Special Review

Inmate Healthcare
Follow-up Review

March 2010

OFFICE OF LEGISLATIVE AUDITS
DEPARTMENT OF LEGISLATIVE SERVICES
MARYLAND GENERAL ASSEMBLY

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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF LEGISLATIVE AUDITS
MARYLAND GENERAL ASSEMBLY

March 26, 2010

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Executive Director

Bruce A. Myers, CPA
Legislative Auditor

Senator Verna L. Jones, Co-Chair, Joint Audit Committee
Delegate Steven J. DeBoy, Sr., Co-Chair, Joint Audit Committee
Members of Joint Audit Committee
Annapolis, Maryland

Ladies and Gentlemen:

We have conducted a follow-up review of the actions taken by the Department of Public Safety and Correctional Services (DPSCS) – Office of Inmate Health Services (OIHS), as of December 31, 2009, to address selected findings in our February 21, 2007 performance audit report. The follow-up review was requested by the Joint Audit Committee.

Our February 21, 2007 report contained 12 findings. In accordance with the Committee's request, we assessed OIHS's progress in implementing the recommendations for the 7 findings in that report most directly involving quality of care issues. The degree of implementation, based on our follow-up review, is as follows:

Degree of Implementation	Number of Findings
Corrected	1
Substantial Progress	0
In Progress	3
Minimal Progress	3
No Progress	0
Total Findings Reviewed	7

OIHS had initiated at least some corrective action on all 7 findings and had established a corrective action plan, which included timelines and processes to monitor the implementation of the plan for all the findings in the audit report. Nevertheless, full resolution of most of the 7 findings reviewed had not yet been achieved.

The status of each of the 7 findings we reviewed is identified in Exhibit 1, which also includes the DPSCS' self-assessment of the implementation status for all 12 report findings. Exhibit 2 describes, in detail, the status for each of the aforementioned 7 findings. DPSCS' response is included as an appendix to this report.

We wish to acknowledge the cooperation extended to us by DPSCS staff during this review, especially the staff of OIHS.

Respectfully submitted,

Bruce A. Myers, CPA
Legislative Auditor

Background Information

Effective July 1, 2005, the Department of Public Safety and Correctional Services (DPSCS) entered into six new inmate healthcare service contracts with five vendors. These new contracts were to provide for inmate healthcare services in the following six areas: (1) medical, (2) dental, (3) mental health, (4) pharmaceutical, (5) utilization management, and (6) electronic patient health records.[1] The contracts established the following four service delivery areas (SDA) in Maryland: Baltimore, Jessup, Eastern, and Western. DPSCS exercised contract options to extend these contracts through June 30, 2010.

The medical services contractor is the primary provider of healthcare services to inmates and notifies the other contractors when additional services are required (such as dental care, mental health counseling, prescription medication, and specialty care). In general, the medical and mental health contractors are to perform an immediate cursory exam of inmates upon arrival at a DPSCS facility to determine whether hospitalization or infirmary care is necessary. The medical contractor is responsible for performing a more detailed medical exam of each inmate within seven days of arrival at a DPSCS facility to determine whether each inmate requires routine follow-up care, specialty care, or no additional treatment. The medical contractor is also responsible for responding to inmate sick call requests within 48 hours during weekdays and within 72 hours on weekends.

The utilization management services contractor (UM contractor) is responsible for controlling the costs of outside care (such as from hospitals or specialists) by establishing a network of secondary care providers and by authorizing and making all payments for usage of such providers. The UM contractor is also responsible for conducting periodic peer reviews of all providers of healthcare services, which includes employees of the other contractors and secondary care providers.

The contractor for the electronic patient health records (EPHR) is responsible for implementing a computer system that provides a full medical history, in an electronic format, for each inmate that could be accessed from any EPHR system terminal in DPSCS facilities and offices to allow users to readily determine whether appropriate healthcare services were provided.

[1] The vendor selected for the medical services contract was also selected to implement a computer system for electronic patient health records.

