC, there are 11.5 full-time equivalent employees (FTE) who perform accounting, human resource, and purchasing functions which are charged directly to the correctional managed care accounts. A set fee covering these employees' salaries, benefits, and supplies was negotiated between TTUHSC and TTUHSC Correctional Health Care.

University providers' management cite the difficulty of identifying percentage of time spent by support function staff on different programs; however, the total cost of providing inmate health care is not known without factoring in support services. Further, best management practices increasingly emphasize the importance of identifying total costs in order to manage effectively. One frequently neglected component of total cost is indirect support services.

**The university providers should allocate costs among all their managed care programs.** UTMB and TTUHSC operate managed health care programs for entities, both private and governmental, other than the Department. Both the university providers attempt to segregate and/or allocate resources used by Department and non-Department managed care programs. Whereas UTMB appears to have made an effort to segregate the Department's managed care funds and staff roles from its other managed care programs, TTUHSC's cost allocation efforts appear to have been implemented more recently.

The allocation of staff time at UTMB is based upon management's estimation of work loads incurred by each respective program. No time sheets for direct administrative support staff are maintained to substantiate this allocation. Aside from the Department's managed care contract, UTMB also operates managed care programs for the Texas Youth Commission, Federal Beaumont Prison, and others. As of May 1997, UTMB had 20 budgeted positions to perform activities for these programs. Of these, 17 budgeted positions work exclusively on non-Department programs and are paid out of non-Department funds. Three budgeted FTEs perform activities for both the Department and one or more of the non-Department managed care programs. Of these 3 positions, 1.23 FTEs are charged to non-Department funding sources.

Direct service staff members, such as dentists who perform services for more than one of UTMB's contracted correctional health care programs, have their time logged by unit administrators. Time and expenses, based on the logs, are then charged back to the appropriate accounts.

At TTUHSC, the allocation of staff time is derived from estimates of relative workloads. No timekeeping system or other studies support the allocations. In addition to Department managed care, TTUHSC has a Medicaid managed care program and a number of Preferred Provider Organization (PPO) contracts. The PPOs are located at the satellite campuses.

In fiscal year 1997, TTUHSC established a 5 percent administrative fee for managed care programs, including Department managed care. The fee is assessed as 5 percent of revenues received from each managed care program and was charged retroactively in fiscal year 1997 for fiscal year 1996. This administrative fee was arbitrarily set; no methodology was used to derive the 5 percent fee. In addition, as the fee is assessed against total revenues, as opposed to total expenditures, it does not reflect the amount of resources required to do the job. A fee set on revenues also fails to account for TTUHSC's reserve fund balance of \$4 million for Department medical services, among other considerations.

The administrative fee assessed by TTUHSC for the Department's medical services contains a profit margin. For fiscal year 1996, the 5 percent administrative fee assessed for correctional health care (exclusive of psychiatric) was \$2,250,759, while costs were \$1,296,717, leaving a profit of \$954,042 (42 percent). The administrative fee for fiscal year 1997 is \$2,504,022. Administrative salaries and costs are listed as \$1,167,592, leaving a profit of \$1,336,430 (53 percent).

There are 30.75 administrative FTEs involved in TTUHSC's managed care programs (both Department and non-Department). Of these, 21.8 FTEs are funded out of Department funds, while the remaining 8.95 FTEs are funded from other managed care funds.

Estimates of workloads associated with various programs, without the benefit of time sheets or supporting studies, may yield an inaccurate estimation of costs for different programs. Without accurate identification of costs incurred on behalf of the Department and other managed care programs, costs may be either understated or overstated. Without an accurate cost allocation system in place, there is no protection against subsidization of commercial managed care initiatives. Although we found no evidence of this in our review, this issue becomes even more significant as both UTMB and TTUHSC expand their managed care initiatives within and outside of the State.

**The centralized pharmacy does not track all unused medicines.** The centralized pharmacy, operated by UTMB Managed Care through a contract with the University of Houston School of Pharmacy, does not have an overall system in place to track all unused, returned medicines. Unused medicines are sent back almost daily to the central pharmacy in Huntsville, where they are manually sorted to be reclaimed or destroyed. (Drugs which have not expired and are unit packaged are reshelfed and reissued. Medicines which have expired or are not unit packaged are destroyed.) The exact cost of the returned drugs is not known; the dollar amount of destroyed drugs is not estimated or tracked by the pharmacy. Because pharmacy costs are a major component of the capitation rate, these costs must be accurately identified.

There is no computerized or manual inventory record of the reclaimed medicines sent back to the centralized pharmacy from the UTMB prison units. Although reclaimed drugs are reshelfed and reissued, the costs for these drugs are not calculated. Therefore, pharmacy costs cannot be accurately calculated and inventories do not accurately reflect the cost of drugs issued to inmates.

Unlike returned medicines from the UTMB sector units, when medicines are returned to the central pharmacy from the TTUHSC sector units, a dollar value is assigned to those medicines than can be reissued. This amount varies each month between \$30,000 and \$40,000. TTUHSC Managed Care contracts with UTMB Managed Care for the purchasing and dispensing of medicines to inmates in the TTUHSC sector. The credit for the reusable drugs is reflected on TTUHSC's monthly statement from UTMB Managed Care, along with the monthly charge for medicines issued to inmates in the TTUHSC sector units and a percentage of salary costs to operate the pharmacy.

Pharmacy management anticipates the implementation of an automated system, which tracks medicines through bar coding, by the end of December 1997. Once the new system is in place, reusable, reclaimed drugs will be credited to both university providers through a bar code sorting process. The system will be able to track medicines by drug, unit, and inmate number. This feature will provide health care managers with better information, including an inmate's compliance record with prescribed medications.

#### Assumption of Risk

The Department's managed health care system is unlike managed health care organizations in the private sector in two respects. First, a health maintenance organization in the private sector assumes all risk for the provision of health care services to its members, regardless of the cost. In the case of the Department's prison system, the State is ultimately responsible for funding the inmates' health care. For example, the contracts between the Committee and the university providers include a provision which allows the university providers to be reimbursed for expenses due to natural or manmade disasters. Secondly, private health maintenance organizations do not assume legal guardianship of their patients. While the State can delegate responsibility to the university providers to provide health care to the inmates, the State is still legally responsible for the inmates' welfare. Legal opinions state that a state cannot contract away its responsibility for the inmates' health care; however, this responsibility is shared with the university providers through the contractual agreements.

Section 2-C:

#### University Providers' Catastrophic Reserve Funds Lack Sufficient Methodology

The existence and size of a catastrophic reserve fund for correctional managed health care is an area that warrants review. The funding of a reserve and any adjustments to the fund amount directly impact the capitation rate. If the reserve fund is considered an allowable component of managed health care costs, once the appropriate fund balance is obtained, the capitation rate should be adjusted downward.

Each university provider has established reserve funds for unanticipated, catastrophic costs. At the end of fiscal year 1996, UTMB had reserved \$5 million and TTUHSC had reserved \$4 million for catastrophic medical expenses. There has been no actuarial analysis on the question of how large the reserve funds should be. The disparity in the amount reserved by each school magnifies this issue. UTMB has approximately 80 percent of the

inmate population and has reserved \$5 million, while TTUHSC has 20 percent of the inmate population and has reserved \$4 million for catastrophic medical care.

**The lack of analysis over the appropriate amount of a reserve fund creates uncertainty as to the amount of funds the university providers should receive under the capitated rate.** In fiscal years 1995 and 1996 the university providers realized a profit margin, of which a portion was plowed back into managed care for catastrophic reserves. If the appropriate amount of the reserve were identified, the margin and capitated rate could be reduced once the reserve amount was reached.

The university providers may not find similar correctional health care programs after which to model a catastrophic reserve methodology. Data to perform an actuarial analysis may be limited or nonexistent for correctional managed health care. A number

of factors, such as the number of patients and past risk experience, must be considered in establishing a catastrophic risk reserve fund. Since inmates generally have poorer health than the general population, this fact needs to be considered as well.

Section 2-D:

### Fixed and Variable Costs Associated with Providing Health Care Impact the Rate

As shown in Table 2, the Department's inmate population doubled between 1993 and 1996 and continues to grow. To accommodate the increasing census, the prison system undertook a major construction program to build new units and modify some existing ones.

Table 2

Inmate Population and Health Care Costs Fiscal Years 1993 through 1997			
Fiscal Year	Average Daily Population	Health Care Cost	Cost/Inmate Per Day
1993	60,490	\$132,429,450	\$5.99
1994	73,244	\$144,750,669	\$5.41
1995	100,508	\$196,210,567	\$5.35
1996	121,601	\$229,881,339	\$5.18
1997	125,110	\$238,772,783	\$5.23

Source: Correctional Managed Health Care Advisory Committee

#### Cost Factors

Costs are generally classified as either fixed costs or variable costs.

Fixed costs associated with providing inmate health care are those costs which do not vary as more inmates are added to the correctional system. The fixed costs of providing medical care at a prison unit do not increase while the activity is within the capacity of the unit. Once the capacity is exceeded (the average daily population exceeds a certain level), more capacity (more prison units) and thus, fixed costs must be added to the system. Costs related to capacity and overhead, such as salaries of medical staff and equipment, are examples of fixed costs. Fixed costs will be specific to each operating unit.

Variable costs are directly related to the number of inmates in a unit. At some point before a prison unit reaches capacity, the fixed costs (such as staffing and equipment) have been realized and should not increase as the unit population increases. When additional inmates are added to the unit after that point, the cost of adding each additional inmate only includes a variable cost component.

If a newly constructed unit was immediately occupied to capacity, the daily cost to provide medical care to the inmates there would consist of both the fixed and variable cost components. However, at units where occupancy gradually increased, at some point the fixed costs would cease to be a factor as the unit reached capacity. That is because the necessary equipment

would have been purchased and the minimal staffing level achieved before all inmates were added to the unit.

If the trend of the past five years continues, the incarcerated population at the Department will keep growing and the need for new or expanded prison units will remain. Excess capacity will result if all new beds are not filled as soon as they are available. Tracking of the baseline costs of opening new or expanded units will enable health care managers to calculate fixed and variable costs associated with prison expansion. At the point where fixed costs do not increase but the unit has excess capacity, the cost of providing health care to the unit's additional inmates should be only the variable cost component. Thus an opportunity may exist to reduce health care costs as excess capacity is depleted at existing units.

Recommendation: The Committee should annually evaluate the components and costs of providing health care to the inmates. This information should be provided to the Legislative Budget Board for use by the Legislature in determining the appropriation for the managed health care strategy. Before the capitation rate for the next biennium is set, allowable and unallowable cost components of the health care appropriation should be clearly defined.

Committee's Response:

*The CMHCAC and its partners will continue to work closely with the LBB and Legislative staff in providing information relating to the components and costs of providing health care to the offender population and establishing an appropriate capitation rate. TDCJ concurs with the recommendation however, the university providers disagree with the setting of allowable v. unallowable cost components suggested by this recommendation because it significantly changes the nature of the contracts. If the state wants to continue acquiring health care through risk contracts then the concept of what is an "allowable" or "unallowable" cost would not be applicable. Under risk contracting the "at-risk" provider is liable for any and all costs and is afforded the flexibility to allocate funds as needed to manage their risk. The state has successfully been able to shift financial risk to managed care organizations in a number of instances—correctional health care, state employee health plans and the evolving Medicaid Managed Care programs. Reverting to a structure other than risk contracting for correctional health care will be more costly to the state.*

Auditor's Comment:

The university providers disagree with our recommendation that allowable and unallowable cost components of the health care appropriation should be clearly defined before the capitation rate is set for the next biennium. Without analyzing prior health care cost components or defining allowable and unallowable costs for managed health care, it is difficult to assess the reasonableness of the capitation rate.

Recommendation: To ensure a common financial reporting system for all medical services provided, the Committee should establish financial reporting requirements consistent with health care industry standards. University providers should identify and report all expenditures of correctional managed health care to the Committee, according to these requirements, on a regular basis.

Committee's Response: *The CMHCAC partners concur and will establish a work group comprised of financial officers from the partner agencies to establish a common financial reporting system. The revised reporting system would be in place by the start of the next fiscal year.*

Recommendation: UTMB and TTUHSC should develop a method to identify the costs of providing indirect support services for Department managed care. An appropriate charge back system should be developed to reimburse the universities for the costs incurred in providing indirect support services.

Committee's Response: *The university providers concur and have already taken action to insure that appropriate indirect support services are charged to the TDCJ managed care contracts.*

Recommendation: Proper allocation of expenditures and segregation of funding sources for Department and non-Department managed care programs is essential to maintain accountability for each medical school's programs. Both UTMB and TTUHSC should review present allocation methods to ensure accuracy of the estimated workloads driven by different programs. The medical schools should consider use of a timekeeping system or conduct random moment time studies for staff who perform activities for Department and other non-Department managed health care programs.

Committee's Response: *The university providers concur. Where allocation of costs and effort are applicable, the university providers will utilize methodologies similar to those used for federal grants and contracts.*

Recommendation: The Committee should identify the data elements needed to perform an actuarial study on financial risk and should begin to collect this data. After an appropriate baseline of information is established, an analysis of the risk and required amount of reserves should be performed.

Committee's Response: *The CMHCAC and the university providers concur and in anticipation of this need, included language in the current university*

*contracts to select a mutually acceptable actuary to assist in this process. The study will be completed by the time the next appropriation request is to be submitted.*

Recommendation: The centralized pharmacy should continue its efforts to automate all aspects of the drug dispensing process. Identifying the total cost of reclaimed, reissued medicines should enable the managed health care program to accurately calculate inmate pharmacy cost. Moreover, the pharmacy will be able to accurately value its inventory when complete costs are known.

Committee's Response: *The CMHCAC partners concur. Automation improvements are scheduled for installation in January of 1998.*

Recommendation: The university providers should track the fixed costs associated with establishing a health clinic in a new prison unit or modifying a current unit to accommodate an increased population.

Committee's Response: *The CMHCAC partners concur.*

A summary management letter from the Committee and detailed responses from the Department, TTUHSC, and UTMB are included in the "Managements' Responses" section of this report, beginning on page 49.

### Section 3: TRANSPORTATION AND SECURITY COSTS

## Transportation and Security Costs Related to Health Care Are Not Tracked

It is not possible to precisely track all related transportation and security costs incurred when inmates are moved for medical reasons. Although transportation and security costs are a component of the total cost of the Department's health care program, these costs have not been quantified; thus the total cost of delivering medical care to the Department's inmates is unknown. Under the terms of the contracts between the Department and the two university providers, the Department is responsible for the costs of transporting inmates for non-emergency medical reasons. The two university providers are responsible for emergency medical transportation costs.

Inmate transportation is headquartered in Huntsville. The Department's Classification Division schedules and monitors movement of inmates, while the Transportation Division is responsible for the actual transportation of inmates. In fiscal year 1996, a total of 4.2 million miles were driven to transport inmates for general and medical reasons. Inmates in outlying areas who are scheduled for medical transportation generally ride regular "chain buses" along with inmates who are being moved for non-medical reasons. Once inmates transported from outlying areas reach Huntsville, there

is a dedicated medical bus run from Huntsville to Hospital Galveston, the prison hospital.

The Department estimates that approximately 55 percent of all regular chain bus passengers are transported for medical reasons. The Department uses 89 separate codes to detail the reasons why inmates on regular chain buses are being transported. Although there are eight separate codes related to medical transports, some medical transportation is coded under non-medical categories such as “en route.” The Department’s Internal Audit Division has noted that efficiency of the transportation system takes a “back seat” to effectiveness of medical and security concerns.

Although the Department collects data on security costs associated with transportation runs, its analyses frequently do not capture overtime incurred by security staff; therefore, the security costs related to transportation of inmates are understated.

**Cost savings attributed to increased use of telemedicine consultations are not verifiable with respect to transportation and security costs.** The absence of one or more medical passengers does not mean that the regularly scheduled bus, with fuel, maintenance, and security costs, will not run to transport other inmate passengers. Although Classification Code data and Department estimates indicate an overall reduction in the total number of inmates transported on chain buses for medical reasons, claims pertaining to cost avoidance attributed to the impact of telemedicine are unsustainable.

**Efforts are being made to improve transportation and security efficiency.** The Medical Transportation Committee (Transportation Committee) is a standing committee which includes members from the Committee, the Department, UTMB, and TTUHSC. The Transportation Committee meeting minutes indicate that the group has identified a number of strategies to improve the efficiency of transportation and security. These include:

- Studying the possibility of coordinating patient intake/discharges with dedicated medical bus runs. This could eliminate having buses empty on one leg of the trip from Huntsville to Galveston.
- Controlling/reducing security officer accumulation of overtime through better coordination of scheduling.
- Concentrating ambulatory chronic patients at the Stiles Unit to minimize the need for transporting regularly to Galveston. The opening of the Texas City Regional Medical Facility (RMF) is another example of redefining the mission of units and concentrating categories of patients with special needs to minimize transportation of inmates.
- Using local referral options to reduce long distance medical transfers.

- Increasing the use of telemedicine to reduce return to clinic appointments and associated need for transportation.

Recommendation: The Transportation Committee should continue to study and improve operations with the objective of controlling and/or lowering the total cost of inmate health care provision in a manner consistent with maintenance of acceptable levels and quality of care.

Committee's Response: *The CMHCAC partners concur. The Transportation Committee was established by the Committee to serve as an operating level work group that could evaluate and weigh potential transportation efficiencies against both security and medical considerations.*

Recommendation: The Department should improve controls over key data elements to ensure the accuracy and completeness of information such as reasons for inmate transfers and accumulation of overtime by security officers on medically related duties. The Department should consider application of operations research techniques to maximize the use of available resources dedicated to transportation and security.

Committee's Response: *TDCJ concurs and will refer this issue to the joint transportation committee. Like some aspects of the monitoring program, consideration should be given to whether or not privately contracted services could assist in such improvements.*

A summary management letter from the Committee and detailed responses from the Department, TTUHSC, and UTMB are included in the "Managements' Responses" section of this report, beginning on page 49.

Section 4: PERFORMANCE EVALUATION AND MONITORING

## Correctional Managed Health Care Lacks a Comprehensive Monitoring System

The Department's correctional managed health care system does not have a comprehensive monitoring system that clearly evaluates overall performance and holds providers accountable for performance standards. As mentioned previously, the monitoring roles of the Department, the Committee, and the university providers are not clearly defined within the various contracts. Moreover, there are concerns about data integrity and the ability of the various evaluation processes to provide meaningful information to management for decision-making.

Section 4-A:

### **Management Does Not Have a Formal Tracking and Reporting System to Assist in Monitoring and Evaluating Health Care Operations at the Prison Units**

The present monitoring system is made up of separate evaluation processes that monitor and/or evaluate some aspects of performance. These processes include:

- Accreditation by the National Commission on Correctional Health Care (NCCHC)
- Operational Review
- Quality Improvement/Quality Management Program (QI/QM)
- Access to Care reports
- Inmate Grievances and Patient Liaison Correspondence program
- Peer Review

Each process gathers information; however, the processes do not interface or link with each other to provide a comprehensive monitoring and evaluation system. Furthermore, because the basis of several of these processes is self-monitoring, review of operations by another party becomes even more necessary. The evaluation processes are summarized below.

The **NCCHC accreditation process** involves on-site surveys of the units every three years conducted by NCCHC-appointed review teams and annual self-reported verification by the Department of continued compliance with the standards in the interim years. To obtain and maintain accreditation by the NCCHC, each unit must be 100 percent compliant with applicable "essential" standards and at least 85 percent compliant with applicable "important" standards. Essential standards are those that relate to health, safety, and welfare of prison inmates and the critical components of a health care system. Important standards represent acceptable practices for health care providers.