The contract amounts are to be evaluated annually by the contractors and the Office of Inmate Health Services (OIHS), and adjusted based on the consumer price index. The total cost for these six contracts during fiscal year 2009 was approximately $150 million, according to DPSCS records, and is summarized in the following table:

Table 1
Inmate Healthcare Contract Costs

Contract	Fiscal Year 2009 Contract Amounts	Fiscal Year 2009 Actual Expenditures
Medical Services	$ 67,869,007	$ 66,646,547
Mental Health Services	12,384,915	12,069,813
Dental Services	7,797,800	7,712,897
Pharmaceutical Services	27,219,573	26,777,062
Utilization Management	34,627,318	34,937,505
Electronic Patient Health Records (EPHR)	1,639,324	1,693,519
Total	**$151,537,937**	**$149,837,343**

OIHS, within the DPSCS Office of Treatment Services, is responsible for monitoring the five inmate healthcare contractors to ensure that services are provided in accordance with the related contracts. Approximately 40 OIHS employees (30 regular and 10 contractual employees) throughout the State have been assigned to monitor the inmate healthcare contracts. The responsibilities of OIHS include determining whether contractors met contract requirements to provide sufficient qualified staffing and timely healthcare treatment services (such as healthcare for inmates with infectious diseases or chronic health conditions). For example, the medical, dental, and mental health contracts require each contractor to submit work schedules, for OIHS approval, detailing the daily working hours for all employees during each month. OIHS employees also participate in investigations of inmate healthcare-related complaints received from inmates, DPSCS corrections personnel, and contractor employees. All contractors are required to attend monthly quality improvement meetings held in each SDA as well as quarterly statewide meetings held at OIHS headquarters in Baltimore.

Invoice processing for contractor billings is handled by the DPSCS Office of the Secretary. Specifically, OIHS is responsible for advising the Office to pay the invoices after comparing the invoice totals to monthly budgeted amounts,

verifying hours billed, billing rates, and the mathematical accuracy of the invoices. These responsibilities are addressed in our fiscal compliance audits of DPSCS' Office of the Secretary.

Historic Problems With Inmate Healthcare

In the past, numerous complaints had been made about deficiencies in Maryland's inmate healthcare program, particularly in the Baltimore jail system, and some have resulted in investigations and lawsuits. For example, in August 2002, the Federal Department of Justice (DOJ) cited the Baltimore City Detention Center (BCDC, formerly the Baltimore city jail) for 107 different violations of health and safety standards, including 45 violations related to medical care and mental health patient treatment. In January 2007, the State reached an agreement with DOJ to resolve these violations by January 2011. The aforementioned DOJ investigation was conducted to determine whether the State had complied with provisions of a 1993 federal consent decree regarding health and safety conditions in the Baltimore jail system that had not sufficiently improved since the initial lawsuit was filed in 1971. In August 2009, the State reached a partial settlement agreement with the American Civil Liberties Union and the Public Justice Center, which represented the parties in the original lawsuit. This settlement requires the State to make certain improvements in healthcare and living conditions for inmates at BCDC.

Contract Settlements and Liquidated Damages

DPSCS entered into seven settlement agreements during the period from January 2007 through December 2008 for contract claims (such as for liquidated damages) with contactors providing services under its inmate health service contracts that resulted in certain contractors paying DPSCS $3,381,000, and DPSCS paying certain contractors $141,383. Specifically, these settlements were with three current contractors that provided services under the medical, mental health, and utilization management services modules of the current inmate health contracts that cover the period from June 1, 2005 through June 30, 2010, and one former contractor whose inmate healthcare contract ended in June 30, 1998. The inmate health services contracts permit DPSCS to assess liquidated damages against any contractor that fails to perform in a manner consistent with the contract provisions. The settlements were negotiated agreements, which specified that DPSCS would hold the contractors harmless from any further claims related to this period, including any claims associated with billing overpayments or deviations from the contract terms as related to services provided. In addition, for

contract violations during calendar year 2009, we were advised by OIHS management personnel that liquidated damages totaling approximately $278,000 had been assessed against the medical services contractor.