**NCCHC requires that corrective actions be submitted for any deficiencies identified during the on-site survey; however, no on-site follow-up visits to the units are conducted to verify the corrective actions actually took place.**

Achieving and maintaining accreditation by the NCCHC for all of the Department's health care facilities is a requirement of the *Ruiz* final settlement. (For more information on the *Ruiz* case, please see the text box on page 9.) NCCHC accreditation is also a performance requirement for the units in the contracts between the Committee and university providers. Currently, all Department facilities are NCCHC accredited or, if the facility is newly constructed, have submitted applications for accreditation.

NCCHC standards serve as the common basis for most of the other monitoring processes used by the Department, the Committee, and the university providers. The Department's *Health Services Division Policy Manual*, Operational Review audit questions, and QI/QM indicators are partially based on NCCHC standards.

Our review, as well as a recent Department internal audit report, identified a number of problems with the Operational Review process. These problems include:

- No criteria or performance standards exist to determine, quantitatively, when a unit is assessed to be in compliance. Without this, no quantifiable conclusions about compliance can be reached.

The **Operational Review process** was established by the Department to ensure unit compliance with the *Ruiz* final settlement and the Department policies and procedures. The Operational Review instrument is divided into eight sections, covering various medical disciplines such as medical, administration, nursing, and dental services. The Department's Health Services Division conducts the Operational Review audits to determine compliance with NCCHC standards and the Department's *Health Services Division Policy Manual*. Operational Reviews are to be conducted at each unit at least every two years. In addition, special audits may be performed at units six months after opening, when a new service provider takes over, or when significant deficiencies are identified.

A threshold of acceptable compliance and defined measurable performance standards has not been established for the Operational Review process. Reported results do not identify the number of units and/or subcontracted health care providers that are in compliance. If Operational Review results were compiled in terms of meeting a set rate of compliance, management would have a better assessment of provider performance.

- Audit results are not monitored or measured in terms of NCCHC accreditation requirements to assure management of compliance with NCCHC standards.

Although partially based on NCCHC standards and designed to prepare the unit for NCCHC accreditation reviews, the Operational Review results are not evaluated by NCCHC-established compliance rates for "essential" and "important" NCCHC standards.

- Compiling the results of individual unit Operational Review audits does not provide a systemwide identification and assessment of trends or specific and recurring areas of noncompliance.

In calendar year 1996, 33 UTMB and 11 TTUHSC medical units managed by the university providers underwent the Operational Review audit process. If the compliance rate were set at 80 percent or 90 percent, the results reported for 1996 would be as follows:

Table 3

Operational Review Audits Summary of Compliance			
1996*	UTMB	TTUHSC	All Units
Percentage of units with <b>less than</b> 80 percent compliance rate	18%	45%	25%
Percentage of units with <b>less than</b> 90 percent compliance rate	57%	100%	68%
*For the calendar year 1996, each medical record reviewed counted as one audit question to determine compliance or noncompliance.			

Source: Texas Department of Criminal Justice Health Services Division

Based on information reported by the Department, one fourth of these units did not have at least an 80 percent compliance rate.

- The Operational Review schedule was not based on a unit risk analysis or prior performance.
- Although the Department’s Health Services Division administers the Operational Review process and must approve the units’ corrective action plans, it lacks the authority to enforce the corrective action plans. If there is no enforcement process to ensure corrective action, problems identified by the Operational Review process could continue indefinitely.

An example of a problem which has not been successfully addressed through a corrective action plan is the verification of the “Access to Care” reporting process. The second most frequently missed question on the Operational Review audits for 1996 requires the audit team to verify the access to care numbers self-reported by the units through their QI/QM process. In 48 of the 58 units audited, the Operational Review team could not duplicate the previously reported access to care figures. (The 58 units included the 44 units managed by the university providers as well as 14 other Department units, which are either state jails or private prisons.) One unit, which was reviewed three times over a 26-month period, repeatedly missed the access to care verification. Although staff training on procedures was recommended and conducted after each audit to correct the problem, the problem was not corrected during this period.

NCCHC requires that a comprehensive **quality improvement program** be in place for the health clinics at the prison units. A quality improvement plan ensures that care provided meets established standards. In Department prisons with an average daily population of 500 or more, a multi-disciplinary quality improvement committee (made up of university provider health care staff members from various disciplines such as medicine, nursing, mental health, dentistry, health records, and pharmacy) monitors all major aspects of health care. Examples include admission screening and evaluation, sick call services, chronic disease services, nursing services, and pharmacy services. The disciplines' committees meet quarterly to establish indicators, develop corrective action plans based on monitoring findings, and assess the effectiveness of corrective actions.

A **QI/QM program** is being maintained by each unit; however, **gaps exist in overall monitoring, evaluations, and enforcement of the program.** We noted problems such as:

- The current QI/QM system does not have a way to identify systemwide problems. The results of the QI/QM reports are not used to identify either positive or negative trends.
- QI/QM indicators are not routinely used to address problem areas identified in Operational Review audits or areas targeted for improvement in corrective action plans. Some units continue to report each year on indicators that have been at 100 percent compliant, instead of focusing on other problem areas that could benefit from the scrutiny.

- Although the process requires units to monitor and report performance, there is no enforcement of reporting requirements. The Department's Office of Professional Standards receives annual plans as well as monthly reports from all prison units; however, it only administers the reporting process.

While these reports include compliance findings for clinical indicators and corrective actions taken, the Department's Health Services Division does not verify that corrective actions took place. In fact, at the time of our review, a number of units were delinquent in submitting their annual plans. The Office of Professional Standards has no power to enforce submission of the annual plans or any reports required of the units. Recently, the Health Services Division Medical Director has attempted to notify units whose reports are delinquent.

- The QI/QM program currently in place has had no significant changes since before the implementation of managed care. Although both the prior and current contracts between the Department and the Committee state that the Committee is to ensure that the university providers develop and maintain an ongoing self-monitoring plan, the Department's Office of Professional Standards has continued to monitor data submission for the QI/QM process, three years after implementation of managed care.

Plans to revise the current QI/QM program have been initiated. A joint Department, UTMB, and TTUHSC committee was formed in July 1995 to revise the current policies and develop a new quality improvement program; however, as of August 1997, the new program had not been implemented. Implementation of the new quality improvement program is pending, awaiting the hiring of the new Health Services Division Medical Director.

**Access to Care monitoring** is a major component of performance evaluation. Ensuring full access to health care for all prisoners is one of the five general orders in the *Ruiz* final settlement entered into in December 1992. Furthermore, access to medical care must be provided for any medical condition, if the denial of medical care will result in pain, suffering, deterioration, or degeneration. The main tracking mechanism for Access to Care is the self-monitoring by discipline through the QI/QM process. Unit staff members monitor access to care monthly through QI/QM indicators; weekly access to care reporting is required for new units or when compliance drops below 80 percent.

**Our review of the Access to Care reporting processes revealed problems such as inability to verify timely access to care and lack of standardized processes to record and track sick call requests. Problems include:**

- The only copy of the inmate's sick call request is returned to the inmate. Without this source document, one cannot have complete assurance that the inmate's sick call request was processed within the required 24-hour period, thus providing timely access to care.

Department policy requires inmates to request sick call by completing a single copy form and placing it in one of many locked boxes located around inmate cell housing areas. The sick call requests are collected, sorted daily by health care staff, and entered into a sick call log. Health care staff members make regular rounds in segregation units, allowing inmates on lock-down status to voice their health needs daily. The sick call request form is returned to the inmate with the disposition of his/her request noted. A copy of the initial sick call form is not retained by the medical unit.

- Lack of standardized processes for recording dental sick call requests prevents verification of timely access to care. Auditors could not verify specific dental access to care indicators at 9 of 17 medical units reviewed during the audit. Some of the inconsistencies noted were:
  - Sorting of sick call requests varied among the units. At 11 of the 17 medical units reviewed, sick call requests were not initially logged into a master sick call log. Sick call requests were first sorted into three disciplines—medical, dental, or mental health, then requests were placed in boxes for the various disciplines to retrieve and log into their individual sick call registers.
  - Dental sick call register forms varied among the units. The time of the sick call request entry to the register was not clearly evident on all dental sick call registers. Some dental sick call registers had a column for “date appointment made” but did not have a column to note the date the sick call request was received, thus preventing a reviewer from determining whether the appointment was made within the required time period (48 hours or 72 hours on a weekend).

- A process used to screen inmates for elective dental procedures was recently ruled unacceptable. In a recent civil action the United States Eastern District Court entered an order against a UTMB correctional managed health care dentist. The court found the dentist was “deliberately indifferent” to the needs of a Department offender and ordered the dentist to pay \$1,000 in damages. The court also stated that the “prison system’s adherence to the plaque index is unacceptable to the extent that it has the effect of denying dental care to inmates with serious dental problems.” Dentists at the prison units use the plaque test as a means to compel inmates to use good oral hygiene. As a general rule, inmates must pass the test in order to receive dental care, although exceptions are permitted in serious situations.
- Discussions with health care staff members revealed that it could not be readily determined whether dental and mental health sick call requests were promptly being retrieved and logged each day by the various disciplines.
- Operational Review audits performed in 1996 often could not verify the Access to Care results reported by the QI/QM process. Of the 58 medical units reviewed in 1996, Operational Review staff could not independently verify QI/QM Access to Care indicators in 48 of the units, primarily because medical staff were not following established criteria for data collection on the indicators. In an effort to remedy this widespread problem, written instructions on conducting Access to Care audits were issued to all units by the Medical Director of the Department’s Health Services Division; however, the Department cannot enforce any corrective action.

**Medically related information and feedback received from the grievance and liaison correspondence processes are not effectively managed, communicated, or evaluated:**

- Results from the data collected on medically related inmate grievances and the liaison correspondence program are not used consistently by the health care managers to alert them to potential problems or identify trends, even when the number of grievances exceeds the system average. At the unit level, the grievance and liaison correspondence processes are used as a means to answer individual complaints.

The escalating numbers of grievances and liaison correspondences concerning a specific unit do not alone trigger a special inquiry. For example, in the case mentioned below, the sizeable number of unit complaints over a period of time

The **grievance process** allows inmates to file a written complaint about any matter, such as classification, facility operations, or medical. The grievances are collected, recorded, and investigated at the prison unit level, with final disposition determined by the unit's warden.

If the inmate is not satisfied with the response given at the unit level or wants to pursue the issue, the inmate can file a Step II grievance. The Step II grievances are also collected at the unit level, and then forwarded to a Regional Grievance Coordinator to be further investigated, with final disposition determined by the Regional Director.

If the inmate is not satisfied with the response given at the regional level, the inmate can file a Step III grievance. The Step III grievances are collected at the unit level, and then forwarded to the Department's Programs and Services Division to be further investigated. However, medically-related Step III grievances would be forwarded by the Department's Programs and Services Division to the Department's Office of Professional Standards, where they are investigated. Medically-related grievances make up about 10 percent of the total grievances filed.

On September 1, 1996, the formal grievance process was changed from a three-step to a two-step method, basically eliminating the regional level review. However, during fiscal year 1997, there were still some units generating grievances under the three-step method. As a result, the Step II grievances, processed under the former method, by-passed the regional level review and were forwarded to the Department's Programs and Services Division to be reviewed.

**Liaison correspondences** are generally complaints or questions that can be initiated by anyone, such as an inmate, family or friend of the inmate, or correctional staff. The liaison correspondences are sent directly to the Department's Office of Professional Standards, where they are recorded, reviewed, and investigated.

eventually prompted a review of the correspondence content by staff members of the Department's Health Services Division, not the university provider. Review of the systemwide liaison correspondence and grievance reports from this prison health unit in fiscal years 1995 and 1996 revealed:

- The unit had the greatest number of combined liaison correspondences and grievances systemwide for both fiscal years 1995 and 1996.
- The number of combined health-related liaison correspondences and grievances at that unit nearly doubled from 1995 to 1996. Totals increased from 224.30 items per 1,000 inmates in 1995 to 438.07 items per 1,000 inmates in 1996.
- In 1996, the unit's 354.4 liaison correspondences per 1,000 inmates and 83.6 grievances per 1,000 inmates were more than four times the systemwide average. The 1996 systemwide average was 84.3 liaison correspondences per 1,000 inmates and 20.6 grievances per 1,000 inmates.
- Coding of grievances and liaison correspondence by complaint area does not provide sufficient detail. The medical grievances and liaison correspondences are manually coded into categories and subcategories; detailed counts according to subcategories cannot be retrieved from the database and must be tabulated manually. The medical grievances and liaison correspondences are coded into 31 major categories and also subcategorized within each major category.

Management reports only provide the total number of grievances by broad category; thus reports do not provide sufficient detail to be meaningful for management decision-making. Managers are expected to request special unit

reports containing the subcategory detail not provided by the broad category reports.

For example, the category "Access to Care Issues" contains 13 subcategories, which include among others "delays in being seen," "specialist issues," "administrative segregation issues," and "waiting area issues." The category "Medication Issues" includes 17 subcategories including "denial of medication," "medication not effective," "allergic reactions", and "pill line/window issues." Unless a manual count is taken on every grievance and liaison correspondence within a category, the subcategory totals are not reported, thereby depriving managers of a valuable source of feedback about operations.

- Logging of grievances is performed manually at all levels of the process. Work performed at the units to categorize and encode the grievances is duplicated at the agency level because the information systems at the prison units and at Department headquarters in Huntsville are independent of one another. The grievances are first collected and logged in at the units; the units then send their grievances and monthly tallies to the Department's Programs and Services Division to be sorted; the medically-related ones are then forwarded to Professional Standards within the Health Services Division. Professional Standards staff members categorize the medical grievances and re-enter them into their logging system.
- The grievance and liaison correspondence information system is not capable of performing automated queries; therefore, reports must be developed manually. As a result, management cannot easily manipulate grievance and liaison correspondence data to identify trends or poor performance.

All grievance and liaison correspondence information is entered into the paradox database. The paradox database is used to generate a printed log of grievances and liaison correspondences; then queries are manually calculated from the printed log and entered into the paradox database to generate a printed report.

Management resources are not being used efficiently when logging and tracking processes are duplicated at more than one level of the organization. Various levels of correctional managed health care management at both UTMB and TTUHSC have developed their own independent tracking and reporting systems in order to produce management reports, since many managers are neither receiving nor are aware of systemwide reports generated by the Department.

Figure 2



As shown in Figure 2, the total number of medical grievances and liaison correspondence being logged and tracked has increased over the last 6 years.

- Distribution of systemwide medical grievance and liaison correspondence reports is very limited. The distribution of systemwide totals of medical grievance and liaison correspondence reports is limited to the Department's Health Services Division and correctional health care upper management, such as:

- Correctional Managed Health Care Advisory Committee Executive Director
- TTUHSC Correctional Health Care Medical Director
- UTMB Managed Care Medical Director
- UTMB Managed Care Associate Medical Director

Department management reported that the grievance and liaison correspondence processes are in the process of being further automated. The estimated completion date is January 1998.

Cases are referred to university provider **peer review** committees from various sources (including the Department's Health Services Division) to determine if appropriate care was provided by individual health care staff members. Both UTMB and TTUHSC have peer review for various disciplines (physicians, dental, nursing, and psychology) to review all identified cases, incidents, or practices that may not meet the standards of acceptable medical or dental care in a correctional setting. The review committees recommend corrective action and follow the progress of the corrective action implemented.

**Medical staff members from the Department's Health Services Division do not have voting privileges in the formal peer review process.** Prior to 1997, the Department's medical staff did not participate in the university providers' peer review meetings. With the adoption of the new contract between the Department and the Committee, a Department senior physician will be appointed to each university peer

review committee, but only as an *ad hoc* member. The Department's representative on the Committee may request that corrective action be taken against the physician in question, including removal from treating the Department's patients pending the provider's peer review process. However, the Department does not determine the

outcome; any dispute over a practitioner will be referred to the Committee and the decision of the Committee will be binding.

Section 4-B:

### **No Standardized System Exists to Ensure Monitoring Is Performed Consistently Across All Units**

Managers at various levels of the organization complained that they cannot easily integrate the multiple reports they receive or use them to plan for improving performance. Some system reports were either unknown to managers or were not used; many managers had developed their own tracking mechanisms or evaluation processes.

The main responsibility for monitoring the units, including subcontracted units, is concentrated at the university provider regional management level by discipline. Managers use QI/QM reports, Operational Review results, unit tallies of grievances, cost reports, information gathered from on-site visits at the units, and individually developed systems.

**The university providers' subcontractors are not being consistently monitored, given the weaknesses that exist in the current information and monitoring systems.** Where responsibility for providing health care has been subcontracted to local providers, regional management teams are responsible for monitoring the subcontractors. Just as monitoring and evaluation processes vary by region, subcontractor monitoring suffers from lack of integrated evaluation systems and inconsistent processes.

**In fiscal year 1996, UTMB began a process to integrate evaluation systems by requiring that Regional Nursing Director Site Audit/Evaluations be performed for the nursing discipline.** The goal is to visit each unit, interview staff, review unit goals, and review results of all performance evaluation processes: NCCHC accreditation results, Access to Care statistics, QI/QM indicator reports, operation review audit results, staffing patterns, and pharmacy inspection review results. However, the results of these reviews remain at the regional level. A formal process to aggregate results and communicate them to UTMB correction managed care management would provide meaningful feedback about operations and performance. Other disciplines in the UTMB sector are beginning to formulate a similar program. Whereas TTUHSC regional management has monitoring systems in place, its process does not formally integrate information from all evaluation systems.

Section 4-C:

## **A Closer Look at One Prison Unit's Performance Evaluation System Report Illustrates the System's Monitoring Problems**

Taken collectively, the results of the monitoring processes do not allow for an accurate overall evaluation of the prison unit. Some of the processes may indicate satisfactory performance; however, in at least one instance, a closer look revealed serious problems.

**A special audit was conducted in September 1996 at the prison health unit mentioned in Section 4-A with the large number of medical grievances and liaison correspondences.** The audit was initiated by the Department's Health Services Division and prompted by the extreme nature of numerous liaison correspondences from other inmates, family members of inmates, and medical staff members. These correspondences alleged lack of adequate medical care and abuse and neglect of several chronically ill inmates, who all died before the special audit.

Findings from the special audit included:

- Sick call requests were not being picked up daily and/or not entered onto the Sick Call Log on a daily basis.
- Over 50 percent of the offenders referred to a health care provider were not seen within seven days from receipt of the sick call request, a requirement of Access to Care.
- A unit mortality review summary in October 1996 found the level of care in 67 percent (16 out of 24) of deaths at the unit was improper.
- The mortality review summary indicated 54 percent (13 out of 24) of the cases had been referred to physician peer review and 42 percent (10 out of 24) had been referred to nursing peer review.
- Early in fiscal year 1996, it was reported that grievances were not leaving the unit to be submitted to the Office of Professional Standards within the Department's Health Services Division.

**Routine monitoring and evaluation processes had not detected any of the problems found by the special audit.** The various performance reports produced before the special audit showed:

- The unit was NCCHC accredited.
- The Operational Review audit in March 1996 showed 90 percent overall compliance rate.
- QI/QM reports indicated few problems.

**Warning signs for this unit existed but went undetected.** Grievance reports indicated that the unit had the highest number of grievances and liaison correspondences of any unit in both fiscal years 1995 and 1996. In 1996, the unit's liaison correspondences of 354.4 per 1,000 inmates and grievances of 83.6 per 1,000 inmates were more than four times the systemwide average. These totals were reported at least quarterly and were distributed to the Department's Health Services Division, UTMB managed care upper management, and the Committee. Two of the three areas receiving the most grievances and liaison correspondences for 1995 and 1996 were "treatment issues" and "complaints against staff."

**The corrective action plan submitted by management as a result of the special audit did not address all the findings and made no reference to using any of the monitoring processes available to address the problem areas.** Also, documented evidence of corrective actions taken since the audit was not included. The corrective action plan was not approved by the Department's Health Services Division. As of August 1997, no new corrective action plan had been submitted nor had a follow-up audit been conducted.

Managers must closely track performance information such as volume and content of grievances and correspondences and QI/QM indicators, which when used properly, will alert them to problem areas or trends. A streamlined process that integrates the input from the various information/monitoring systems would allow managers to more easily evaluate operations, identify problems, and hold providers accountable for performance standards.