Electronic Patient Health Records Computer System (EPHR)

One of the six contracts executed in 2005 by DPSCS required a vendor to develop and implement a computer system to electronically track patient health records. That contract required that the patient health records include each inmate's health history while in DPSCS custody, including all medical exams, diagnoses, laboratory test results, medications administered, and secondary care services (such as visits to hospitals or specialists). Upon implementation, OIHS planned to use the reporting capabilities of EPHR to analyze the adequacy of inmate health services provided by the contractors (such as to track the timeliness of inmate sick call visits and chronic care patient visits), thereby allowing OIHS to address certain of the quality of care issues identified during our performance audit. However, we were advised by OIHS management personnel that certain limitations in EPHR's reporting capabilities have prevented them from using the system to monitor inmate health services on a global basis (such as the ability to determine how many inmates received a particular drug) to the extent intended.

Scope, Objectives, and Methodology

We conducted a follow-up review of the actions taken by the Department of Public Safety and Correctional Services (DPSCS) – Office of Inmate Health Services (OIHS) as of December 31, 2009 to address selected findings in our February 21, 2007 performance audit report.

This review was conducted based on a request we received from the Joint Audit Committee to determine the status of the corrective actions taken by OIHS to address the findings related to the quality of inmate health care services. We determined that 7 of the 12 findings in the February 2007 report were most directly related to quality of care.

Our review consisted of obtaining the December 31, 2009 status report from OIHS (describing the level of implementation of each prior audit report recommendation), performing tests and analyses of selected information, and holding discussions with OIHS personnel as we deemed necessary to determine the status of OIHS's corrective actions for the seven findings. Our review did not constitute an audit conducted in accordance with generally accepted government auditing standards. Had we conducted an audit in accordance with generally accepted government auditing standards, other matters may have come to our attention that would have been reported. Our review was conducted primarily during December 2009 through January 2010.

DPSCS' response to our follow-up review is included as an appendix to this report. As prescribed in the State Government Article, Section 2-1224 of the Annotated Code of Maryland, we will advise DPSCS regarding the results of our review of its response.

Exhibit 1: Status of Findings in February 21, 2007 Audit Report

Prior Finding	Status Based on Auditor's Review as of 12/2009	Status as Determined by OIHS as of 12/2009
Sufficiency of Contractor Staffing		
1. Staffing levels provided, as reported by the medical contractor, should be periodically verified to supporting documentation.	N/A	Corrected
2. OIHS should closely monitor contractor compliance with pre-approved work schedules.	N/A	Corrected
3. OIHS should determine the appropriate contractor staffing levels needed to provide all required services to inmates.	N/A	Corrected
Monitoring of Service Delivery Requirements in Medical Services Contract		
4. Medical exams of arrestees should be completed within seven days of arrest as required.	In Progress	In Progress
5. A process should be put in place to ensure that inmates with chronic medical conditions receive appropriate treatment as required.	Minimal Progress	In Progress
6. Corrective actions should be taken to address reported healthcare deficiencies.	Minimal Progress	Corrected
7. A methadone detoxification program should be implemented as required.	Corrected	Corrected
8. Action should be taken to address identified service delivery problems and medical contractor reports should be verified for reliability.	Minimal Progress	In Progress
9. A timely independent review should be conducted of the adequacy of care rendered subsequent to each inmate death.	In Progress	In Progress
10. OIHS should ensure that all significant healthcare violations and performance deficiencies are identified and documented timely and that full liquidated damages are assessed as soon as practical.	N/A	Corrected
11. Outstanding issues delaying the implementation of the electronic patient records computer system need to be resolved.	N/A	Corrected
12. Actions should be taken to address contractor reported weaknesses in coordination.	In Progress	In Progress

N/A – Not applicable since we did not review the implementation status of this finding

Note: Shaded findings are more fully described in Exhibit 2.

Exhibit 2: Status of Selected Findings From February 2007 Inmate Healthcare Report

Arrestee Medical Exams

Prior Finding 4
Medical exams of arrestees should be completed within seven days of arrest as required.

Prior Report Recommendation 4
We recommended that the Office of Inmate Health Services (OIHS) ensure that medical exams are completed within seven days for all arrestees, as required in the inmate medical contract.