Recommendation: Define monitoring roles and responsibilities of the Department's Health Services Division, the Committee, and university providers. Whereas self-monitoring is an important basis of a good monitoring process, an independent review by a party with enforcement authority would strengthen the process.

Committee's Response: *The CMHCAC partners concur that better definition of roles and responsibilities relating to monitoring would be of benefit to all the parties. Accordingly, the CMHCAC will form a joint work group to examine the potential options available, including the possibility of contracting for these services. The work group would be charged with reengineering the monitoring processes to insure they provide meaningful information for management and are consistent with health care industry standards.*

Recommendation: A comprehensive, standardized monitoring system should be established that integrates the various information/monitoring processes already in place. A formal tracking system should be established to assist in evaluating providers against defined measurable performance standards.

Committee's Response: *The CMHCAC partners concur that while there are many monitoring and reporting activities currently taking place, there is a need for better integration of the data resulting from these efforts. As noted above, the CMHCAC will form a joint work group to initiate a reengineering of the monitoring processes to insure they yield meaningful data consistent with health care industry standards. As a part of this planning effort, the work group will further integrate measures of performance with the information system development now underway.*

Recommendation: To promote consistent and effective monitoring, results and feedback from each of the monitoring processes should be continuously shared among appropriate management and staff at the Department's Health Services Division, the Committee, the university providers, the regional offices, and the medical units.

Committee's Response: *The CMHCAC partners concur. As a part of reengineering the monitoring process, a review of effective means for communicating, disseminating and following-up on results will be conducted.*

Recommendation: Tie the Operational Review compliance threshold more closely to NCCHC standards compliance for accreditation of units.

Committee's Response: *The CMHCAC partners concur that NCCHC accreditation should serve as the principal guidance for the monitoring efforts. Such changes will be considered as part of the monitoring process reengineering effort.*

Recommendation: Use a multiple copy sick call request form so that a copy of the inmate's original sick call request can be maintained in the medical record to verify timeliness of access to care.

Committee's Response: *The CMHCAC partners concur in principle with the need to insure the timeliness of access to care, but offer an alternate solution to using a multiple copy sick call request form. The electronic medical record and electronic clinical management systems currently being reviewed and implemented will provide a means to verify access to care data without requiring another copy of the sick call request form be produced and maintained.*

Recommendation: Consider standardizing the logging process for sick call requests to ensure that the medical units collect consistent access to care data elements.

Committee's Response: *The CMHCAC partners concur in principle with the need to insure the consistency of access to care, but offer an alternate solution to using a manual logging system. The electronic medical record and electronic*

*clinical management systems currently being reviewed and implemented will provide a consist means to collect access to care data.*

**Recommendation:** Health Services Division management should continue its efforts to enhance and automate the grievance and liaison processes. As management evaluates its options with automating the grievance and liaison correspondence processes, management should identify critical success factors:

- Consider streamlining the duplicative processes.
- Include management at all levels in identifying types of reports needed for evaluation and expand distribution of reports.
- Consider expanding grievance/liaison correspondence coding list and querying function to meet managements needs at all levels in order to identify systemwide and unit-specific trends and red flags.
- Include controls to ensure the accuracy of performance measure data.

**Committee's Response:**

*The CMHCAC partners concur. An action plan for automation improvements is currently underway. Additional enhancements will be considered as part of the monitoring process reengineering effort.*

A summary management letter from the Committee and detailed responses from the Department, TTUHSC, and UTMB are included in the "Managements' Responses" section of this report, beginning on page 49.

#### Section 5: FIXED ASSETS

### **The Department Is Not Notified About Capital Assets Purchased for Its Inmates' Health Care by the University Providers**

Although purchased with funds appropriated for the Department's managed health care program, the existing inventory system does not enable the Department to track these capital assets. If the current partnership should fail, the Department could not easily identify capital assets purchased with its managed health care dollars. Managed health care assets purchased by the university providers since September 1994 and prior to the end of fiscal year 1997 totaled over \$3,500,000. Most of these assets, approximately 97 percent, were purchased by UTMB.

**The current contract between the Department and the Committee does not address the disposition of future asset purchases.** The contract between the Department and the Committee provides for the return, to the Department, of the assets originally transferred to UTMB and TTUHSC if the contract with a provider is canceled. However, this provision is not extended to assets purchased by the university providers with the Department's managed health care funds.

**The contract between the Committee and the Department does not restrict the use of capital assets purchased with the Department's managed care funds.** However, it does include a provision restricting the use of the fixed assets transferred by the Department to the university providers to State entities or individuals. Potentially, this omission would allow the university providers to use the assets they purchase with Department funds on patient populations other than those within their state contracts. The contract allows the transferred assets to be moved "as needed among Department facilities" but cannot be removed from Department premises. The university providers are required to "notify the Department's Health Services of the nature of use of such assets for the benefit of any state entity or individual other than Department."

**The current contract between the Department and the Committee does not address the cost allocation of capital assets if the asset benefits a health care program other than the Department.** This is relevant now that the university providers have expanded their managed care initiatives to include entities such as inmates of the Beaumont Federal Prison, youth at the Texas Youth Commission, and others. It is possible for the university providers to treat patients in the correctional health care beds in Galveston or Lubbock. If multi-program usage of capital assets is not tracked, capital asset expenses for the Department's managed health care may be overstated. Furthermore, at replacement time, the provider may not be able to equitably allocate the replacement cost of the asset to the programs it benefited.

Capital assets used in the prison health clinics prior to managed care have been transferred to TTUHSC and UTMB and properly recorded on the State Property Accounting system. Newly acquired capital assets, which are for use in the prison health clinics and hospitals, have been properly labeled with university identification tags. The providers can account for these assets through identifying codes specific to each prison health unit.

Recommendation: The Department and the Committee should consider a contract amendment which ensures an ongoing inventory of all capital assets purchased with Department's managed health care funds. This amendment should also address:

- The disposition of the Department's managed health care capital assets if a provider contract is canceled.
- The cost allocation of capital assets which benefit programs other than the Department's.

- The use of capital assets purchased with Department's managed health care funds.

Committee's Response:

*TDCJ concurs, however the university providers disagree with this recommendation. The providers have a risk contract with the CMHCAC and receive no funding designated for capital asset acquisition. An amendment such as recommended would change the character of the contract considerably. As an alternative to the recommendation, the university providers can provide Committee and TDCJ with listings of any university assets located at TDCJ facilities.*

A summary management letter from the Committee and detailed responses from the Department, TTUHSC, and UTMB are included in the "Managements' Responses" section of this report, beginning on page 49.

Section 6: CREDENTIALING

## Credentialing Processes for Practitioners Need to Be Improved

Overall, the existing credentialing processes for both UTMB and TTUHSC are largely decentralized and the lines of accountability are not clearly defined. Management is over-reliant on self-reporting from medical staff members for timely reporting of discrepancies in their licensure status. Further, management relies heavily on licensing and governing boards to thoroughly review credentials of medical professionals and to regulate those with board restrictions, while not being completely aware of the licensing and governing boards' limitations. Improvements in the credentialing process should give assurance that qualified individuals are providing consistent quality care to Department inmates in compliance with appropriate standards.

**Discussions with management and staff within the credentialing processes for both UTMB and TTUHSC revealed discrepancies in accountability over licensure verification and monitoring.** The existing credentialing processes for UTMB and TTUHSC are largely decentralized. In addition, the credentialing procedures have not been formalized or completely documented. Confusion in interpreting the credentialing processes and determining the lines of accountability has been compounded by staff turnover and reassignment of duties. Because some staff members incorrectly assumed that others were verifying credentials, gaps remain in the credentialing processes of both providers.

**Both university providers omitted a number of key steps in their credentialing processes.** These steps include:

- Checking the practitioner's references
- Verifying the practitioner's graduation from the appropriate professional school
- Verifying completion of a residency program, if applicable

Additionally, with the exception of the nursing disciplines at the university providers, none of the other disciplines reviewed used a checklist in the applicant's file to track verification of credentials. Without proper screening of complete information about each applicant, neither provider can be assured that only qualified candidates are being hired.

**Management relies on the practitioners to self-report changes in their licensure status.** On at least three occasions UTMB supervising managers told auditors they were not aware of a practitioner's board restrictions until notification was received through the newspaper or another health care employee. The Texas State Board of Medical Examiners does publish a quarterly statement which includes those physicians who have recently been issued board restrictions. However, supervising managers have not always carefully tracked these reports.

**Management relies on accreditation processes and licensing boards to thoroughly review credentials of medical professionals and to regulate those with board restrictions.** For example, one process relied upon by UTMB managers, the NCCHC accreditation process, does not thoroughly review credentials of practitioners. Unit and regional managers in both sectors told auditors that the NCCHC performs a thorough review of credentials when accrediting a correctional medical facility. This is not true. The NCCHC accreditation review of credentials merely consists of obtaining a list of all medical staff members and ensuring a current license is on hand for those staff members listed. NCCHC investigators do not call any of the licensing boards to determine if there are any licensure discrepancies.

Management at both university providers rely on the state licensing boards to monitor practitioners with board restrictions. Unless directed by the Texas State Board of Medical Examiners, managers do not create additional or specific monitoring procedures as a result of the board restrictions. Currently within the UTMB sector there are six physicians and two nurses with board restrictions and one nurse in the Texas Peer Assistance Program for Nurses. Within the TTUHSC sector, there are two physicians with board restrictions. TTUHSC management stated it was not aware of any nurses within its system who have board restrictions or are in the Texas Peer Assistance Program for Nurses.

**The university providers rely on their subcontractors to verify credentials of staff who provide services to Department inmates.** TTUHSC subcontracts a majority of its health care services to local practitioners and hospitals. UTMB employs most of its health care providers directly, although it does subcontract for some services. The current contracts between the university providers and their subcontractors do not require the subcontractor to immediately notify the university providers if there are licensure discrepancies; therefore, neither university provider is aware of any licensure discrepancies with subcontracted medical staff.

UTMB's and TTUHSC's managements rely on Medicare certification and the Joint Commission on Accreditation of Health Care Organizations' (JCAHO) accreditation of the free world hospitals (subcontractors) to perform a verification of the medical staff

members' credentials for those staff members who are subcontracted. (Free world hospitals are local, non-prison hospitals that contract with the university providers.) And management further assumes any discrepancies noted during the certification and accreditation processes would be duly noted and taken care of within hospital management. However, discussions with the Medicare certification and JCAHO accreditation staff members indicated that these expectations are false.

**UTMB has taken steps toward standardizing and centralizing the credentialing processes for correctional health care staff.** In July 1997, UTMB awarded a contract to a vendor who will verify and monitor credentials of physicians, mid-level practitioners (physician assistants and advanced nurse practitioners), and dentists. Registered nurses and licensed vocational nurses are not included in this contract.

Recommendation: Management should formalize the credentialing process to ensure roles and accountability are clearly defined. Important steps in establishing a formalized credentialing process should include, among others:

- Clearly defining credentialing staff members' roles and lines of accountability
- Documenting policies and procedures and effectively communicating them to staff
- Including a checklist in all applicant files, documenting the credentials to be verified, the date checked, and by whom
- Expanding the list of credentials to be verified to include:
  - Checking applicant references to inquire about past performance
  - Verifying the practitioner's graduation from the appropriate professional school
  - Verify completion of a residency program, if applicable

Committee's Response: *The CMHCAC partners concur. Both university providers have initiated action to strengthen the credentialing processes.*

Recommendation: Management should enhance monitoring controls over credentials to ensure awareness of any licensure discrepancies. These controls should include:

- Formalized and documented policies and procedures for monitoring credentials

- Monitoring tools for supervising management to use when reviewing medical professionals with licensure discrepancies
- Periodic review of evidence that subcontractors verified credentials of the practitioners providing services to Department inmates

Committee's Response:

*The CMHCAC partners concur. Both university providers have initiated action to strengthen the credentialing processes.*

Recommendations:

Consider requiring the subcontractors to immediately notify the university providers in writing of any licensure discrepancies of the staff who provide services to Department inmates.

Committee's Response:

*The CMHCAC partners concur that requiring notification of any license restrictions is appropriate.*

A summary management letter from the Committee and detailed responses from the Department, TTUHSC, and UTMB are included in the "Managements' Responses" section of this report, beginning on page 49.

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## Managements' Responses



### **CORRECTIONAL MANAGED HEALTH CARE ADVISORY COMMITTEE**

**David R. Smith, M.D.  
Chairman**

December 10, 1997

Lawrence F. Alwin, CPA  
State Auditor  
Two Commodore Plaza  
206 East Ninth Street, Suite 1900  
Austin, Texas 78701

Re: SAO Report on the Correctional Health Care program

Dear Mr. Alwin:

Thank you for the opportunity to provide this consolidated management response to the issues raised in your recent review of the correctional health care program. As requested by your office, this response consolidates the responses received from the Texas Department of Criminal Justice, the University of Texas Medical Branch at Galveston and the Texas Tech University Health Sciences Center.

Before commenting specifically on each of the recommendations, we believe it important to note that the review contains some very positive findings that speak well of the CMHCAC partnership. While not highlighted in detail within the report, the successes and efficiencies acknowledged by the SAO and their clinical consultant clearly indicate that Texas offenders are being provided increased access to a higher quality health care at a lower cost than by pre-managed care practices.

Eight of the nine clinical categories examined by the indicated a positive increase in the mean level of compliance under the managed care program. Access to care shows a 27.7% improvement. Chronic care compliance increased over 158% and clinical encounter compliance improved 35.7%. Only the compliance rate for intrasystem transfers showed a slight decline, although still demonstrating a compliance rate of 93.8%. This indicator may be directly related to the rapid pace of prison expansion and the increased movement of offenders as a result of that expansion during the timeframe under review by the SAO. A further examination of the individual performance indicators in each of the categories finds that 22 clinical indicators showed statistically significant improvements which averaged 85.4%.

Lawrence F. Alwin  
December 10, 1997  
Page 2

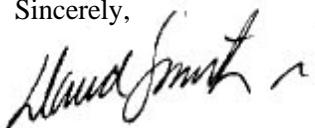
In terms of cost efficiencies, the program has clearly exceeded expectations. Costs per offender have declined from \$5.99 per offender per day in FY 1993 prior to implementation of this initiative to \$5.23 per offender in FY 1997, a 12.7% decrease (without consideration of the impact of inflation). In an almost unprecedented move, the university providers returned funding they had earned under the arrangements when their efficiency efforts produced faster results than had been anticipated. Overall cost savings resulting from the program are projected to exceed \$125 million in the first five years. These savings are a direct result of the innovations and diligent efforts of the university providers to reduce pharmacy costs, better manage utilization of resources, improve staffing efficiencies, provide more health care onsite, negotiate competitive rates for specialty and hospital services, and expand the use of technologies such as telemedicine.

We also believe that the national recognition of the success of this program should not go unmentioned. Recognized both by the National Managed Health Care Congress and by the National Commission on Correctional Health Care, the program has set a new standard for correctional health care across the nation. The involvement of university medical providers in prison health care is being emulated in a number of states including Connecticut, Georgia, Florida, and Mississippi.

Clearly by redefining traditional roles, the correctional health care partnership established by the enactment of SB 378 during the 73<sup>rd</sup> Legislative Session has successfully accomplished its goals of increasing access, improving quality and managing costs. At the same time, the partners realize that, as with any program as complex as the correctional health care delivery system, refinements and improvements can and should be made. Towards that end we appreciate the efforts of the State Auditor's Office in identifying areas for improvement.

Once again, we appreciate the opportunity to respond to this review. We are convinced that the successes and efficiencies achieved by the correctional health care program speak very highly of the professional efforts and dedication of the staff involved in the delivery of medical care. As we continue to refine the system, the state can expect this same dedicated and professional effort as these recommendations are considered.

Sincerely,



David R. Smith, M.D.  
President, TTUHSC and Chairman  
Correctional Managed Health  
Care Advisory Committee



## TEXAS DEPARTMENT OF CRIMINAL JUSTICE

P.O. Box 99 • Huntsville, Texas 77342-0099

Wayne Scott  
Executive Director

Art Mosley  
Deputy Executive Director

December 9, 1997

Jim Riley  
Executive Director, CMHC  
1300 11<sup>th</sup> Street, Ste. 415  
Huntsville, Texas 77340

Dear Mr. Riley:

Attached please find the Texas Department of Criminal Justice's response to the State Auditor's draft audit report of the Managed Health Care program.

Sincerely,

A handwritten signature in cursive script that reads "Art Mosley".

Art Mosley  
Deputy Executive Director  
Texas Department of Criminal Justice

AM/lw  
Attachment

Recommendations: (page 9 of Draft)

The Department is encouraged to pay its Health Services Division physicians through its own payroll system.

***TDCJ Response:*** Concur

The Department is encouraged to continue its efforts to hire an Independent Health Services Division Medical Director, who is independent of the contracted health care providers.

***TDCJ Response:*** Concur, action plan in process

Health Services Division should secure sufficient staff to perform all aspects of the Operation Review audits, eliminating reliance on staff from the university providers to assist in the audits.

***TDCJ Response:*** Concur, action plan in process

Consider an amendment to the current contracts between TDCJ and the CMHCAC and the CMHCAC and the university providers which enables the Department to hold the university providers accountable for monitoring their subcontractors' performance.

***TDCJ Response:*** Concur, Proposed addendum submitted to CMHCAC by the Department on 8-29-97. Agreement will be incorporated into the next biennium contract.

In all applicable subcontracts, include by reference any relevant state licensing or health regulations for the services being contracted.

***TDCJ Response:*** Concur

Roles and responsibilities of all parties should be clearly defined and specifically stated in the contracts.

***TDCJ Response:*** Concur

Information relating to potential problems as well as any action affecting managed health care must be shared with all parties within the organization. This includes TDCJ executive management, the TDCJ Health Services Division management, the CMHCAC, the university providers, their subcontractors, and unit and regional management.

***TDCJ Response:*** Concur

TDCJ should consider adding staff who will be responsible for monitoring all operational and financial aspects of the contract between TDCJ and the CMHCAC. This staff would also oversee

the monitoring of the providers by the CMHCAC, and have the authority to review all financial and operational records related to the provision of health care to TDCJ inmates.

***TDCJ Response:*** *Concur; action plan in process for operational monitoring and TDCJ's Financial Services Division/Contract Section will monitor the financial aspects of the contract; action plan is being developed.*

Recommendations: (page 18 of Draft)

Before the capitation rate for the next biennium is set, allowable and unallowable cost components of the health care appropriation should be clearly defined by the Legislature.

***TDCJ Response:*** *Concur*

To ensure a common financial reporting system for all medical services provided, the CMHCAC should establish financial reporting requirements consistent with health care industry standards. University providers should identify and report all expenditures of correctional managed health care to the CMHCAC, according to these requirements, on a regular basis.

***TDCJ Response:*** *Concur*

UTMB and TTUHSC should develop a method to identify the costs of providing indirect support services for TDCJ managed care. An appropriate charge back system should be developed to reimburse the universities for the costs incurred in providing indirect support services.

***TDCJ Response:*** *Concur*

Proper allocation of expenditures and segregation of funding sources for TDCJ and non-TDCJ managed care programs is essential to maintain accountability for each medical school's programs. Both UTMB and TTUHSC should review present allocation methods to ensure accuracy of the estimated workloads driven by different programs. The medical schools should consider use of a timekeeping system or conduct random moment time studies for staff who perform activities for TDCJ and other non-TDCJ managed health care programs.

***TDCJ Response:*** *Concur*

UTMB and TTUHSC should identify the data elements needed to perform an actuarial study on financial risk and should begin to collect this data. After an appropriate baseline of information is established, an analysis of the risk and required amount of reserves should be performed.

***TDCJ Response:*** *Concur*

The centralized pharmacy should continue its efforts to automate all aspects of the drug dispensing process. Identify the total cost of reclaimed, re-issued medicines should enable the managed

health care program to accurately calculate inmate pharmacy cost. Moreover, the pharmacy will be able to accurately value its inventory when complete costs are known.

***TDCJ Response: Concur***

The university providers should track the fixed costs associated with establishing a health clinic at a new prison unit or modifying a current unit to accommodate an increased population.

***TDCJ Response: Concur***

The CMHCAC should annually evaluate the components and costs of providing health care to the inmates. This information should be provided to the Legislative Budget Board for use by the Legislature in determining the appropriation for the managed health care strategy.

***TDCJ Response: Concur***

Recommendations: (page 21 of Draft)

The Transportation Committee should continue to study and improve operations with the objective of controlling and/or lowering the total cost of inmate health care provision in a manner consistent with maintenance of acceptable levels and quality of care.

***TDCJ Response: Concur; action plan in process***

TDCJ should improve controls over key data elements to ensure the accuracy and completeness of information such as reasons for inmate transfers and accumulation of overtime by security officers on medically related duties. TDCJ should consider application of operations research techniques to maximize utilization of available resources dedicated to transportation and security.

***TDCJ Response: Concur.*** There is joint committee of TDCJ and CMHCAC staff which meets at least quarterly to discuss these issues and make recommendations. This issue will be referred to that committee by TDCJ.

Recommendations: (page 35 of Draft)

Define monitoring roles and responsibilities of TDCJ's Health Services Division, CMHCAC, and university providers. Whereas self-monitoring is an important basis of a good monitoring process, an independent review by a party with enforcement authority would strengthen the process.

***TDCJ Response: Concur.*** This issue was addressed in TDCJ's Internal Audit Report of CMHCAC and Health Services Operational Review Audit Tool. Action plans are in process.

A comprehensive, standardized monitoring system should be established that integrates the various information/monitoring processes already in place. A formal tracking system should be established to assist in evaluating providers against defined measurable performance standards.

***TDCJ Response: Concur***

To promote consistent and effective monitoring, results and feedback from each of the monitoring processes should be continuously shared among appropriate management and staff at TDCJ Health Services Division, the CMHCAC, the university providers, the regional offices, and the medical units.

***TDCJ Response: Concur***

Tie the Operational Review compliance threshold more closely to NCCHC standards compliance for accreditation of units.

***TDCJ Response: Concur; action plan in process***

Use a multiple copy sick call request form so that a copy of the inmate's original sick call request can be maintained in the medical record to verify timeliness of access to care.

***TDCJ Response: Concur but, alternative action plan is implementation of electronic medical record; separate file for sick call requests or electronic entry of sick call requests.***

Consider standardizing the logging process for sick call requests to ensure that the medical units collect consistent access to care data elements.

***TDCJ Response: Concur but, alternative action plan is implementation of electronic medical record.***

Health Services Division management should continue its efforts to enhance and automate the grievance and liaison processes. As management evaluates its options with automating the grievance and liaison correspondence processes, management should identify critical success factors:

- Consider streamlining the duplicative processes.
- Include management at all levels in identifying types of reports needed for evaluation and expand distribution of reports.
- Consider expanding grievance/liaison correspondence coding list and querying function to meet managements needs at all levels in order to identify system wide / unit specific trends and red flags.
- Include controls to ensure the accuracy of performance measure data.

***TDCJ Response: Concur; action plan for automation implemented 10/1/97.***

Recommendations: (page 37 of Draft)

TDCJ and the CMHCAC should consider a contract amendment which ensures an ongoing inventory of all capital assets purchased with TDCJ Managed Health Care funds. This amendment should also address:

- the disposition of the TDCJ managed health care capital assets if a provider contract is canceled.
- the cost allocation of capital assets which benefit programs other than TDCJ
- the use of capital assets purchased with TDCJ managed health care funds

***TDCJ Response: Concur***

Recommendations: (page 39 & 40 of Draft)

Management should formalize the credentialing process to ensure roles and accountability are clearly defined. Important steps in establishing a formalized credentialing process should include, among others:

- clearly defining credentialing staff's roles and lines of accountability
- documenting policies and procedures and effectively communicating them to staff
- including a checklist in all applicant files, documenting the credentials to be verified, the date checked, and by whom
- expanding the list of credentials to be verified to include:
  - checking applicant references to inquire about past performance
  - verifying the practitioner's graduation from the appropriate professional school
  - verify completion of a residency program, if applicable

***TDCJ Response: Concur***

Management should enhance monitoring controls over credentials to ensure awareness of any licensure discrepancies. These controls should include:

- formalized and documented policies and procedures for monitoring credentials
- monitoring tools for supervising management to use when reviewing medical professionals with licensure discrepancies
- periodic review of evidence that subcontractors verified credentials of the practitioners providing services to TDCJ inmates

***TDCJ Response: Concur***

Consider requiring the subcontractors to immediately notify the university providers in writing of any licensure discrepancies of the staff who provide services to TDCJ inmates.

***TDCJ Response: Concur***



## TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

DAVID R. SMITH, M.D.  
President

3601 4th Street  
Lubbock, Texas 79430  
(806)743-2900  
Fax (806) 743-2910

### Memorandum

**To:** Jim Riley, Executive Director  
Correctional Managed Health Care

**From:** David Smith, M.D.  
President, TTUHSC

**Date:** December 3, 1997

**Subject:** Comments on State Audit Report

A handwritten signature in black ink, appearing to read "David Smith", with a flourish at the end.

We have a major disagreement with the "cost" focus of the audit and its recommendations. The entire concept of managed care is to allow the provider the widest latitude possible while encouraging innovation, quality and the potential for reward for assuming risk. This is a capitated system under managed care, not a fee for service or cost based system.

In the West Texas sector, Texas Tech University Health Sciences Center (TTUHSC) has heavily involved the local community hospitals and individual preferred providers in the correctional managed health care system. We accomplished this quickly and expanded rapidly to meet the legislatively mandated rapid prison expansion plans in West Texas. We have impeded private community doctors and hospitals and must rely on them for success. The cost based restriction suggested by the audit would greatly encumber the successes realized through our managed care initiatives.

Concerning the issue of a catastrophic reserve fund, we must keep in mind many factors that will affect our future in the correctional system. Some of those factors include an increasingly aging population, increased communicable diseases (tuberculosis, AIDS, etc.) and a growing prison population. The reserve in fact does not consider the expenses the Universities would experience in extracting themselves from this contractual arrangement (i.e., personnel cost, etc.)

Page Two

Regarding the fifth paragraph on page 14 of the draft audit, we disagree with the content and believe it should have read as follows: "The administrative fee assessed by TTUHSC for TDCJ medical services contains a reserve. For fiscal year 1996, the 5% administrative fee assessed for correctional health care (exclusive of psychiatric) was \$2,250,759 while direct costs were \$1,296,717, leaving excess reserves of \$954,042 or 2.12% of capitated earned revenue. The budgeted administrative fee (exclusive of psychiatric) for fiscal year 1997 is \$2,504,022, while budgeted administrative salaries are listed as \$1,167,592, leaving a reserve of \$1,336,430 or 3% of earned capital revenue. However, the above mentioned administrative fees do not reflect any indirect costs that were considered in establishing the 5% administrative fee.

Overall, the audit points out some areas that definitely need attention, and we pledge to work towards continuous improvement of health care in the criminal justice system. We need to strike a balance between innovative successes and our ability to grow with the state within the rules established.

Our comments related to specific audit recommendations are attached.

**CORRECTIONAL MANAGED HEALTH CARE DRAFT AUDIT REPORT  
TTUHSC COMMENTS**

**Section 1: Governance and Organizational Structure**

RECOMMENDATIONS:

TDCJ is encouraged to pay its Health Services Division physicians through its own payroll system.

*No comment.*

TDCJ is encouraged to continue its efforts to hire an independent Health Services Division Medical Director, who is independent of the contracted health care providers.

*No comment.*

Health Services Division should secure sufficient staff to perform all aspects of the Operation Review audits, eliminating reliance on staff from the University providers to assist in the audits.

*No comment.*

Consider an amendment to the current contracts between TDCJ and the CMHCAC and the CMHCAC and the university providers which enables TDCJ to hold the university providers accountable for monitoring their subcontractors performance.

*Non-concur - under current law, TTUHSC contracts with CMHCAC.*

In all applicable subcontracts, include by reference any relevant state licensing or health regulations for the services being contracted.

*Concur - will implement with new or renewal of current contracts.*

Roles and responsibilities of all parties should be clearly defined and specifically stated in the contracts.

*Concur - will implement with new or renewal of current contracts.*

Information relating to potential problems as well as any action affecting managed health care must be shared with all parties within the organization. This includes TDCJ executive

management, TDCJ Health Services Division management, the CMHCAC, the university providers, their subcontractors, and unit and regional management.

*Concur - there are a tremendous variety of present processes of identifying, solving and exchanging information on potential problems. Some of these are participating in multiple state wide committee meetings, the regularly scheduled CMHCAC committee meeting, frequent visits with staffs at TDCJ headquarters, wide telephonic contracts with counterparts at TDCJ and UTMB, leadership presence at all audit outbriefs, and constant contact and communication with the TDCJ centralized preventative medicine department. Internally we see it as a big management duty to assure that our staffs are kept fully abreast of all system wide problems and recommended solutions, These are but a few present mechanisms for sharing information throughout the system, but we certainly concur with any initiative to keep informed and exchange information to better server our wards.*

TDCJ should consider adding staff who will be responsible for monitoring all operational and financial aspects of the contract between TDCJ and the CMHCAC. This staff would also oversee the monitoring of the providers by the CMHCAC, and have the authority to review all financial and operational records related to the provision of health care to TDCJ inmates.

*Alternative solution - we recommend that the present system of financial oversight by the CMHCAC and operational monitoring by TDCJ be continued. The charge of financial oversight is a legislative mandate to the CMHCAC and to change this would substantially affect not only the legislative intent and directive but also the contractual obligations of all parties. This could eventually be much more expensive to the State.*

## **Section 2: Capitation Rate**

### **RECOMMENDATIONS:**

Before the capitation rate for the next biennium is set, allowable and unallowable cost components of the health care appropriation should be clearly defined by the Legislature.

*Non-concur - the contract was designed and accepted as a capitation, managed care, risk contracting system and not a fee for service or cost based process. Much already exists to estimate capitation rates and this was vested on the CMHCAC committee. Within the managed care system there already exists a negotiation process for a capitation rate. The original Legislative intent was to stop the tremendously escalating cost for correctional health care and to revert to another system would potentially not do this and be more expensive to the state.*

To ensure a common financial reporting system for all medical services provided, the CMHCAC should establish financial reporting requirements, consistent with health care industry standards.

University providers should identify and report all expenditures of correctional managed health care to the CMHCAC, according to these requirements on a regular basis.

*Concur - recommend a joint work group consisting of each agency's financial officer established to develop a common system.*

UTMB and TTUHSC should develop a method to identify the costs of providing indirect support services for TDCJ managed care. An appropriate charge back system should be developed to reimburse the universities for the costs incurred in providing indirect support services.

*Concur.*

Proper allocation of expenditures and segregation of funding sources for TDCJ and non-TDCJ managed care programs is essential to maintain accountability for each medical school's programs. Both UTMB and TTUHSC should review present allocation methods to ensure accuracy of the estimated workloads driven by different programs. The medical schools should consider use of a timekeeping system or conduct random moment time studies for staff who perform activities for TDCJ and other non-TDCJ managed health care programs.

*Concur.*

UTMB and TTUHSC should identify the data elements needed to perform an actuarial study on financial risk and should begin to collect this data. After an appropriate baseline of information is established, an analysis of the risk and required amount of reserves should be performed.

*Concur- preliminary estimates in comparison with similar systems indicate our reserves are significantly lower than industry standards.*

The centralized pharmacy should continue its efforts to automate all aspects of the drug dispensing process. Identifying the total cost of reclaimed, re-issued medicines should enable the managed health care program to accurately calculate inmate pharmacy cost. Moreover, the pharmacy will be able to accurately value its inventory when complete costs are known.

*Concur.*

The university providers should track the fixed costs associated with establishing a health clinic in at a new prison unit or modifying a current unit to accommodate an increased population.

*Concur.*

The CMHCAC should annually evaluate the components and costs of providing health care to the inmates. This information should be provided to the Legislative Budget Board for use by the Legislature in determining the appropriation for the managed health care strategy.

*Concur.*

### **Section 3: Transportation and Security Costs**

#### RECOMMENDATIONS:

The Transportation Committee should continue to study and improve operations with the objective of controlling and/or lowering the total cost of inmate health care provision in a manner consistent with maintenance of acceptable levels and quality of care.

*Concur.*

TDCJ should improve controls over key data elements to ensure the accuracy and completeness of information such as reasons for inmate transfers and accumulation of overtime by security officers on medically related duties. TDCJ should consider application of operations research techniques to maximize utilization of available resources dedicated to transportation and security.

*Concur.*

### **Section 4: Performance Evaluation and Monitoring**

#### RECOMMENDATIONS:

Define monitoring roles and responsibilities of the TDCJ's Health Services Division, CMHCAC, and university providers. Whereas self-monitoring is an important basis of a good monitoring process, an independent review by a party with enforcement authority would strengthen the process.

*Concur - recommend we convene a Joint Work Group to examine options to more efficiently coordinate monitoring efforts. At present there are already three external monitoring processes which mandate external accountability. These are TDCJ internal audits, the NCCHC inspections, and access to care reports. All of these have to be accounted external to our internal system. TDCJ has always had enforcement authority which has been exercised on numerous occasions when deemed necessary by the medical director of TDCJ health services division.*

A comprehensive, standardized monitoring system should be established that integrates the various information/monitoring processes already in place. A formal tracking system should be established to assist in evaluating providers against defined measurable performance standards.

*Concur - need to streamline the various processes to make them more meaningful and efficient.*

To promote consist and effective monitoring, results and feedback from each of the monitoring processes should be continuously shared among appropriate management and staff at TDCJ Health Services Division, the CMHCAC, the university providers, the regional offices, and the medical units.

*Concur.*

Tie the Operational Review compliance threshold more closely to NCCHC standards compliance for accreditation of units.

*Concur - this was one of our recommendations to the TDCJ ad hoc audit committee.*

Use a multiple copy sick call request form so that a copy of the inmate's original sick call request can be maintained in the medical record to verify timelines of access to care.

*Alternative solution - rather than multiple paper copies we recommend continued development of electronic records and other initiatives to alleviate this problem.*

Consider standardizing the logging process for sick call requests to ensure that the medical units collect consistent access to care data elements.

*Alternative solution - recommend electronic medical record and other initiatives to alleviate this situation.*

Health Services Division management should continue its efforts to enhance and automate the grievance and liaison processes. As management evaluates its options with automating the grievance and liaison correspondence process, management should identify critical success factors

- Consider streamlining the duplicative processes.
- Include management at all levels in identifying types of reports needed for evaluation and expand distribution of reports.
- Consider expanding grievance/liaison correspondence coding list and querying function to meet management's needs at all levels in order to identify system wide/unit specific trends and red flags.
- Include controls to ensure the accuracy of performance.

*Concur.*

## **Section 5: Fixed Assets**

### RECOMMENDATIONS:

TDCJ and the CMHCAC should consider a contract amendment which ensures an ongoing inventory of all capital assets purchased with the Department's Managed Health Care funds. This amendment should also address:

- the disposition of the TDCJ managed health care capital assets if a provider contract is canceled
- the cost allocation of capital assets which benefit programs other than TDCJ
- the use of capital assets purchased with TDCJ managed health care funds

*Non-concur - all capital equipment is accounted for in the University's invention, and identified as STATE equipment. We have accounted for the equipment and are maintaining it. We can currently provide an annual report to TDCJ accounting for the equipment in the facilities.*

## **Section 6: Credentialing**

### RECOMMENDATIONS:

Management should formalize the credentialing process to ensure roles and accountability are clearly defined. Important steps in establishing a formalized credentialing process should include among others:

- clearly defining credentialing staff's roles and lines of accountability.
- documenting policies and procedures and effectively communicating them to staff
- including a checklist in all applicant files, documenting the credentials to be verified, the date checked, and by whom
- expanding the list of credentials to be verified to include:
  - checking applicant references to inquire about past performance
  - verifying the practitioner's graduation from the appropriate professional school
  - verify completion of a residency program, if applicable

*Concur - we have initiated improvements in our credentialing processes for Texas Tech Health Sciences Center employees and will require all our subcontracted hospitals to do the same.*

Management should enhance monitoring controls over credentials to ensure awareness of any licensure discrepancies. These controls should include:

- formalized and documented policies and procedures for monitoring credentials

- monitoring tools for supervising management to use when reviewing medical professionals with licensure discrepancies
- periodic review of evidence that subcontractors verified credentials of the practitioners providing services to TDCJ inmates

*Concur.*

Consider requiring the subcontractors to immediately notify the university providers in writing of any licensure discrepancies of the staff who provide services to TDCJ inmates.

*Concur - subcontractors will be required to immediately notify TTUHSC in writing of any license restrictions, consistent with State law, on staff that provide medical care to TDCJ inmates.*

## The University of Texas Medical Branch at Galveston



*School of Medicine  
Graduate School of Biomedical Sciences  
School of Allied Health Sciences  
School of Nursing*

*Marine Biomedical Institute  
Institute for the Medical Humanities  
UTMB Hospitals and Clinics*

*Office of the  
Vice President for Business Affairs*

December 8, 1997

### MEMORANDUM

TO: Jim Lynaugh

FROM: Richard S. Moore *ASM*  
Vice President of Business Affairs

SUBJECT: UTMB's comments on SAO Report

Attached please find UTMB's comments to the State Auditor's Office recommendations.  
Please advise if I can provide any additional information.

RSM:ma  
Attachment  
Transmitted via fax 409/294-3970

Copy to: Dr. John Stobo  
E. J. Pederson  
Dr. James F. Arens  
Leon Clements

SUITE 621, ADMINISTRATION BUILDING 301 UNIVERSITY BOULEVARD GALVESTON, TEXAS 77555-0126  
PHONE (409)772-6454 FAX (409)772-1724

## **CORRECTIONAL MANAGED HEALTH CARE AUDIT REPORT**

### **Section 1: Governance and Organizational Structure:**

Recommendations:

*TDCJ is encouraged to pay its Health Services Division physicians through its own payroll system.*

UTMB has no comment

*TDCJ is encouraged to continue its efforts to hire an independent Health Services Division Medical Director, who is independent of the contracted health care providers.*

UTMB has no comment

*Health Services Division should secure sufficient staff to perform all aspects of the Operation Review audits, eliminating reliance on staff from the university providers to assist in the audits.*

UTMB has no comments

*Consider an amendment to the current contracts between TDCJ and the CMHCAC and the CMHCAC and the university providers which enables TDCJ to hold the university providers accountable for monitoring their subcontractors performance.*

UTMB disagrees with this recommendation. UTMB as a provider, contracts with CMHCAC and not TDCJ, and therefore is accountable to CMHCAC for contract compliance. Amending the contract as recommended would essentially bring another "party" (TDCJ) into the agreement and would change the character of the contract substantially.

*In all applicable subcontracts, include by reference any relevant state licensing or health regulations for the services being contracted.*

UTMB agrees with this recommendation

*Roles and responsibilities of all parties should be clearly defined and specifically stated in the contracts.*

UTMB agrees with this recommendation

*Information relating to potential problems as well as any action affecting managed health care must be shared with all parties within the organization. This includes TDCJ executive*

*management, TDCJ Health Services Division management, the CMHCAC, the university providers, their subcontractors, and unit and regional management.*

UTMB agrees with this recommendation

*TDCJ should consider adding staff who will be responsible for monitoring all operational and financial aspects of the contract between TDCJ and the CMHCAC. This staff would also oversee the monitoring of the providers by the CMHCAC, and have the authority to review all financial and operational records related to the provision of health care to the TDCJ inmates.*

UTMB has no comment

## **Section 2: Capitation Rate**

### Recommendations:

*Before the capitation rate for the next biennium is set, allowable and unallowable cost components of the health care appropriation should be clearly defined by the Legislature.*

UTMB disagrees with this recommendation. If the state wants to continue acquiring this health care through “risk contracts” then the concept of what is an “allowable” or “unallowable” cost would not be applicable. The state has been able to shift financial risk to Managed Care Organizations in a number of instances — Correctional Care, State employee health plans, and evolving Medicaid Managed Care programs. Reverting to a structure other than “risk contracting” for Correctional Care will be more costly to the State.