Status – In Progress
OIHS had not established an adequate process to ensure that all intake medical exams were completed timely. In this regard, although OIHS produced daily reports of arrestees who were still in custody after seven days at the Baltimore Central Booking and Intake Center (BCBIC), it did not compare these reports to electronic medical records to ensure the inmates had received a medical exam as required in the inmate medical contract. While we were advised that OIHS personnel tracked the timeliness of medical exams, limited documentation of such monitoring was available. Specifically, documentation indicated that OIHS employees tested 10 inmates arrested from November 2009 to January 2010 and determined that 9 inmates received medical exams within seven days and 1 inmate received an exam on the eighth day. Our test of 15 inmates arrested in November 2009 disclosed that 12 of these arrestees had their medical exam within seven days as required, two inmates had an exam on the ninth day after their arrest, and one inmate was released on the ninth day without having an exam. According to State records, BCBIC processed 73,326 arrestees during fiscal year 2009, although the number of arrestees that were in custody for more than seven days was not determinable.

Inmates with Chronic Medical Problems

Prior Finding 5
A process should be put in place to ensure that inmates with chronic medical conditions receive appropriate treatment as required.

Prior Report Recommendation 5
We recommended that OIHS establish a process to ensure that all inmates with chronic care conditions receive required services from the contractor's medical staff.

Status – Minimal Progress
OIHS did not establish a process to ensure that all inmates with chronic medical conditions (such as infectious diseases, heart disease, or diabetes) were added to the medical contractor's database of chronic care patients to receive services from the contractor's staff as required in the inmate medical contract. Our test of 70 inmates, whom the medical services contractor reported as having an infectious disease that was considered to be a chronic medical condition during the period from May 2009 through August 2009, disclosed that 15 of these inmates had not been added to the contractor's chronic care database as of November 2009.

We also noted that the contractor's chronic care database did not include the dates of inmates' last medical visit as required. As a result, OIHS could not readily determine whether all inmates with chronic conditions had received medical visits every three months as required. OIHS did perform an audit during calendar year 2009 to determine if inmates with a specific chronic medical condition (HIV) received appropriate treatment. OIHS' April 2009 audit of 82 inmates with HIV determined that 27% of these inmates were not visited quarterly as required for their chronic medical condition. According to the medical contractor's records (which we noted above was incomplete), there were 9,319 inmates with chronic medical conditions as of November 30, 2009.

Service Delivery Monitoring - Audits

Prior Finding 6
Corrective actions should be taken to address reported healthcare deficiencies.

Prior Report Recommendation 6

1. We recommended that OIHS require corrective action plans from contractors to address service delivery deficiencies identified in audits conducted by OIHS and by the contractors, as well as service delivery weaknesses discussed in the periodic meetings with the contractors.

2. We also recommended that OIHS establish procedures to ensure that the corrective action plans are implemented, and retain documentation that establishes corrective actions have been fully implemented.

Status – Minimal Progress

1. OIHS did not always require formal corrective action plans from contractors to address service delivery deficiencies identified in audits conducted by OIHS. Specifically, our review of eight OIHS audits completed between September 2007 and November 2009 identified six audits where OIHS should have required corrective action plans from the medical contractor to address certain service delivery deficiencies identified by the audits (such as failure to provide required services to inmates who were diabetic or had HIV). However, as of January 2010, OIHS had only obtained three corrective action plans from the medical contractor for these six audits. Furthermore, one of these three corrective action plans did not address the weaknesses discussed in the related audit findings.

   OIHS also did not have a process to ensure all contractor performed audits were submitted as required. These audits were self assessments to monitor compliance with contract requirements. Specifically, the medical contractor was required to complete 66 audits during calendar year 2009 according to OIHS records, but OIHS had not determined how many of these audits were actually completed, and did not have any of the audits on hand. As a result, OIHS could not determine how many contractor audits required corrective action plans based on service delivery deficiencies identified.

2. OIHS had established a policy to require that the corrective action plans be implemented by contractors within four months of the date that the service delivery deficiency was identified. However, we were advised by an OIHS

management employee that, due to limited staffing for this task, OIHS has been unable to verify that all corrective action plans had been implemented; consequently, documentation of plan implementation was not maintained.

Methadone Treatment Program

Prior Finding 7
A methadone detoxification program should be implemented as required.

Prior Report Recommendation 7
We recommended that OIHS ensure the required methadone detoxification program is implemented as soon as possible.

Status – Corrected
In 2008, OIHS established a methadone detoxification program at the four intake and pretrial correctional facilities located in Baltimore City, as required by the medical services contract, after receiving federal licenses to operate the program. According to DPSCS records, the methadone program treated 1,082 detainees during fiscal year 2009.

Service Delivery Monitoring - Reports

Prior Finding 8
Action should be taken to address identified service delivery problems and medical contractor reports should be verified for reliability.

Prior Report Recommendation 8
1. We recommended that OIHS ensure that contractor service delivery reports contain all required information, that OIHS periodically review the underlying medical records for contractor reports to ensure reliability, at least on a test basis, and that OIHS investigate and resolve any discrepancies**.**
2. We also recommended that OIHS take action to address any identified service delivery deficiencies.

Status – Minimal Progress
1. OIHS did not always obtain service delivery reports required by the medical service contract and, for those reports that were received, it did not ensure that the information contained on the reports was reliable. Our review of

OIHS records used to track contractor reports received indicated that the majority of reports had not been received for the medical services contractor as of December 2009. The contractor was required to submit various reports to OIHS at intervals that were either daily, weekly, monthly, or annually. For example, OIHS did not receive any of the fiscal year 2009 monthly incident review reports that the medical services contractor was required to submit that would have detailed adverse incidents, such as assaults on contractor staff and lapses in protocol. Furthermore, while OIHS did verify that two reports related to infectious diseases, prepared by the medical services contractor, included all applicable inmates, it did not verify that medical data on these reports, or on any other reports received, were accurate.

2. Our review of service delivery reports prepared by the medical contractor during the period from July through November 2009 did not identify any significant deficiencies that warranted follow-up actions by OIHS staff. However, as noted above, many of the required reports were not received from this contractor. In our follow-up review for Finding 6, we determined that OIHS performed various audits that addressed the timeliness of sick call visits and medication administration errors, which were the two areas identified in our preceding performance audit Finding 8 as needing follow-up actions.

Independent Death Reviews

Prior Finding 9
A timely independent review should be conducted of the adequacy of care rendered subsequent to each inmate death.

Prior Report Recommendation 9
We recommended that OIHS establish a process to ensure that an independent physician reviews each inmate death in a timely manner to evaluate the adequacy of medical care provided to the inmate.

Status – In Progress
OIHS did not ensure that all inmate deaths were reviewed timely by an independent physician to evaluate the adequacy of medical care provided to the inmate. Specifically, of the 214 inmate deaths that occurred during the period from January 1, 2007 through November 30, 2009, 124 of these deaths had not been reviewed by an independent physician as of January 5, 2010 according to

OIHS records, including 98 deaths that had occurred from 181 days to 734 days prior to our review. Although a DPSCS directive and an OIHS written policy required that independent physician reviews be completed for each inmate death, there was no requirement specifying the time frame within which these reviews had to be completed.

OIHS revised its process to conduct inmate death reviews in 2008 to ensure that OIHS nursing staff reviewed all deaths in a timely manner. In addition, OIHS nursing staff now prioritizes such cases into one of five rankings and assigns higher priority rankings to those deaths which may have been preventable so these cases are reviewed first by the OIHS medical director. Our test of supporting documentation for all 12 inmate deaths with the two highest priority rankings during calendar years 2006 through 2009 (as of November 2009) disclosed that all 12 inmate deaths were reviewed by OIHS nursing staff within 21 days of the date of death and were subsequently reviewed by OIHS' medical director, which serves as the required independent physician review to evaluate the adequacy of care.

Coordination of Services Among Health Contractors

Prior Finding 12
Actions should be taken to address contractor-reported weaknesses in coordination.

Prior Report Recommendation 12
We recommended that OIHS ensure that identified deficiencies in coordination among contractors are resolved as soon as possible, and document the measures taken to resolve the deficiencies and the results achieved. In particular, OIHS should ensure that inmate health records are readily available to providers of mental health services, require the utilization management contractor (referred to as the UM contractor) to perform the required peer reviews of secondary care providers, and ensure that the medical services contractor submits required documentation to support emergency room admissions.