*To ensure a common financial reporting system for all medical services provided, the CMHCAC should establish financial reporting requirements, consistent with health care industry standards. University providers should identify and report all expenditures of correctional managed health care to the CMHCAC, according to these requirements, on a regular basis.*

UTMB agrees with the recommendation

*UTMB and TTUHSC should develop a method to identify the costs of providing indirect support services for TDCJ managed care. An appropriate charge back system should be developed to reimburse the universities for the costs incurred in providing indirect support services.*

UTMB agrees with this recommendation

*Proper allocation of expenditures and segregation of funding sources for TDCJ and non-TDCJ managed care programs is essential to maintain accountability for each medical school's programs. Both UTMB and TTUHSC should review present allocation methods to ensure accuracy of the estimated workloads driven by different programs. The medical schools should*

*consider use of a timekeeping system or conduct random moment time studies for staff who perform activities for TDCJ and other non-TDCJ managed health care programs.*

UTMB agrees with this recommendation. Where allocation of costs and effort are applicable, UTMB will utilize methodologies similar to those used for Federal grants and contracts.

*UTMB and TTUHSC should identify the data elements needed to perform an actuarial study on financial risk and should begin to collect this data. After an appropriate baseline of information is established, an analysis of the risk and required amount of reserves should be performed.*

UTMB agrees with this recommendation

*The centralized pharmacy should continue its efforts to automate all aspects of the drug dispensing process. Identifying the total cost of reclaimed, re-issued medicines should enable the managed health care program to accurately calculate inmate pharmacy cost. Moreover, the pharmacy will be able to accurately value its inventory when complete costs are known.*

UTMB agrees with this recommendation. Efforts are underway to complete these automation efforts during the first quarter (calendar) of 1998.

*The university providers should track the fixed costs associated with establishing a health clinic in a new prison unit or modifying a current unit to accommodate an increased population.*

UTMB agrees with this recommendation

*The CMHCAC should annually evaluate the components and costs of providing health care to the inmates. This information should be provided to the Legislative Budget Board for use by the Legislature in determining the appropriation for the managed health care strategy.*

UTMB has no comment

### **Section 3: Transportation and Security Costs**

#### Recommendations:

*The Transportation Committee should continue to study and improve operations with the objective of controlling and/or lowering the total cost of inmate health care provision in a manner consistent with maintenance of acceptable levels and quality care.*

UTMB has no comment

*TDCJ should improve controls over key data elements to ensure the accuracy and completeness of information such as reasons for inmate transfers and accumulation of overtime by security*

*officers on medically related duties. TDCJ should consider application of operations research techniques to maximize utilization of available resources dedicated to transportation and security.*

UTMB has no comment

#### **Section 4: Performance Evaluation and Monitoring**

##### Recommendations:

*Define monitoring roles and responsibilities of TDCJ Health Services Division, the CMHCAC, and university providers. Whereas self-monitoring is an important basis of a good monitoring process, an independent review by a party with enforcement authority would strengthen the process.*

UTMB disagrees with this recommendation. While it is important that monitoring and responsibilities are clearly defined, the approaches utilized should conform to health care industry standards.

*A comprehensive, standardized monitoring system should be established that integrates the various information/monitoring processes already in place. A formal tracking system should be established to assist in evaluating providers against defined measurable performance standards.*

UTMB disagrees with this recommendation. While it is important that monitoring and responsibilities are clearly defined, the approaches utilized should conform to health care industry standards.

*To promote consistent and effective monitoring, results and feedback from each of the monitoring processes should be continuously shared among appropriate management and staff at TDCJ Health Services Division, the CMHCAC, the university providers, the regional offices, and the medical units.*

UTMB agrees with this recommendation

*Tie the Operational Review compliance threshold more closely to NCCHC standards compliance for accreditation of units.*

UTMB agrees with this recommendation

*Use a multiple copy sick call request form so that a copy of the inmate's original sick call request can be maintained in the medical record to verify timeliness of access to care.*

UTMB agrees with this recommendation

*Consider standardizing the logging process for sick call requests to ensure that the medical units collect consistent access to care data elements.*

UTMB agrees with this recommendation

*Health Services Division management should continue its efforts to enhance and automate the grievance and liaison processes. As management evaluates its options with automating the grievance and liaison correspondence processes, management should identify critical success factors:*

- *Consider streamlining the duplicative processes.*
- *Include management at all levels in identifying types of reports needed for evaluation and expand distribution of reports.*
- *Consider expanding grievance/liaison correspondence coding list and querying function to meet management's needs at all levels in order to identify system wide/unit specific trends and red flags.*
- *Include controls to ensure the accuracy of performance measure data.*

UTMB has no comment

## **Section 5: Fixed Assets**

### Recommendations:

*TDCJ and the CMHCAC should consider a contract amendment which ensures an ongoing inventory of all capital assets purchased with TDCJ Managed Health Care funds. This amendment should also address:*

- *the disposition of the TDCJ managed health care capital assets if a provider contract is canceled*
- *the cost allocation of capital assets which benefit programs other than TDCJ*
- *the use of capital assets purchased with TDCJ managed health care funds*

UTMB disagrees with this recommendation. UTMB has a risk contract with CMHCAC, and does not receive any funding designated for capital asset acquisition. An amendment such as recommended would change the character of the contract considerably. UTMB can provide CMHCAC and TDCJ with listings of any UTMB assets located at Department facilities.

## **Section 6: Credentialing**

### Recommendations:

*Management should formalize the credentialing process to ensure roles and accountability are clearly defined. Important steps in establishing a formalized credentialing process should include, among others:*

- *clearly defining credentialing staff's roles and lines of accountability*
- *documenting policies and procedures and effectively communicating them to staff*
- *including a checklist in all applicant files, documenting the credentials to be verified, the date checked, and by whom*
- *expanding the list of credentials to be verified to include:*
  - *checking applicant references to inquire about past performance*
  - *verifying the practitioner's graduation for the appropriate professional school*
  - *verify completing of a residency program, if applicable*

*Management should enhance monitoring controls over credentials to ensure awareness of any licensure discrepancies. These controls should include:*

- *formalized and documented policies and procedures for monitoring credentials*
- *monitoring tools for supervising management to use when reviewing medical professionals with licensure discrepancies*
- *periodic review of evidence that subcontractors verified credentials of the practitioners providing services to TDCJ inmates*

*Consider requiring the subcontractors to immediately notify the university providers in writing of any licensure discrepancies of the staff who provide services to TDCJ inmates.*

UTMB agrees with this recommendation

## Objectives, Scope, and Methodology

### Objectives

The primary objectives of this project were to:

- Evaluate and report on the condition of key management controls of the Texas Department of Criminal Justice (Department) Managed Health Care System.
- Evaluate and report on the contractual relationships between the Department, the Correctional Managed Health Care Advisory Committee (Committee), The University of Texas Medical Branch at Galveston (UTMB), and the Texas Tech University Health Sciences Center (TTUHSC).
- Compare aspects of the health care system at the Department prior to and after the implementation of managed care in the areas of cost, process quality, and scope of services.

Management controls are the policies, procedures, and processes used to carry out an organization's objectives. They should provide reasonable assurance that:

- Goals are met.
- Assets are safeguarded and efficiently used.
- Reliable data are reported.
- Laws and regulations are complied with.

Management controls, no matter how well designed and operated, can only provide reasonable assurance that the organization's objectives will be achieved. However, monitoring established controls can assist in detecting and correcting weaknesses in a timely manner.

### Scope

The scope of this audit included:

- Consideration of the managed health care overall management systems: policy management, information management, performance management, and resource management.
- Review of contract provisions in the contracts between the Department and the Committee, the Committee and the university providers (UTMB and TTUHSC), and the university providers and their subcontractors.
- Review of the appropriation for the managed health care strategy.

- Review of the expenditures and the cost allocation systems related to managed health care.
- Review of the scope of services and system changes implemented under the managed health care system.

Mental Health Services was not included in our evaluation because of the newness of the program to the managed health care environment.

## Methodology

Information collected included the following:

- Interviews with members and staff of the Committee
- Interviews with Department Board members, executive management, and staff
- Interviews with medical and administrative staff of UTMB Managed Care
- Interviews with medical and administrative staff of TTUHSC Managed Care
- Interviews with management and staff of the Legislative Budget Board
- Interviews with members of the Legislature and legislative staff
- Interviews with members of special interest groups
- Interviews with Department inmates
- Documentary evidence such as:
  - Revenue and expenditure data
  - Contracts
  - Various management reports
  - Audit reports from the State Auditor's Office and the Department's Internal Audit Division relating to Department health care
  - Recommendations of the Texas Performance Review relating to Department health care
  - Legal opinions

Procedures and tests conducted:

- Review of the governance of the managed health care system
- Review of sufficiency of contract provisions
- Analysis of costs related to managed health care
- Review of cost allocation methods and policies of the university providers
- Review of performance monitoring and evaluation processes
- Review of the credentialing processes for correctional health care staff
- Collaboration with a correctional health care consultant, retained in partnership with the internal audit departments at the Texas Department of Criminal Justice and the Texas Youth Commission.

Criteria used:

- State Auditor's Office Accountability Methodology
- State Auditor's Office Contract Administration Model
- Department's Health Services Division Policies and Procedures
- *Ruiz* Final Settlement
- Section 501.059, Texas Government Code
- National Commission on Correctional Health Care (NCCHC) standards
- Other standards and criteria established during fieldwork

**Other information**

Fieldwork was conducted from January 1997 to July 1997. The audit was conducted in accordance with applicable professional standards, including:

- Generally Accepted Government Auditing Standards
- Generally Accepted Auditing Standards

There were no significant instances of noncompliance with these standards.

The audit work was performed by the following members of the State Auditor's Office:

- Babette Laibovitz, MPA, CGFM (Project Manager)
- Linda C. Buford, CPA
- Kyle K. Doerr, MBA
- Francine B. Guitierrez, CPA
- William D. Hurley, CPA
- Ester Jayme
- Gilberto F. Mendoza, CPA
- Abayomi A. Owolabi, MBA, MBA HCM
- M. Betsy Schwing, CPA
- Lisa A. Walters, CPA
- John C. Young, M.P. Aff.
- Julie L. Ivie, CIA (Quality Control Reviewer)
- Charles R. Hrcir, CPA, CGFM (Audit Manager)
- Craig D. Kinton, CPA (Audit Director)

Consulting work was performed by Jacqueline Moore and Associates of Chicago, IL.

In addition, the following Department internal auditors assisted us in collecting data at a number of prison units:

- Lynda Brackett, CIA
- Frank Anizan
- Robert Mask

## Health Care Costs

### Expenses Have Decreased as a Portion of Revenues Under Managed Health Care

Table 3 summarizes reported revenues and expenses of the two university providers for the fiscal years 1995 and 1996, the first two years of managed health care. Note that the net balance, or profit, increased substantially for both university providers in 1996, probably as a result of savings realized using managed care mechanisms. The excess revenue over expenses allowed the university providers to set aside catastrophic reserve funds as well as refund money to the State's general revenue fund.

Table 3

Reported TTUHSC and UTMB Summary Revenues and Expenses for Fiscal Years 1995 and 1996 - Unaudited				
	TTUHSC		UTMB	
	1995	1996	1995	1996
Average Daily Population	20,351	25,378	80,157	96,223
Revenue	\$22,035,620	\$47,607,010	\$159,933,150	\$194,238,617
Expenses	\$22,010,300	\$40,251,548	\$159,880,652	\$164,268,796
Revenue Over Expenses	\$25,320	\$7,355,462	\$52,498	\$29,969,821
Refund to State		(\$2,000,000)		(\$10,000,000)
Net Balance	\$25,320	\$5,355,462	\$52,498	\$19,969,821

Source: Correctional Managed Health Care Advisory Committee

Table 4 translates the dollars in Table 3 into percentages. Note that expenses for both university providers decreased as a percentage of revenues from fiscal year 1995 to fiscal year 1996.

Table 4

Reported TTUHSC and UTMB Summary Revenues and Expenses as Percentage of Revenues Fiscal Years 1995 and 1996 - Unaudited				
	TTUHSC		UTMB	
	1995	1996	1995	1996
Average Daily Population	20,351	25,378	80,157	96,223
Revenue	100.00%	100.00%	100.00%	100.00%
Expenses	99.89%	84.55%	99.97%	84.57%
Revenue Over Expenses	0.11%	15.45%	0.03%	15.43%
Refund to State		(4.20%)		(5.15%)
Net Balance	0.11%	11.25%	0.03%	10.28%

Source: Correctional Managed Health Care Advisory Committee

It is difficult to compare the two university providers' costs of services because the providers have different operating philosophies and accounting strategies. Likewise, it is not possible to compare the efficiencies of the two providers. UTMB owns and operates its own teaching hospital, while TTUHSC contracts with the University Medical Center Hospital. Most inmates requiring specialty care or hospitalization in the UTMB sector are transported to the Department's hospital (Hospital Galveston), which adjoins UTMB's teaching hospital in Galveston. In contrast, a significant amount of health services are provided by subcontractors in the TTUHSC sector. This operating philosophy helps support local hospitals and medical specialists in towns where Department units are located.

Tables 5 through 11 provide more detail for cost information that is summarized above.

In the tables, "On-site" refers to revenues generated or expenses incurred at Department prison units. "Off-site" refers to revenues generated or expenses incurred somewhere other than a prison unit, such as a prison hospital. "Free World Care" encompasses care given outside of a prison-maintained location. "Med Surg" in Tables 6 and 7 refers to the 48 bed medical surgical facility located at the Montford Unit in Lubbock.

Table 5

Reported TTUHSC Revenues and Expenses - Fiscal Year 1995 Unaudited		
Average Daily Population: 20,351		Per Day
<b>Revenue</b>	\$22,035,620	\$2.967
<b>Expenses</b>		
Salaries	\$5,855,555	\$0.788
Fringe Benefits	620,773	0.084
Operating Expenses	831,577	0.112
Consultants	317,968	0.043
Subcontracts	14,384,427	1.936
<b>Total Expenses</b>	<b>\$22,010,300</b>	<b>\$2.963</b>
<b>Revenue Over Expenses</b>	<b>\$25,320</b>	<b>\$0.003</b>

Source: Correctional Managed Health Care Advisory Committee

Table 6

Reported TTUHSC Revenues and Expenses - Fiscal Year 1996 Unaudited					
Average Daily Population: 25,378					
	On-Site	Off-Site	Pharmacy	Med Surg	Total
<b>Revenue</b>	\$28,441,929	\$14,057,434	\$5,107,647		\$47,607,010
<b>Expenses</b>	\$27,602,577	\$7,306,289	\$4,643,328	\$699,354	\$40,251,548
<b>Revenue Over Expenses</b>	\$839,352	\$6,751,145	\$464,319	(\$699,354)	\$7,355,462

Source: Correctional Managed Health Care Advisory Committee

Table 7

Reported TTUHSC Revenues and Expenses Per Day - Fiscal Year 1996 Unaudited					
Average Daily Population: 25,378					
	On-Site	Off-Site	Pharmacy	Med Surg	Total
<b>Revenue</b>	\$3.07	\$1.52	\$0.55		\$5.14
<b>Expenses</b>	\$2.98	\$0.79	\$0.50	\$0.08	\$4.35
<b>Revenue Over Expenses</b>	\$0.09	\$0.73	\$0.05	(\$0.08)	\$0.79

Source: Correctional Managed Health Care Advisory Committee

Table 8

Reported UTMB Revenues and Expenses - Fiscal Year 1995 Unaudited						
Average Daily Population: 80,157/100,508*						
	On-Site	Off-Site	Pharmacy	Hospital	Other	Total
Revenue	\$88,232,667	\$15,455,309	\$18,399,178	\$36,858,897	\$987,099	\$159,933,150
Expenses	\$85,845,571	\$16,770,157	\$16,846,112	\$40,418,812		\$159,880,652
Revenue Over Expenses	\$2,387,096	(\$1,314,848)	\$1,553,066	(\$3,559,915)	\$987,099	\$52,498

\* In Fiscal Year 1995 UTMB provided off-site care for the total inmate population of 100,508  
Source: Correctional Managed Health Care Advisory Committee

Table 9

Reported UTMB Expenditure Detail - Fiscal Year 1995 Unaudited						
	On-Site	Off-Site	Pharmacy	Hospital	Other	Total
Free World Care		\$15,270,157		\$40,418,812		\$55,688,969
Salaries	\$62,258,175					\$62,258,175
Benefits	\$462,913					\$462,913
Contracted Units	\$8,868,828					\$8,868,828
Unit Operations	\$14,255,655		\$16,846,112			\$31,101,767
Physician Plan		\$1,500,000				\$1,500,000
Total	\$85,845,571	\$16,770,157	\$16,846,112	\$40,418,812	\$0	\$159,880,652

Source: Correctional Managed Health Care Advisory Committee

Table 10

Reported UTMB Revenues and Expenses - Fiscal Year 1996 Unaudited						
Average Daily Population: 96,241						
	On-Site	Off-Site	Pharmacy	Hospital	Other *	Total
Revenue	\$108,440,409	\$30,292,998	\$19,373,429	\$34,167,684	\$1,964,097	\$194,238,617
Expenses	\$97,288,930	\$21,901,564	\$11,897,790	\$34,167,684	(\$987,172)	\$164,268,796
Revenue Over Expenses	\$11,151,479	\$8,391,434	\$7,475,639	\$0	\$2,951,269	\$29,969,821

\* TTUHSC contracts with UTMB for its pharmacy services. The \$2,951,269 represents the revenues and expenses of UTMB that were associated with these contracted services.

Source: Correctional Managed Health Care Advisory Committee

Table 11

Reported UTMB Expenditure Detail - Fiscal Year 1996 Unaudited						
	On-Site	Off-Site	Pharmacy	Hospital	Other	Total
Free World Care UTMB		\$8,014,452				\$8,014,452
Free World Care TTUHSC					(\$987,172)	(\$987,172)
Physician Plan		\$13,887,112				\$13,887,112
UTMB/Department Hospital				\$34,167,684		\$34,167,684
Salaries	\$69,442,558		\$1,032,445			\$70,475,003
Benefits	\$853,534		\$16,978			\$870,512
Drugs/Supplies			\$10,848,367			\$10,848,367
Contracted Units	\$16,927,719					\$16,927,719
Unit Operations	\$9,285,067					\$9,285,067
Equipment	\$780,052					\$780,052
<b>Total</b>	<b>\$97,288,930</b>	<b>\$21,901,564</b>	<b>\$11,897,790</b>	<b>\$34,167,684</b>	<b>(\$987,172)</b>	<b>\$164,268,796</b>

Source: Correctional Managed Health Care Advisory Committee

# Location of Prison Units



Executive Services September 1997

**REGION I**

- Diagnostic Unit (Huntsville)
- Diboll Transfer
- Eastham Unit (Lovelady)
- Ellis Unit (Huntsville area)
- Estelle Unit (Huntsville area)
- Ferguson Unit (Midway)
- Goodman Transfer (Jasper)
- Goree Unit (Huntsville)
- Holliday Transfer (Huntsville)
- Huntsville Unit
- Lewis Unit (Woodville)
- Luther Unit (Navasota)
- Pack Unit (Navasota)
- Terrell Unit (Livingston)
- Wynne Unit (Huntsville)

**REGION II**

- Beto Unit (Palestine)
- Boyd Unit (Teague)
- Coffield Unit (Palestine area)
- Gatesville Unit (Gatesville/Female)
- Gurney Transfer (Palestine area)
- Hilltop Unit (Gatesville/Female)
- Hobby Unit (Marlin/Female)
- Hodge MROP Unit (Rusk)
- Hughes Unit (Gatesville)
- Michael Unit (Palestine area)
- Moore,C. Transfer (Bonham)
- Mountain View Unit (Gatesville/Female)
- Murray Unit (Gatesville/Female)
- Powledge Unit (Palestine)
- Skyview Psychiatric Unit (Rusk)
- Telford Unit (New Boston)
- Ware Transfer (Colorado City)

**REGION III**

- Central Unit (Sugar Land)
- Clemens Unit (Brazoria)
- Darrington Unit (Rosharon)
- Hightower Unit (Dayton)
- Hospital Galveston (Medical)
- Jester II & III Units (Richmond)
- Jester IV Psychiatric Unit (Richmond)
- LeBlanc Unit (Beaumont)
- Ramsey I, II, III Units (Rosharon)
- Retrieve Unit(Angleton)
- Stiles Unit (Beaumont)
- Texas City (Medical)

**REGION IV**

- Briscoe Unit (Dilley)
- Connally Unit (Kenedy)
- Cotulla Transfer
- Fort Stockton Transfer
- Garza East Transfer (Beeville)
- Garza West Transfer (Beeville)
- Lynagh Unit (Fort Stockton)
- McConnell Unit (Beeville)
- Segovia Transfer (Edinburg)
- Stevenson Unit (Cuero)
- Torres Unit (Hondo)

**REGION V**

- Allred Unit (Wichita Falls)
- Clemens Unit (Amarillo)
- Dalhart Unit
- Daniel Unit (Snyder)
- Jordan Unit (Pampa)
- Middleton Transfer (Abilene)
- Montford Psychiatric Unit (Lubbock)
- Neal Unit (Amarillo/Female)
- Roach Boot Camp (Childress)
- Roach Unit (Childress)
- Robertson Unit (Abilene)
- Rudd Transfer (Brownfield)
- Smith Unit (Lamesa)
- Tulia Transfer
- Wallace Unit (Colorado City)
- Western Regional Medical Facility (Lubbock)

**PRIVATE PRISONS**

- Bridgeport Pre-Release
- Cleveland Pre-Release
- Diboll Pre-Release
- Kyle Pre-Release
- Lockhart Pre-Release(Female)
- Moore,B. Pre-Release (Overton)
- Venus Pre-Release

**STATE JAIL DIVISION**

- Bartlett State Jail
- Bradshaw State Jail (Henderson)
- Cole State Jail (Bonham)
- Dawson State Jail (Dallas)
- Dominguez State Jail (San Antonio)
- Formby State Jail (Plainview)
- Gist State Jail (Beaumont)
- Hutchins State Jail (Dallas)
- Kegans State Jail (Houston)
- Lindsey State Jail (Jacksboro)
- Lopez State Jail (Edinburg)
- Lychner State Jail (Atascosita)
- Plane State Jail (Dayton/Female)
- Sanchez State Jail (El Paso Area)
- Travis Co. State Jail (Austin)
- Willacy Co. State Jail (Raymondville)
- Woodman State Jail (Gatesville/Female)

**SUBSTANCE ABUSE**

- Glossbrenner SAFF (San Diego)
- Halbert SAFF (Female - Burnet)
- Havins SAFF (Brownwood)
- Henley SAFF (Dayton)
- Jester I SAFF (Richmond)
- Johnston SAFF (Winnsboro)
- Ney SAFF (Hondo)
- Sayle SAFF (Breckenridge)
- Wheeler SAFF (Plainview)

Source: Texas Department of Criminal Justice graphic

## Legislation

Government Code, Sec. 501.059. Correctional Managed Health Care Advisory Committee.

- (a) The Correctional Managed Health Care Advisory Committee to the Texas Department of Criminal Justice is established.
- (b) The committee consists of:
  - (1) two members employed full-time by the department, at least one of whom is a physician, appointed by the executive director;
  - (2) two members employed full-time by The University of Texas Medical Branch at Galveston, at least one of whom is a physician, appointed by the president of the medical branch; and
  - (3) two members employed full-time by the Texas Tech University Health Sciences Center, at least one of whom is a physician, appointed by the president of the university.
- (c) A committee member serves at the pleasure of the appointing official or until termination of the member's employment with the entity the member represents.
- (d) An appointment to the committee shall be made without regard to the race, creed, sex, religion, disability, or national origin of the appointee.
- (e) A committee member serves without compensation but is entitled to reimbursement for actual and necessary expenses incurred in the performance of the duties of the committee.
- (f) The committee shall meet at least once in each quarter of the calendar year and at any other time at the call of the chairman.
- (g) The committee may hire a managed health care administrator and may employ personnel necessary for the administration of the committee's duties.
- (h) The committee shall develop a managed health care plan for all persons confined by the department that includes:
  - (1) the establishment of a managed care network of physicians and hospitals that will serve the department as the exclusive health care provider for persons confined in institutions operated by the department;

- (2) cost containment studies;
  - (3) care case management and utilization management studies performed for the department; and
  - (4) concerning the establishment of criteria for hospitals, home health, or hospice providers, a provision requiring the managed health care plan to accept certification by the Medicare program under Title XVIII, Social Security Act, as amended (42 U.S.C. Section 1395 et seq.), as an alternative to accreditation by the Joint Commission on Accreditation of Health care Organizations.
- (i) To the extent possible the committee shall integrate the managed health care provider network with the public medical schools of this state and the component and affiliated hospitals of those medical schools.
  - (j) For those services for which the public medical schools and their components and affiliates cannot provide, the committee shall initiate a competitive bidding process for contracts with other providers for medical care to persons confined by the department.
  - (k) The committee may enter into a contract on behalf of the department to fully implement the managed health care plan under Subsection (h).
  - (l) The department shall pay necessary costs for the operation of the committee, including costs of personnel, from funds appropriated by the legislature to the department.
  - (m) The committee shall evaluate and recommend to the board sites for new medical facilities that appropriately support the managed health care provider network.
  - (n) The committee may, in addition to providing services to the department, contract with other governmental entities for similar health care services and integrate those services into the managed health care provider network.
  - (o) To implement the managed health care plan, The University of Texas Medical Branch at Galveston and the Texas Tech Health Sciences Center, for employees who are entitled to retain salary and benefits applicable to employees of the Texas Department of Criminal Justice under Section 9.01, Chapter 238, Acts of the 73rd Legislature, Regular Session, 1993, may administer, offer, and report through their payroll systems participation by those employees in the Texas employees uniform group insurance benefits program and the Employees Retirement System of Texas.
  - (p) The advisory committee may hold a meeting by telephone conference call or other video or broadcast technology.

Added by Acts 1993, 73rd Leg., ch. 238, Sec. 8.01, eff. May 22, 1993; Amended by Acts 1993, 73rd Leg., ch. 988, Sec. 1.08, eff. Sept. 1, 1993; Acts 1995, 74th Leg., ch. 384, Sec. 1, eff. June 8, 1995; Acts 1995, 74th Leg., ch. 965, Sec. 26, eff. June 16, 1995.

## **An Evaluation of Managed Health Care in the Texas Prison System**

by Jacqueline Moore and Associates

Section I:

### **Objective and Scope of Project**

The purpose of this study was to evaluate health care delivery to inmates at the Texas Department of Criminal Justice (TDCJ) prior to and after the implementation of managed care. Structural characteristics, utilization data, personnel staffing, vacancy rates, inmate population characteristics, and mortality data were reviewed. Mental Health Services were not included in this study because they were recently transferred to the managed care system and sufficient data was not available to evaluate the effect of managed care.

For purposes of this study, the prior period is defined as September 1992 through August 1994. The current period is September 1994 through August 1996.

Section II:

### **Process Compliance Analysis**

Section II-A:

#### **Sample Selection**

A sample of 17 institutions was drawn from a list of 87 supplied by the TDCJ. (State jails and private prisons were excluded from the population for sampling purposes.) The institutions were grouped into four strata: provider, population, gender, and infirmary capability. The sample was randomly selected by power analysis program.

Since two thirds of the care is provided by UTMB, eleven facilities were selected to represent UTMB; six facilities were selected to represent TTUHSC. Within each stratum, the requisite number of institutions was randomly sampled. The probability that an institution was sampled was proportional to its size (number of inmates) compared with the total number of inmates in the stratum. This allowed the use of unweighted averages within a stratum as an unbiased estimate of the average across all inmates in all institutions within the stratum.

#### **Methodology**

The scope of the clinical services evaluation focused on nine critical areas which included access to care, chronic care, clinical encounter, emergency services, infection control regarding HIV and tuberculosis (TB), intra-system transfer, specialty consults, and dental care.

In addition to chart audits, confidential interviews were conducted with the unit health administrator, director of nurses (DON), physicians, wardens, and ten inmates at each of the facilities selected to participate in the study. The interviews consisted of structured

questionnaires containing both open and closed ended responses. A structured questionnaire was used to ensure comparability of the responses.

### **Construction of the Instruments**

In designing instruments for this study, it was decided to modify audit forms originally developed by Dr. Joseph Paris for the State of Georgia, and audit forms utilized by the Correctional Medical Authority in the State of Florida. Modifications to the forms were made according to criteria contained in the TDCJ Operational Review Process, which is currently utilized to measure compliance with TDCJ rules, regulations, policies and practices. The questions on the interview forms were derived from the NCHC Standards for Health Services in Prisons and stipulations contained in the Final Settlement of the *Ruiz* Consent Decree.

### **Pilot & Reliability Test**

A pilot test of the instruments was conducted during the week of February 3 - 7, 1997. The pilot test and subsequent audits were assessed for interrater and intrarater reliability. Interrater reliability refers to the consistency of classifications of two or more raters who classify a specified group of persons using the same measurement tool on the same occasion. Intrarater reliability refers to the consistency with which a single rater classifies a group of persons using a specified measuring tool on two separate occasions.

### **Limitations of the Study**

Both measures used, interview and chart audit, have inherent methodological limitations which can affect the results of the study. Moreover, the data collected for this project has characteristics which limit the conclusions which can be drawn.

**Methodological limitations:** The utility of a chart audit in obtaining valid data is dependent on the documentation of the care. If a chart does not contain documentation of a particular behavior, it could be assumed that the behavior was not done. This may or may not be the case. An omission on the record could mean that the care was performed and not documented. Likewise, the presence of an activity on a record does not necessarily mean that the provider has performed it. Thus, it may be that the audit measures only what was recorded and not the actual care that was provided.

Limitations associated with interview as a source of information consist of either the difficulty associated with the construction of the questionnaire or the accuracy of the response. This latter reactive effect on the respondents cannot be overlooked. By singling out an individual to be tested, the evaluator forces a role-defining decision regarding "What kind of person will I be as I answer these questions?"

**Limitations of the data:** Data collected included information about staffing, utilization, telemedicine, monitoring, and other processes. The data was collected from the TDCJ for the time period prior to managed care and from the university providers after the implementation of managed care. TDCJ collected and reported information in a different format than the university providers, which hindered our ability to provide meaningful

comparisons. Complete data was not available for each fiscal year from each university provider. The university providers also collected and reported data in different formats, which made comparisons difficult. Data was obtained from the State Auditor's Office, through correspondence with the university providers. There was no attempt to audit the data.

Section II-B:

## **Results of Data Analysis**

### **Procedures**

Chart audits were utilized to examine the process of care in nine critical areas of clinical service using 5-9 performance measures for each area. The auditor scored each measure or indicator as in compliance (meets all requirements), out-of-compliance (fails one or more requirements) or is not applicable. The latter category indicated the behavior was not applicable for a particular situation, there was not an opportunity to document the occurrence by chart audit, or refusal to receive care was signed. Although the goal was to review the charts of ten patients/inmates for each critical area, from each of the 17 adult facilities, for a total sample of 170 (except for chronic care where the goal was 16 per facility for a total of 272), this was not always possible. For example, a facility may not have had ten inmates with the specific type of clinical care desired. Thus for some critical areas of clinical service, fewer than 170 charts were reviewed.

### **Overall Level of Compliance**

A summary of the overall mean compliance levels for the adult facilities is presented in Table [1]. Included is the mean level of compliance for each cohort (or time period) of charts along with the standard error of the mean. When the changes are examined for each area, a significant increase in overall mean level of compliance under managed care is noted for three of the six areas for which data are available both prior to and under managed care. In three areas -- dental care and infection control for HIV and for PPD -- only data under managed care are available. Almost half (48.8%) of the charts reviewed for dental care performance indicators had compliance levels below .80 with 30% having compliance levels ranging from .50 to .60. It should be noted that TDCJ policy does not require the units to maintain separate dental logs. Thus some units recorded dental requests on sick call logs while others reported them on dental logs. This may have affected some compliance scores and accounted for the lower overall level of compliance for dental care.

Each chart was then categorized as in compliance with all relevant indicators or as not in compliance with one or more relevant indicators. That is, charts with a level of compliance of 1.0 were considered as in compliance; all other charts were categorized as not in compliance. The proportion of charts rated compliant by area of clinic service is reported in Table [2].

**TABLE [1]: MEAN LEVEL OF COMPLIANCE FOR ADULT FACILITIES PRIOR TO  
MANAGED CARE AND UNDER MANAGED CARE**

AREA	PRIOR TO MANAGED CARE			UNDER MANAGED CARE		
	n	Mean	Standard Error (SE) <sup>a</sup>	n	Mean	Standard Error (SE) <sup>a</sup>
Access to Care	170	.845	.0173	169	.913	.0157
Chronic Care	196	.636	.0155	271	.803	.0107
Clinical Encounter	170	.884	.0113	170	.928	.0105
Consultation Request	138	.862	.0174	168	.889	.0129
Dental Care	---	---	---	170	.768	.0185
Emergency Care	67	.811	.0203	148	.843	.0126
Infection Control: HIV	---	---	---	121	.895	.0147
Infection Control: PPD	---	---	---	143	.884	.0131
Intrasystem Transfer	137	.942	.0094	165	.938	.0078

<sup>a</sup> SE is the Standard Error of the Mean defined as the standard deviation (SD) divided by the square root of sample size. The SE is used to construct confidence intervals around the point estimate. For example, a 95% confidence interval is approximately the mean  $\pm 2$  times the SE. The Standard Deviation is a descriptive measure of the variability within a distribution.

**TABLE [2]: PROPORTION OF CHARTS COMPLIANT FOR ALL INDICATORS PRIOR TO AND UNDER MANAGED CARE**

AREA	PRIOR TO MANAGED CARE			UNDER MANAGED CARE			
	n	Proportion Compliant (p <sub>1</sub> )	Standard Error (SE) <sup>a</sup>	n	Proportion Compliant (p <sub>2</sub> )	Standard Error (SE) <sup>a</sup>	Percent Change <sup>b</sup> (p <sub>2</sub> -p <sub>1</sub> )/p <sub>1</sub>
Access to Care	170	.635	.037	169	.811	.030	+27.7
Chronic Care	196	.107	.022	271	.277	.027	+158.9
Clinical Encounter	170	.529	.038	170	.718	.035	+35.7
Consultation Request	138	.594	.042	168	.601	.038	
Dental Care	---	---	---	170	.459	.038	
Emergency Care	67	.299	.056	148	.372	.040	
Infection Control: HIV	---	---	---	121	.639	.037	
Infection Control: PPD	---	---	---	143	.538	.042	
Intrasystem Transfer	137	.708	.039	165	.661	.037	

<sup>a</sup> Standard error is computed as  $[p(1-p)/n]^{1/2}$ ; a 95% confidence interval can be constructed around the point estimate using  $p \pm 1.96$  (standard error)

<sup>b</sup> Only statistically significant changers are reported

### Individual Performance Measure Compliance

Tables A.1 through A.9 at the end of this report show the percent compliant prior to and under managed care for each performance measure within each of the areas assessed. Because compliance is defined as the ratio of the number of charts compliant on an indicator to the sum of the number of charts for which the indicator is applicable, the sample size involved in determining compliance becomes small for some indicators. Areas assessed included the following:

- **Access to Care (Table A.1)** - The percent compliant on individual access to care indicators increased on three of the five indicators. One exception concerned routine lab or x-ray, when required, being provided and reviewed within seven days. Compliance decreased from 92.3% prior to managed care to 78.9% under managed care. The other exception was for the reporting of missed clinic appointments in the no show log that demonstrated 80% compliance prior to managed care and decreased to only 70.6% compliance under managed care. However, the sample sizes for which this indicator was applicable in each of the time periods was small, reflecting the fact that some units only count the number of missed appointments. Auditors also noted that counseling was not routinely done.

- **Chronic Care (Table A.2)** - Prior to managed care, compliance on the indicators of chronic care for diabetes, hypertension, pulmonary, and seizures ranged from 30.5% for education regarding illness to 97.9% for medical problems listed on the master problem list. These same two indicators also had the lowest (64.2%) and highest (97.0%) compliance following managed care. Because the inmate may have had a chronic illness for a long time and may also have been incarcerated for a long time, it was difficult to know whether inmate education had been provided. In reviewing charts, auditors accepted only education within the prior year as evidence of compliance. Additionally, units sometimes indicated they provided inmate education, but it was not documented in the medical record and consequently was considered as noncompliance. These factors contributed to the relatively lower levels of compliance for patient education.
- **Clinical Encounter (Table A.3)** - For each of the eight indicators in the area of clinical encounter, the percent compliance exceeded 74% prior to managed care and 84% under managed care. Two of the indicators refer to the nursing sick call protocol. Units, however, varied in their use of nursing protocols; some always used the form while some never used the form although they referred to it in chart notes. Both were accepted as evidence of compliance.
- **Consultation Request (Table A.4)** - Compliance for the eight indicators related to a consultation request ranged from 76.7% to 90.6% prior to managed care and from 77.8% to 97.0% under managed care. Prior to managed care, approval forms were not utilized, which accounts for the relatively few numbers of patients in the sample for that time period. Also, because the forms were not utilized, it was difficult to determine how much time elapsed between the consultation request and the consultation. However, the compliance for this measure was consistent in the two time periods (76.8% prior to managed care and 79.2% under managed care).
- **Dental Services (Table A.5)** - Only data under managed care was available for the area of dental services. As noted earlier, TDCJ policy does not require units to maintain separate dental logs which accounts for the low compliance for the two measures concerning documentation. For the other three indicators of dental service, compliance in meeting all requirements exceeded 95%.
- **Emergency Services (Table A.6)** - Compliance on most indicators used to assess emergency services was high (>80%). The one exception was that the "medical chart shows the patient sent out by the health care staff in less than 30 minutes of making a request for emergency services." This question could not be answered with the information in the medical charts. Generally the only time recorded in the chart was the time when the patient was seen for emergency care, making it difficult to determine whether the inmate was seen within 30 minutes of request as stated in the indicator.
- **Infection Control (Tables A.7 and A.8)** - In general, compliance with the indicators related to infection control exceeded 80% with the exception of three indicators: a two-step skin test for offenders over 45 years of age, although this indicator was applicable for only 14 inmates (50.0%); education regarding medication compliance and side effects (62.1%); and post-

counseling and providing results of HIV test (75.7%) In addition, auditors noted that although HIV testing may have been provided, units were sometimes late with the testing, ranging from one to five months.

- **Intrasystem Transfer Forms (Table A.9)** - Most compliance rates for the indicators in the area of intrasystem transfers exceeded 90% both prior to and under managed care. Less than 90% each time were compliant with the "receiving facility" portion of the intrasystem transfer form completed by a nurse within 24 hours. Sometimes the nurse would sign the form but not include the time and auditors could not find the time recorded in clinic notes. This could present a risk management issue for inmates who may have experienced problems on the chain bus during transfer. Also, one unit had the staff sign blank forms in order to expedite the process when an inmate was transferred into a receiving facility. This was considered noncompliance when auditing the charts.