Status – In Progress
Regarding coordination of services among contractors, OIHS provided documentation that it held routine meetings with the UM contractor to discuss the adequacy of inmate health care services provided and coordination among the other contractors. In addition, OIHS revised its medical recordkeeping policies to require all contractors to store each inmate's health records in the Electronic

Patient Health Records (EPHR) automated system maintained by the medical contractor. We were advised that the mental health contractor (that was specifically mentioned in the preceding performance audit) is now required to access EPHR to obtain inmate medical records, and it has not advised OIHS of any difficulties in accessing individual medical records since our previous audit.

Regarding another area of coordination, OIHS did not ensure that the UM contractor performed the required peer reviews of secondary care providers. Specifically, OIHS had not received any peer reviews from the UM contractor. While OIHS acknowledged that it did not enforce secondary care peer reviews, we were advised that OIHS management did not believe that such peer reviews were necessary to achieve its care goals and that the requirement for such peer reviews will be removed from future contracts.

Regarding a final area of coordination noted in our preceding performance audit, the UM contractor reported that the medical contractor submitted required documentation for 96 percent of emergency room admissions during calendar year 2009, including 6 individual months where 98 percent of the required documentation was submitted. However, OIHS had not established a process to verify the accuracy of these UM contractor statistics to ensure emergency room admissions were properly supported (such as reviewing the emergency room referral documentation approved by a medical contractor physician), even on a test basis.

APPENDIX

Department of Public Safety and Correctional Services

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March 19, 2010

Mr. Bruce A. Myers, CPA
Legislative Auditor
Office of Legislative Audits
301 West Preston Street – Room 1202
Baltimore, Maryland 21201

Dear Mr. Myers:

The Department of Public Safety and Correctional Services has reviewed the draft follow-up performance review dated March 5, 2010, which identifies the status of **Inmate Healthcare** findings first issued in February 2007. The Office of Inmate Health Services (OIHS), as well as the Department, appreciates the effort of the Legislative Auditors to evaluate the status of the Department's inmate healthcare delivery system. Based on this review, the Legislative Auditors hopefully have a better understanding of the various complexities and challenges that exist in providing and measuring adequate healthcare services within a prison environment.

As the Department continues to enhance its inmate healthcare delivery system, we believe that these findings will help guide the Department's future management of the inmate healthcare contracts.

Attached are Deputy Secretary Philip Pié's itemized responses to the follow-up review, with which I concur. Be assured we remain committed to fully resolve all of the agreed upon findings noted in this follow-up review. I trust this responds to your request.

Sincerely,

Gary D. Maynard
Secretary

c: G. Lawrence Franklin, Deputy Secretary for Administration
Philip Pié, Deputy Secretary, Programs and Services
Thomasina Hiers, Assistant Secretary/Chief of Staff
Susan D. Dooley, Director of Financial Services
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March 19, 2010

Mr. Gary D. Maynard, Secretary
Department of Public Safety and Correctional Services
300 East Joppa Road, Suite 1000
Towson, Maryland 21286

RE: Performance Audit Report – Inmate Healthcare

Dear Secretary Maynard:

Below are the responses to the draft Performance Audit Report for Inmate Healthcare. This was a follow up review of the Inmate Healthcare audit published in February 2007. While not all of the items cited in that audit have been corrected, the Department continues to make significant progress in providing quality healthcare to inmates.

Although it is reasonable to expect that the Department should monitor and document every element of a contract to ensure that services have been rendered, a check list of completions does not always guarantee success in healthcare management. It also does not guarantee good outcomes. The quality of healthcare received by inmates in Maryland is reflected by the clinical outcomes achieved in disease management, as well as documentation by experts and agencies whose experience in the delivery of services and care for inmates are nationally recognized and serve as the reference for standards of care for inmate health services. An example of some of the clinical outcomes we can be proud of are as follows:

- Maryland inmates, when compared to the community and other state correctional systems, have a higher percentage of diabetics who have exceptional performance outcomes related to Hemoglobulin A1C, which exceeds national average standards. The control and management of the complications of this disease is directly related to this measurement. At a National Commission on Correctional Health Care (NCCHC) conference in San Antonio, Texas, a DPSCS multi-vendor presentation on Diabetic Care in Corrections scored one of the highest evaluations of any of the other presentations, outlining the steps for care of the chronic diseases in Maryland inmates, and the outcomes from that management.