### **Compliance Comparison - Prior to and Under Managed Care**

In general, the percent compliant on individual performance measures tended not to differ significantly under managed care when compared to the period before implementation of managed care. Charts from four chronic disease categories were assessed during the audit: diabetes, hypertension, pulmonary (asthma), and seizure. Comparisons were also made across the two time periods for each of these four conditions (Appendix A, Tables A.2.1 through A.2.4). The measure for a patient having a written treatment plan was significantly higher under managed care for each of the four conditions. Additionally, among those with hypertension or pulmonary disease, receiving education on their disease increased significantly under managed care. Other significant increases were noted for those with a special diet being listed on the Master Diet List provided to Food Services (hypertension) and regular monitoring of peak flow or spirometer readings (pulmonary disease).

Section III:

## **Aspects of Managed Health Care Analysis**

Section III-A:

### **Staffing**

In analyzing the health care staffing levels for the TDCJ prison facilities, comparisons were made prior to and after the implementation of managed care. Comparisons also were made against both established models advocated by the Correctional Managed Health Care Advisory Committee (CMHCAC) and established vacancy rates.

**Vacancy rates** were defined as the number of vacant budgeted full time positions for which employers are seeking workers and the perception of the management staff regarding the need or demand for additional services of providers.

Despite the increase in inmate population and new prison facilities that opened between 1993-1996, registered nurse (RN) and physician staff did not increase by a significant amount. The most notable increases were in licensed vocational nurses (LVNs), and the category of "other

staff" which included staff such as medication aides, medical technicians, pharmacy technicians, laboratory technicians, respiratory therapy, physical therapists, and x-ray technicians. Dental staff consisting of dental assistants, hygienists, and dentists increased by over 100 providers between 1993 and 1996 and clerical staff increased by 341 positions during the same period; however the prison population also grew rapidly in this time period.

### **Established Staffing Models**

In 1994, the CMHCAC, with the assistance of a correctional health consultant, conducted an operational staffing study to ensure that quality care was provided in a cost-effective manner.

Staffing allocations which were previously in effect had been derived primarily from requirements promulgated by the Comprehensive Health Care Plan developed in 1984. When the Comprehensive Health Care Plan was approved by *Ruiz*, the inmate population was 36,000; by 1994, it had grown to 95,000 and the existing staffing models were insufficient to meet the need of the increased and changing characteristics of the current inmate population.

UTMB utilizes a cluster management model for certain units rather than duplicating management staff for units in close geographic proximity. In the cluster model, some members of the management team, such as the unit health administrator and the director of nursing (DON), among others, are responsible for one or more units. Three criteria are used to determine which units should be clustered:

- The total population of units clustered can not exceed 4500 inmates.
- Consideration is given to the types of services provided by the facility.
- The units have to be in close proximity to each other.

TTUHSC does not use a cluster pattern for staffing.

### **Comparison with CMHCAC Recommended Staffing Model**

In comparing the 17 TDCJ facilities surveyed to the guidelines recommended by the CMHCAC, it was found that most of the facilities surveyed were staffed according to the recommended staffing model. A few facilities fell short of the recommended staffing patterns in regard to clerical staff, chronic infectious disease (CID) nurses, and record technicians. Oftentimes, a facility would have more LVNs than suggested but would not have medication aides. In comparing current staffing levels to the template model, only one unit reported a critical shortage of manpower.

### **Vacancy Rates**

Vacancy rates, when they occurred, were reported as problematic by all of the facilities surveyed. Many of the DONs felt that the vacancy rates at the institutional level contributed to inadequate staffing. As one DON stated, "If you only have five RNs and you are down one RN position, the facility is short staffed."

Increase in pay was most frequently cited as a positive change that occurred with the implementation of managed health care. Other positive changes that were mentioned regarding

managed care included improved communication with management, increased educational programs, better qualified staff, and the elimination of bureaucratic red tape in hiring new staff.

In conclusion, there are fewer RNs and physicians staffed per inmate, and more LVNs, nursing technicians and medication aides being utilized. The substitution of lower qualified staff is a common trend in managed care settings today among providers in the private sector as well as correctional health care corporations.

It should be noted that although the university providers never formally adopted the recommended CMHCAC staffing model, they were generally in compliance with its recommendations. Facilities surveyed felt that their current staffing patterns were adequate when all of their positions were filled.

It is difficult to specify an adequate staffing pattern for the TDCJ prisons. There are no national standards or guidelines available. Staffing is generally unit specific according to the mission of the unit, the level of care required, the provision of infirmary care, chronic care or diagnostic services, the geographical layout of the facility, inclusion of satellite units, and the security classification of the inmate.

The effectiveness of any correctional system is largely dependent upon staffing considerations regarding quantity, mixture, qualifications and quality. Current contracts with UTMB and TTUHSC do not specify staffing plans.

Section III-B:

### **Pharmaceutical Services**

One vital element of health care delivery is the availability of a reliable medication delivery system. Pharmacy services for TDCJ's managed health care are centralized in Huntsville. The University of Houston began managing pharmacy services for TDCJ in September 1990. Pharmacy services provide prescription services five days a week, within 24 hours of the order being placed. Each prison unit has a limited amount of stock medications to be initiated during weekends, holidays, and for emergency situations. Routine medications are sent to each unit's pharmacy through a computerized ordering system, on a daily basis.

The existing formulary is managed by an interagency Pharmacy and Therapeutics Committee (P&T). The formulary includes classifications of medications utilized in medical treatment. The formulary is designed to provide physicians with a focused group of medications for the treatment of the majority of conditions encountered in the correctional setting. Physicians desiring to use non-formulary medications must first have a telephone consultation with a clinical pharmacist. Clinical pharmacists act as non-formulary approving authorities. If a non-formulary drug is ordered, the clinical pharmacist either approves, suggests an alternative, or denies the request. Any recommendation by the clinical pharmacist can be appealed by the unit physician to the regional medical director. In interviews conducted with physicians during the audit, 16 out of 17 physicians felt that the formulary was adequate and that it reflected current treatment regimens.

Distribution of medications to inmates occurs at regularly scheduled times at pill windows, with either LVNs or medication aides administering the medications. Keep-on-person medications (KOP) are provided to inmates for certain medications. Medications that can be abused such as psychotropic or pain medications, or medications where staff want to ensure compliance, known as directly administered therapy, (such as AIDS medications) are distributed at the pill window.

A protocol has been developed regarding HIV medication. As a result of both new and increasing numbers of medications utilized to treat AIDS patients, the pharmacy reported that the cost of AIDS medications was \$21.76 per inmate per day for 1996. In the spring of 1997, the pharmacy estimated that 125 inmates throughout the Texas system received protease inhibitors at a cost of approximately \$550 per inmate per month .

The pharmacy estimates that approximately 42% of the Texas inmate population is receiving medication. In the 17 prison facilities surveyed, one of the most common complaints received from inmates concerned receiving their prescribed medications. Inmates in 14 of the 17 facilities complained about the medication delivery system. In each individual prison unit, anywhere from three to six inmates out of ten interviewed, reported problems receiving medications. Many of the complaints revolved around the pill window: inmates complained that the lines were too long or that pill windows did not accommodate inmates who worked or went to school.

Previously, correctional officers were allowed to administer selected over-the-counter medications such as maalox or aspirin. These medications were known as "wing medications." A pharmacy directive dated August 1995 and revised in February 1997 has restricted medications distributed by officers to only acetaminophen. Other over-the-counter medicines are available to inmates through the sick call process or pill windows.

The Pharmacy and Therapeutics Committee made a decision to decrease the categories of KOP medications that could be prescribed so that health care providers could monitor patient compliance with treatment regimens. Compliance was felt to be very low for many medications. It has not been determined whether policy changes relating to direct administered therapy have had a positive impact on medication compliance. Prior to managed care, approximately 61% of the medication orders were KOP as compared to 44% currently.

As a result of several policy and procedural changes, inmates have had to wait in pill lines to receive some legend drugs (which require a prescription by a physician) and over-the-counter medications. The result has been long and crowded medication lines.

The new policy changes regarding KOP and over-the-counter medicines have created a source of dissatisfaction among some inmates interviewed regarding pharmaceutical services. Other inmate complaints regarding the pharmacy services involved the renewal system, the availability and timeliness of medications, and missing medications while in segregation status.

In the current medication administration process, it is difficult to audit medications missed or not given. There is a critical drug report, provided by the pharmacy, that tracks specific medication

that are not taken. The report is unit specific and emphasizes certain medications such as TB or chronic care medicines; however, not all medications are reported.

At the time of our review, only the current month was available on the computer medication administration record (MAR) screen. Thus, if an audit was on the fifth day of the month, only the first 5 days would be available. Special requests for other screens would have to be pulled manually, a laborious process, which was not undertaken during this study. Additionally, the current medication screen does not note allergies, nor allow an auditor to see if medications were missed because of a no-show on the part of the inmate, the inmate was off the unit, the medication was not renewed, or because the order was not received from the pharmacy within a timely manner. If an inmate refuses a medication, it is documented on the computer; however, missing medications from the pharmacy are not documented on the MAR.

The current operational review process for TDCJ does not audit the pharmacy system. Departmental pharmacists visit prison facilities on a quarterly basis; however, their reports focus on drug usage data, storage of medications, narcotic counts, and type of medications ordered, but do not address timeliness or missed medications.

Tables [3-5] represent the number of medication orders filled and their cost for FY 1992 - 1996.

**Table [3]  
Cost Of Medication Orders Filled**

	FY 92	FY 93	FY 94	FY 95	FY 96
<b>Legend Drugs</b>	\$5,919,368	\$8,272,392	\$11,482,907	<b>\$13,348,175.50</b>	<b>\$11,148,766.23</b>
<b>OTC Items</b>	\$ 990,402	\$1,087,614	\$ 1,326,053	<b>\$ 1,893,993.00</b>	<b>\$ 1,230,059.32</b>
<b>TOTAL</b>	\$6,909,770	\$9,360,006	\$12,808,960	<b>\$15,242,168.50</b>	<b>\$12,378,825.55</b>

Costs of recycled medications are not calculated into this data.

**Table [4]  
Average Number of Orders Per Inmate Per Year**

	FY 92	FY 93	FY 94	FY 95	FY 96
<b>Inmate Population*</b>	47,651	58,480	70,863	<b>101,295</b>	<b>110,484</b>
<b>Legend Drugs</b>	12.79	12.44	13.59	<b>13.83</b>	<b>12.92</b>
<b>OTC Drugs</b>	6.27	5.49	4.92	<b>4.48</b>	<b>4.64</b>
<b>TOTAL</b>	19.06	17.93	18.51	<b>18.31</b>	<b>17.56</b>

\*Population figures represent the inmate population that is served by the pharmacy . It does not include private prison facilities. Additionally in FY 96 psychotropic medication was only provided to some units.

**Table [5]  
Average Cost of Drugs Per Inmate Per Year**

	FY 92	FY 93	FY 94	FY 95	FY 96
<b>Legend Drugs</b>	\$124.22	\$141.46	\$162.04	<b>\$ 131.78</b>	<b>\$100.91</b>
<b>OTC Medication Orders</b>	\$ 14.17	\$ 12.85	\$ 13.38	<b>\$ 11.90</b>	<b>\$ 9.25</b>
<b>Wing Drugs*</b>	\$ 6.61	\$ 5.75	\$ 5.34	<b>\$ 6.80</b>	<b>\$ 1.88</b>
<b>Average Cost Per Inmate Per Year</b>	\$145.00	\$160.06	\$180.76	<b>\$150.48</b>	<b>\$112.04</b>
<b>Average Cost Per Inmate Per Day</b>	\$ 0.40	\$ 0.44	\$ 0.50	<b>\$ 0.41</b>	<b>\$ 0.31</b>

\* Wing drugs are medications which may be administered by officers in the housing units.

Despite an increase in pharmacy orders filled, the average number of orders filled per inmate has decreased since the implementation of managed care. In 1992 medication orders per inmate averaged 19.06 prescriptions per inmate; in 1996, prescriptions filled decreased to 17.56 per inmate.

Additionally, the pharmacy has also reported cost savings in the average cost of medications purchased per inmate per year. From fiscal year 1994 to fiscal year 1995, there was a 17% reduction in pharmacy costs, and from fiscal year 1995 to fiscal year 1996 a 26% reduction was noted. In reviewing Table [5], it can be seen that the average cost of all medications per inmate per year decreased from a high of \$160.06 per inmate per year in 1993 to \$112.04 per inmate per year reported in 1996; this represents a savings of \$48.02 per inmate.

The director of pharmacy attributed the cost savings to the following factors:

- licensure of the pharmacy as a Class C Institutional Pharmacy enabling the pharmacy to reuse medications that had not been in the inmate's possession
- better economies of scale with bulk purchases through group purchasing organizations
- practicing clinical pharmacy or pharmacotherapy, wherein clinical pharmacists consult with physicians to advise them on optimal drug treatment
- formulary management
- implementation of disease management guidelines

The director felt that the practicing clinical pharmacists as well as formulary management and disease management guidelines had a positive effect on decreasing the amount of medications ordered. As a result, the number of inmates having multiple prescriptions has been reduced. There are 14 clinical pharmacists on-site at various TTUHSC and UTMB medical units, with plans to hire three additional clinical pharmacists at TTUHSC facilities.

Section III-C:

## **Preventive Health**

Traditionally, incarcerated inmates have been from lower socioeconomic strata. As a group, they have not had the benefits of adequate health care on the outside and tend to participate in behaviors that place them at high risk for diseases such as HIV, TB, hypertension, renal failure, sexually transmitted diseases, and heart disease, among others. The preventive health program provided at TDCJ units focuses on two major areas: infectious and/or communicable diseases and chronic care.

On admission to the prison, TDCJ inmates are queried and tested for communicable diseases. Re-testing for tuberculosis is performed on an annual basis. Careful assessment and treatment at the time of intake protects the health of both inmates and staff. Additionally, the information obtained during these sessions aids in the development of relevant treatment plans and health promotion activities for the inmate population.

With the implementation of managed care, each prison unit has been staffed with a new position, an infectious disease nurse known as a CID nurse. The CID nurse is responsible for the tracking and surveillance of all infectious and communicable diseases on the individual prison units. The CID nurses are also responsible for the prison unit's Occupational Exposure Program. CID nurses are responsible for pre and post test counseling for potential HIV inmates and they counsel all inmates testing positive for tuberculosis. On an individual case basis, information is provided to the inmate regarding his disease process and medication compliance.

Chronic illnesses such as hypertension, asthma, diabetes, and seizures are amenable to ongoing management. If these diseases are not properly treated, there is a strong risk of impaired health status and potentially greater health problems. All of the health care units at TDCJ prisons conduct chronic disease programs. Inmates are seen by physicians or midlevel practitioners on a semi-annual basis and individual patient treatment plans specific to the care of the inmate are developed. In chronic care clinics, specific educational programs designed for chronic disease are presented to inmates.

Diet has been shown to play a major role in the prevention of disease. Unfortunately, offenders are given limited choices regarding their diets while they are incarcerated. Most prison diets tend to rely heavily on carbohydrates.

Outcome data referring to a patient's subsequent health status such as an improvement in symptoms or mobility have not been collected either pre or post implementation of managed care. Many managed care organizations in the private sector are reporting outcome measures from the Health Plan Employer Data and Information Set (HEDIS). While HEDIS reporting measures have been used by many health maintenance organizations, it is recognized that their data set is incomplete. Of the 60 measures contained in HEDIS, only nine focus on the quality of care received by individual patients. These nine indicators focus on preventive services which can be readily measured.

Education materials should be developed at a level that can be readily communicated to and understood by inmates. Many of the Texas inmates have never completed high school and 7th grade is the average educational achievement score. Therefore, it is not surprising that inmates may not read the pamphlets that are available. Either the inmate doesn't understand the material presented or they are not inclined to read.

The challenge for preventive health care in corrections is not only to hold on to what is done, but to improve what is done. The latter can only be accomplished by providing meaningful information to inmates on self care and preventive measures.

Section III-D:

## **Utilization Management**

### **Managing Utilization of Medical Services**

Utilization Management is an integral part of a managed health network. Utilization management programs assist in cost control by monitoring all inpatient and specialty services to ensure that medical services are rendered in the most cost-efficient manner.

Utilization review for both UTMB and TTUHSC is provided by utilization review departments. The review process includes pre-certification, concurrent review, and physician advisor review.

Each university provider utilizes different published guidelines to review inpatient hospital stays and specialty requests. All requests for off-site care must be pre-certified. Denials can be appealed by the on-site physician. Denial rates for TTUHSC for fiscal year 1996 were reported as less than 8-10%, depending on the specialty. The denial rate for UTMB for fiscal year 1996 was 14%. In addition to reviewing prospective cases, the utilization review programs perform a concurrent and retrospective audit of all inpatient and off-site medical care and charges.

UTMB contracts with specialists located primarily on their hospital staff. Tertiary care is provided at UTMB Hospital in Galveston. The expansion of prisons into West Texas made routine transfer to the prison hospital in Galveston impractical due to the cost of transportation and security. To serve the TDCJ facilities in West Texas, the TDCJ has recently constructed a 48 bed hospital facility located in Lubbock. The facility will provide inpatient care for inmates in West Texas and outpatient specialty clinics. Additionally, TTUHSC provides inpatient and off-site health care through contracts with area rural hospitals and specialists.

The utilization review programs have been effective in providing more on-site primary care at the facilities, reducing length of stay for inpatient admissions, and reducing waiting time for specialists' appointments. The average length of stay reported in 1990 for inpatient admissions for UTMB was 10.9 days. In 1996 it had decreased to 7.3 days. For fiscal year 1996 TTUHSC has reported an average length of stay of 5.3 days.

With the implementation of a managed care concept by the medical schools, a greater emphasis has been placed on providing primary care services at the unit level. The result has been a decrease in the number of specialty visits and emergency trips referred to UTMB and TTUHSC

hospitals, and an increase in the number of on-site clinic visits. Emergency room visits decreased from .021 visits per 1000 inmates in 1993 to .009 visits per 1000 inmates reported in 1995.

### **Specialty Referral Process**

Over 50% of the physicians interviewed (9 out of 17) felt that the specialty referral process was both long and cumbersome. Physicians estimated that the average waiting time (from the time they initiated the request until the inmate was seen) for a non-urgent request averaged from one to six months, depending upon the service requested. The implementation of a computer-generated appointment system at UTMB in November 1996, has helped to increase the timeliness of approvals, and generate appointments. UTMB has reported that the waiting list for the next available appointment for most routine referrals has been effectively reduced by more than 50%, from 54 days in 1994 to 18 days at the end of 1996. Similar data regarding the scheduling of appointments or the implementation of a computerized system is not maintained at TTUHSC.

Section III-E:

### **Telemedicine**

Under the managed health care system, telemedicine was introduced to TDCJ in October 1994. The system includes two-way video and specialized diagnostic equipment (such as electronic stethoscope, dermatology camera, video monitors and recorders). The patient is presented to the consultant in a clinical setting. The consultant's recommendations and patient disposition are included and maintained in the patient's chart. The patient is then sent back to his unit physician for proper referral, medication and/or follow-up.

Currently, the TDCJ's managed care telemedicine network includes three local hospitals and fourteen remote locations at TDCJ sites. It encompasses a total of 19 general and specialty services. From October 1994 through August 1996, 3,007 inmates utilized telemedicine consults at UTMB sites and another 2000 inmates at TTUHSC managed sites. Proposed plans include the deployment of telemedicine at nine additional units. TTUHSC plans to deploy telemedicine to all of its units with inmate populations over 2,000. Telemedicine consults occurring the most frequently include orthopedics, surgery, internal medicine, and psychiatry.

Telemedicine consults have been very successful in increasing the accessibility of care without traveling great distances. Most conditions encountered in primary care have been found to be suitable for teleconsultation. Only medical disease states that require invasive procedures for a definite diagnosis are in question for adequacy of presentation by telemedicine.

Section III-F:

### **Mortality Rates**

In reviewing mortality data for the TDCJ system, data was collected from mortality logs. All causes of death were established by autopsy findings and HIV statistics obtained from the TDCJ

Office of Preventive Medicine. Table [6] presents leading related causes of death in the TDCJ prison system from fiscal year 1993 through fiscal year 1996.