- Five hundred and eighty HIV inmates identified as having chronic diseases are monitored with Johns Hopkins as well as with a University of Maryland Medical System (UMMS) Infection Control Specialist. Documented data confirms that inmates who have HIV in Maryland have achieved viral load suppression, a hallmark of good care in over 64% of the Maryland inmates compared to less than 50% on average nationally.

- The Institute of Human Virology and Johns Hopkins consultants confirmed that Maryland is treating over 300 inmates with Hepatitis C, which is a greater number of inmates in treatment than the surrounding states. This accomplishment has also been recognized by the legislature in Annapolis, which tracks the care and management of this disease in corrections.

While not reflected in this audit, the Office of Inmate Health Services (OIHS) has continued to work closely with the vendors to achieve good overall results. For example:

- Maryland retained healthcare certification by the American Correctional Association for WCI and ECI;

- Baltimore pretrial NCCHC recertification was achieved;

- Medical contractors achieved Maryland Commission on Correctional Standards (MCCS) certification in 98% of the facilities with only one corrective action pending;

- Department of Health and Mental Hygiene (DHMH) licensing certification was achieved in 100% of the infirmaries statewide;

- Maryland is the only state correctional system to achieve program certification for its Methadone Program;

- In a recent Department of Justice (DOJ) audit, Maryland received a "substantial compliance" rating for access to emergency care, mortality reviews, intake screening, and the care of pregnant inmates;

- Prior finding #'s 1, 2 and 3 (Legislative Audit 2007) concerning staffing were addressed through improved contract monitoring as well as a review of staffing levels and a contract modification to staffing levels as recommended in the past findings; and

- Prior finding # 10 (Legislative Audit 2007) concerning the identification and securing of full liquidated damages was also addressed through the establishment of the OIHS Liquidated Damages Review Board, and fully assessed liquidated damages.

The OIHS has recently been reorganized in order to better differentiate between clinical and healthcare administration. This should position the Department to be able to maintain the positive clinical outcomes while also ensuring that corrective action is taken and contracts are closely audited for compliance.

The OIHS responses to each of the legislative auditor's status findings are reflected below:

Finding #4 – Medical exams of arrestees should be completed within seven days of arrest as required.

Auditor status determination – In Progress.

We agree. Although we did not properly document that we ensure the timely medical exams of arrestees, this did not have a negative impact on inmate healthcare. In fact, external auditing agencies such as the DOJ, NCCHC, as well as the MCCS, who conducted audits related to the receiving screening/intake process, found DPSCS in compliance with this standard. Also, the medical consultant for the DOJ, upon review of the changes in the intake process put in place to ensure the identification and processing of the inmates medically, advised, and we quote, "The DOC is in substantial compliance with this element of the Agreement."

To achieve full compliance in this area, OIHS has or will implement the following:

- The template for "Intake Exams" is presently being developed. By May 15, 2010, it shall be in use, and summary data on completed intake exams will be available.

- By June 1, 2010, the summary report generated will be recorded on an Excel spreadsheet with a comparison of the date the arrestee was received against the 7-day timeframe allotted to complete the exam.

Finding #5 – A process should be put in place to ensure that inmates with chronic medical conditions receive appropriate treatment as required.

Auditor status determination – Minimal Progress.

We agree in part, disagree in part.[1] The chronic care database does not capture all inmates who are designated as having a chronic illness. However, we believe inmates with chronic conditions are receiving care substantial enough to alter the course of complications associated with their disease. In addition, the electronic medical record has the last date of the inmate visit for chronic disease care even if it is not in the chronic disease database. When compared to the community and other state correctional systems, Maryland inmates with chronic conditions, on average, have good outcomes.