**Table [6]  
LEADING CAUSES OF OFFENDER DEATH**

	1993	1994	1995	1996
<b>Population</b>	<b>69,054</b>	<b>92,669</b>	<b>129,468</b>	<b>130,000</b>
<b>AIDS</b>	76	86	151	119
<b>Cardiac</b>	43	50	66	52
<b>Cancer</b>	36	54	71	66
<b>Cirrhosis</b>	17	34	28	8
<b>Pulmonary</b>	14	12	15	32
<b>Lethal Injection (Execution)</b>	16	12	19	8
<b>Suicide</b>	14	12	23	18
<b>Homicide</b>	1	6	10	5
<b>Accident</b>	1	3	4	5
<b>Other</b>	12	10	21	37
<b>Total</b>	230	279	408	350

On a national level, AIDS has become the leading cause of death in correctional systems. In 1993 in Texas, the number of AIDS related deaths reported was 110 per 100,000 inmates; the national average for AIDS related deaths was 89 per 100,000 inmates. In 1996, the Texas rate was reported as 92 per 100,000 inmates.

Suicides per 100,000 inmates in TDCJ prisons averaged 20 in 1993, 13 in 1994, 18 in 1995, and 14 in 1996. In 1995, the suicide rate reported from the Corrections Yearbook for adult/correctional institutions in the U.S. was 17 per 100,000 inmates.

**TABLE A.1: ACCESS TO CARE: ADULT FACILITIES**

PERFORMANCE MEASURE	PRIOR TO MANAGED CARE		UNDER MANAGED CARE		
	n	Proportion Compliant (p <sub>1</sub> )	n	Proportion Compliant (p <sub>2</sub> )	Percent Change <sup>b</sup> (p <sub>2</sub> -p <sub>1</sub> )/p <sub>1</sub>
<b>Offender who submitted a sick call request for medical services was physically triage within 48 hours (72 hours on weekends or holidays).</b>	131	73.3	167	91.6	+25.0
<b>Offender who was referred to a physician or midlevel practitioner was seen by a physician or midlevel practitioner within seven (7) days.</b>	114	77.2	109	86.2	
<b>Offender who requested routine care had a treatment plan formulated during the sick call visit.</b>	160	93.8	153	94.1	
<b>If the offender required routine lab or X-ray services, the service was provided, and the results were reviewed by a midlevel practitioner or physician within seven (7) days.</b>	13	92.3	19	78.9	
<b>Missed clinic appointments on-site and off-site were properly reported in the no show log (SLD-910) or had a refusal signed.</b>	25	80.0	17	70.6	

Note: n refers to the number of charts for which the indicator was relevant.

<sup>b</sup> Only statistically significant changes are reported

**TABLE A.2: CHRONIC CARE ADULT FACILITIES**

PERFORMANCE MEASURE	PRIOR TO MANAGED CARE		UNDER MANAGED CARE		Percent Change <sup>b</sup> (P <sub>2</sub> -P <sub>1</sub> )/P <sub>1</sub>
	n	Proportion Compliant (p <sub>1</sub> )	n	Proportion Compliant (p <sub>2</sub> )	
The medical problems are listed on the master problem list.	194	97.9	271	97.0	
The MAR, Med Pass or compliance record PH-70 or PH-40 shows continuity for all medications ordered..	164	92.7	261	95.4	
Vital signs T, P, R, BP are recorded at each chronic care visit or more frequently.	194	56.2	271	71.6	<b>+27.4</b>
Weight is recorded at each chronic care clinic visit or more frequently.	194	64.9	271	76.4	<b>+17.7</b>
The offender has received education regarding his/her illness.	189	38.1	271	64.2	<b>+68.5</b>
Baseline and regular monitoring of EKG, BUN, Creatine, & Electrolytes; FGS & Accuchecks; Peak flow or Spirometer; or Dilantin and/or other antiseizure drug blood levels.	190	72.6	266	86.1	<b>+18.6</b>
Offender receiving a therapeutic or special diet is listed on the Master Diet List provided to Food Services Supervisor.	26	42.3	77	77.9	<b>+84.2</b>
The patient has a written treatment plan which includes instructions regarding diet, exercise, medication, diagnostic testing, and frequency of follow-up appointments.	190	30.5	268	73.1	<b>+139.7</b>

Note: n refers to the number of charts for which the indicator was relevant.

<sup>b</sup> Only statistically significant changers are reported

**TABLE A.2.1: DIABETES CHRONIC CARE: ADULT FACILITIES**

PERFORMANCE MEASURE	PRIOR TO MANAGED CARE		UNDER MANAGED CARE		Percent Change <sup>b</sup> (p <sub>2</sub> -p <sub>1</sub> )/p <sub>1</sub>
	n	Proportion Compliant (p <sub>1</sub> )	n	Proportion Compliant (p <sub>2</sub> )	
The medical problems are listed on the master problem list.	38	97.4	68	97.1	
The MAR, Med Pass or compliance record PH-70 or PH-40 shows continuity for all medications ordered.	31	86.8	66	93.9	
Vital signs T, P, R, BP are recorded at each chronic care clinic visit.	38	50.0	68	66.2	
Weight is recorded at each chronic care clinic visit or more frequently.	38	65.8	68	72.1	
The offender has received education regarding his/her illness.	38	57.9	68	63.2	
Baseline and regular monitoring of FBS, accuchecks, HbgAC.	38	89.5	67	86.6	
Offender receiving a therapeutic or special diet is listed on the Master Diet List provided to the Food Services Supervisor.	17	47.1	18	66.7	
The patient has a written treatment plan which includes instructions regarding diet, exercise, medication, diagnostic testing, and frequency of follow-up appointments.	37	37.8	68	73.5	<b>+94.4</b>

Note: n refers to the number of charts for which the indicator was relevant.

<sup>b</sup> Only statistically significant changers are reported

**TABLE A.2.2: HYPERTENSION CHRONIC CARE: ADULT FACILITIES**

PERFORMANCE MEASURE	PRIOR TO MANAGED CARE		UNDER MANAGED CARE		
	n	Proportion Compliant (p <sub>1</sub> )	n	Proportion Compliant (p <sub>2</sub> )	Percent Change <sup>b</sup> (p <sub>2</sub> -p <sub>1</sub> )/p <sub>1</sub>
The medical problems are listed on the master problem list.	57	96.5	68	98.5	
The MAR, Med Pass or compliance record PH-70 or PH-40 shows continuity for all medications ordered.	52	94.2	68	94.1	
Vital signs T, P, R, BP are recorded at each chronic care clinic visit.	57	61.4	68	70.6	
Weight is recorded at each chronic care clinic visit or more frequently.	57	68.4	68	76.5	
The offender has received education regarding his/her illness.	56	30.4	68	66.2	<b>+117.8</b>
Baseline and regular monitoring of EKG, BUN, Creatine and electrolytes occur at discretion of physician.	57	84.2	67	82.1	
Offender receiving a therapeutic or special diet is listed on the Master Diet List provided to the Food Services Supervisor.	6	33.3	18	83.3	<b>+150.1</b>
The patient has a written treatment plan which includes instructions regarding diet, exercise, medication, diagnostic testing, and frequency of follow-up appointments.	57	38.6	68	67.6	<b>+75.1</b>

Note: n refers to the number of charts for which the indicator was relevant.

<sup>b</sup> Only statistically significant changers are reported

**TABLE A.2.3: PULMONARY CHRONIC CARE: ADULT FACILITIES**

PERFORMANCE MEASURE	PRIOR TO MANAGED CARE		UNDER MANAGED CARE		Percent Change <sup>b</sup> (p <sub>2</sub> -p <sub>1</sub> )/p <sub>1</sub>
	n	Proportion Compliant (p <sub>1</sub> )	n	Proportion Compliant (p <sub>2</sub> )	
The medical problems are listed on the master problem list.	53	98.1	68	97.1	
The MAR, Med Pass or compliance record PH-70 or PH-40 shows continuity for all medications ordered.	44	88.6	66	97.0	
Vital signs T, P, R, BP are recorded at each chronic care clinic visit.	53	52.8	68	76.5	<b>+44.9</b>
Weight is recorded at each chronic care clinic visit or more frequently.	53	58.5	68	79.4	<b>+35.7</b>
The offender has received education regarding his/her illness.	50	30.0	68	70.6	<b>+135.3</b>
Baseline and regular monitoring of peakflow and spirometer readings.	49	32.7	67	88.1	<b>+169.4</b>
Offender receiving a therapeutic or special diet is listed on the Master Diet List provided to the Food Services Supervisor.	---	---	19	84.2	
The patient has a written treatment plan which includes instructions regarding diet, exercise, medication, diagnostic testing, and frequency of follow-up appointments.	50	14.0	65	80.0	<b>+471.4</b>

Note: n refers to the number of charts for which the indicator was relevant.

<sup>b</sup> Only statistically significant changers are reported

**TABLE A.2.4: SEIZURE CHRONIC CARE: ADULT FACILITIES**

PERFORMANCE MEASURE	PRIOR TO MANAGED CARE		UNDER MANAGED CARE		Percent Change <sup>b</sup> (p <sub>2</sub> -p <sub>1</sub> )/p <sub>1</sub>
	n	Proportion Compliant (p <sub>1</sub> )	n	Proportion Compliant (p <sub>2</sub> )	
The medical problems are listed on the master problem list.	46	100.0	67	95.5	
The MAR, Med Pass or compliance record PH-70 or PH-40 shows continuity for all medications ordered.	37	91.9	61	96.7	
Vital signs T, P, R, BP are recorded at each chronic care clinic visit.	46	58.7	67	73.1	
Weight is recorded at each chronic care clinic visit or more frequently.	46	67.4	67	77.6	
The offender has received education regarding his/her illness.	45	40.0	67	56.7	
Baseline and regular monitoring of dilantin and/or other antiseizure drug blood levels.	46	87.0	65	87.7	
Offender receiving a therapeutic or special diet is listed on the Master Diet List provided to the Food Services Supervisor.	3	33.3	22	77.3	
The patient has a written treatment plan which includes instructions regarding diet, exercise, medication, diagnostic testing, and frequency of follow-up appointments.	46	32.6	67	59.3	<b>+81.9</b>

Note: n refers to the number of charts for which the indicator was relevant.

<sup>b</sup> Only statistically significant changers are reported

**TABLE A.3: CLINICAL ENCOUNTER: ADULT FACILITIES**

PERFORMANCE MEASURE	PRIOR TO MANAGED CARE		UNDER MANAGED CARE		Percent Change <sup>b</sup> (p <sub>2</sub> -p <sub>1</sub> )/p <sub>1</sub>
	n	Proportion Compliant (p <sub>1</sub> )	n	Proportion Compliant (p <sub>2</sub> )	
The nursing sick call protocol used was appropriate to the patient's chief complaint.	162	92.0	162	96.9	
The nursing sick call protocol was completely filled out.	161	83.9	161	90.1	
Vital signs were charted T, P, R, and BP.	166	74.7	166	84.3	<b>+12.9</b>
The signature and degree of the health care provider is legible or the institution uses signature stamps.	160	90.6	160	91.9	
The date and time of the encounter were noted.	160	99.4	160	97.5	
Offenders who required further care had a referral to a physician/midlevel practitioner documented in the medical record.	80	100.0	78	100.0	<b>+25.3</b>
Offender who was referred to a physician or midlevel practitioner was seen within seven (7) days of the original complaint or sooner if clinically indicated.	78	74.4	73	93.2	
If medication was obtained via telephone or verbal order, the order was co-signed within 72 hours.	39	87.2	44	93.2	

Note: n refers to the number of charts for which the indicator was relevant.

<sup>b</sup> Only statistically significant changes are reported

**TABLE A.4: CONSULTATION REQUEST: ADULT FACILITIES**

PERFORMANCE MEASURE	PRIOR TO MANAGED CARE		UNDER MANAGED CARE		
	n	Proportion Compliant (p <sub>1</sub> )	n	Proportion Compliant (p <sub>2</sub> )	Percent Change <sup>b</sup> (p <sub>2</sub> -p <sub>1</sub> )/p <sub>1</sub>
<b>There is a consultation request on the chart (TDCJ form HSM-1).</b>	138	90.6	167	91.0	
<b>A consultation request was initiated by the institutional staff.</b>	60	76.7	168	97.0	<b>+26.5</b>
<b>Consultation requests were approved or denied by the regional medical director at UTMB facilities or by the utilization manager at Texas Tech facilities.</b>	39	79.5	164	90.9	<b>+14.3</b>
<b>If consultation denied, alternative treatment plan initiated.</b>	14	78.6	9	77.8	
<b>All emergent consults were performed within 24 hours, urgent consults within 30 calendar days and non-urgent consults within 180 calendar days of initial request.</b>	99	76.8	120	79.2	
<b>Consultant's report was written and received by the facility within one week of visit.</b>	128	82.8	112	82.1	
<b>There is evidence that, if appropriate, the consultant's recommendations have been reviewed and considered by the on-site physician/midlevel practitioner.</b>	108	88.9	85	89.4	
<b>Follow-up appointments have been requested and scheduled according to the consultant's recommendations.</b>	80	85.0	64	81.3	

Note: n refers to the number of charts for which the indicator was relevant.

<sup>b</sup> Only statistically significant changers are reported

**TABLE A.5: DENTAL SERVICES: ADULT FACILITIES**

<b>UNDER MANAGED CARE</b>			
<b>PERFORMANCE MEASURE</b>	<b>n</b>	<b>Proportion Compliant (p<sub>i</sub>)</b>	<b>95% Confidence Interval</b>
<b>Inmate who submits a sick call request has the request documented in the Nursing Sick Call Log.</b>	150	44.0	36.1-51.9
<b>Inmate who submits a sick call request has the request documented in the Dental Sick Call Register or Dental Sick Call Log within 24 hours.</b>	167	58.1	50.1-65.6
<b>Patient eligible for a follow-up visit was seen within 35 working days.</b>	95	96.8	93.3-100.0
<b>Patient who requests routine care has a treatment plan formulated during the sick call visit.</b>	134	96.3	93.1-99.5
<b>Incoming health records were reviewed by dental staff for priority one conditions.</b>	157	95.5	92.3-98.7

Note: n refers to the number of charts for which the indicator was relevant.

<sup>b</sup> Only statistically significant changes are reported

**TABLE A.6: EMERGENCY SERVICES: ADULT FACILITIES**

PERFORMANCE MEASURE	PRIOR TO MANAGED CARE		UNDER MANAGED CARE		
	n	Proportion Compliant (p <sub>1</sub> )	n	Proportion Compliant (p <sub>2</sub> )	Percent Change <sup>b</sup> (p <sub>2</sub> -p <sub>1</sub> )/p <sub>1</sub>
Medical chart shows the patient sent out by the health care staff in less than 30 minutes of making a request for emergency care.	62	37.1	147	53.1	+43.1
Record indicates that appropriate referrals to a physician or EMS were made.	63	98.4	145	97.9	
If verbal or telephone medication orders were obtained, they are co-signed in the medical record within 72 hours.	27	88.9	49	81.6	
If the patient was sent to the emergency room, upon the offender's return, the medical record indicates patient was seen by a unit health provider within 48 hours of the emergency.	58	86.2	138	89.9	
If the patient was sent to the ER, an appropriate transfer form was completed when the patient was sent.	66	89.4	137	94.9	
An ER summary of discharge sheet from the hospital or clinic was returned with the patient to the unit.	58	84.5	146	84.2	

Note: n refers to the number of charts for which the indicator was relevant.

<sup>b</sup> Only statistically significant changes are reported

**TABLE A.7: INFECTION CONTROL HIV POSITIVE: ADULT FACILITIES**

<b>UNDER MANAGED CARE</b>			
<b>PERFORMANCE MEASURE</b>	<b>n</b>	<b>Proportion Compliant (p<sub>i</sub>)</b>	<b>95% Confidence Interval</b>
<b>An HIV test is documented in the medical record.</b>	121	95.0	91.1-98.9
<b>The offender received pre-counseling prior to the test.</b>	109	80.7	73.3-88.1
<b>The offender received post-counseling and was told the results of the test.</b>	107	75.7	67.6-83.8
<b>If HIV positive, a CD4 count was ordered and recorded on the medical record.</b>	119	95.8	92.2-99.4
<b>If CD4&gt;500, a CBC and Chemistry Panel was ordered and recorded in the medical record.</b>	65	89.2	81.7-96.7
<b>IF the CD4&lt;500, a referral was made tot he unit infectious disease clinic or CID nurse.</b>	67	100.0	-----
<b>If the CD4&lt;200, PCP prophylaxis was initiated.</b>	13	92.3	77.8-100.0
<b>If the CD4&lt;500, documentation in the chart reflects that the offender was seen every 90 days in either chronic care clinic or by the CID nurse.</b>	54	98.1	94.5-100.0

Note: n refers to the number of charts for which the indicator was relevant.

<sup>b</sup> Only statistically significant changers are reported

**TABLE A.8: INFECTION CONTROL PPD POSITIVE: ADULT FACILITIES**

<b>UNDER MANAGED CARE</b>			
<b>PERFORMANCE MEASURE</b>	<b>n</b>	<b>Proportion Compliant (p<sub>i</sub>)</b>	<b>95% Confidence Interval</b>
<b>A PPD or SCR is documented in the medical record within the last year.</b>	141	99.3	97.9-100.0
<b>Offenders over 45 years of age received a two-step skin test.</b>	14	50.0	23.8-76.2
<b>If the offender was PPD positive, an HIV test was offered.</b>	136	83.8	77.6-90.0
<b>If the PPD was positive, Chest X-rays were ordered.</b>	139	96.4	93.3-99.5
<b>The immunization record is complete and up to date. (PPD and tetnas are current).</b>	143	97.9	95.5-100.0
<b>The MAR, pill pass or treatment record indicates that the offender is receiving tuberculosis prophylaxis per protocol, unless a refusal has been signed.</b>	128	96.1	92.7-99.5
<b>There is chart documentation indicating that the offender has been educated regarding medication compliance and side effects.</b>	132	62.1	53.8-70.4
<b>The offender has been seen monthly in a chronic care clinic.</b>	126	84.9	78.6-91.2

Note: n refers to the number of charts for which the indicator was relevant.

<sup>b</sup> Only statistically significant changers are reported

**TABLE A.9: COMPLETENESS OF INTRASYSTEM TRANSFER FORMS: ADULT FACILITIES**

PERFORMANCE MEASURE	PRIOR TO MANAGED CARE		UNDER MANAGED CARE		Percent Change <sup>b</sup> (p <sub>2</sub> -p <sub>1</sub> )/p <sub>1</sub>
	n	Proportion Compliant (p <sub>1</sub> )	n	Proportion Compliant (p <sub>2</sub> )	
There is an intrasystem transfer form in the medical record.	137	97.8	163	99.4	
The “receiving facility” portion of the intrasystem transfer form was completed by a nurse within 24 hours.	135	85.9	163	88.3	
All care recommended in the intrasystem transfer form is reviewed by the on-site physician/midlevel practitioner as evidenced by a signature on the HSN-1 or HO-3A.	137	94.9	163	96.3	
The MAR form or med pass shows continuity for all medications listed in the intrasystem transfer form or an alternative as noted by the on-site physician.	61	95.1	95	98.9	
There is a current physical or annual exam based on policy or refusal.	137	97.1	163	86.5	<b>-10.9</b>
There is an up-to-date tuberculin skin test (PPD in mm) or CXR or a refusal form.	136	97.8	160	96.3	
Chronic problems identified on the intrasystem transfer form are identified on the problem list.	99	98.0	134	93.3	
Special housing was identified.	61	93.4	73	97.3	
Chronic Care clinic follow-up identified & scheduled according to policy.	67	85.1	79	91.9	

Note: n refers to the number of charts for which the indicator was relevant.

<sup>b</sup> Only statistically significant changers are reported

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