To achieve full compliance in this area, OIHS will enhance the data integrity and monitoring. In fact, we have already begun Electronic Medical Records (EMR) education that ensures that chronic care data entry is accurate. OIHS has also audited HIV and Hepatitis C for data integrity with results close to 98% accuracy. The final phase is to be implemented on June 1, 2010. This will include a random selection of 30 chronic care cases each month from the vendor's generated report. The 30 selected cases will be reconciled against individual patient records confirming that these individual patients have or have not been followed up in chronic care clinics. OIHS will also continue to track and monitor positive clinical outcomes that include HIV, diabetes, and heart disease.

[1] **Auditor's Comment:** The Department of Public Safety and Correctional Services' (DPSCS) response acknowledges that the chronic care database does not capture all inmates who are designated as having a chronic illness, but implies that this condition is mitigated by the inclusion of certain chronic care information in the electronic medical records (EMR). However, the Office of Inmate Health Services (OIHS) could not use the EMR to determine if *all* inmates with chronic conditions received required medical care due to limitations in EMR reporting capabilities. The chronic care database was created to monitor this segment of the inmate population. As the chronic care database is not comprehensive, OIHS had limited assurance that all inmates with chronic conditions were fully receiving appropriate treatment.

Finding #6 – Corrective actions should be taken to address reported healthcare deficiencies.

Auditor status determination – Minimal Progress.

We agree in part, disagree in part.[2] In the past, OIHS did not always request corrective action plans in response to all deficiencies. However, OIHS did utilize the quarterly CQI meetings and presentations by the vendor to differentiate the systemic issues from episodic ones and addressed the corrections utilizing a multi-vendor corrective action approach. For example, when diabetic care outcomes related to poor control of blood sugar levels were identified, each vendor addressed the contribution their discipline offered to the correction of the problem utilizing a PowerPoint presentation. The audit data was part of the presentation. The outcome was the lowering of the hemoglobin A1C for the diabetic inmate. The same approach was used for cardiac case management, ER, self injurious behavior, suicide tracking, and medication administration audit issues. Also, OIHS internal audits have indicated a reduction in ER admissions from FY08 to FY09. Further, CQI monitoring of off-site trips to treat seizures resulted in the establishment of an alcohol and drug detoxification unit at BCDC. The data for the CQI monitoring of seizures is not contained in a traditional corrective action plan but is incorporated within the follow-up presentations of the outcomes. OIHS believes this method of tracking audit deficiencies, utilizing outcome data and monitoring systemic core essentials produces better results.

To achieve full compliance, the procedures for monitoring and responding to contractor deficiencies, including monthly audits that are inclusive of, but not limited to, intake, sick call, periodic physicals, and chronic care, will be published no later than May 1, 2010. Prospectively, formal corrective action plans will still be a part of the healthcare plan, but not the sole basis for ensuring compliance.

Finding #7 – A methadone detoxification program should be implemented as required.

Auditor status determination – Corrected.

[2] **Auditor's Comment:** DPSCS' response acknowledges that OIHS did not always request corrective action plans in response to all service delivery deficiencies noted, but indicated that various other procedures were performed that facilitated monitoring of corrective actions. Without a systematic process to ensure that contractor corrective action plans are created and to track the receipt and implementation of the plans, OIHS had limited assurance that all reported healthcare deficiencies were being addressed. Furthermore, the response does not address our comment that OIHS was not ensuring that all contractually required audits were completed.

We agree. In 2008, after receiving federal licenses to operate the program, OIHS established a methadone detoxification program at the four intake and pretrial correctional facilities located in Baltimore City, as required by the medical services contract. According to DPSCS records, the methadone program treated 1,082 detainees during fiscal year 2009.

Finding #8 – Action should be taken to address identified service delivery problems and medical contractor reports should be verified for reliability.

Auditor status determination – Minimal Progress.

We agree in part, disagree in part.[3] Actions taken to address the deficiencies may not have been in a standard corrective action format, but there are a number of emails that document that OIHS was providing instruction and tracking deficiencies. The follow-up correspondence was identified and made available for review to the legislative auditors.

Other actions were also taken to address problems and ensure vendor compliance. For example, in the areas where disease management was a part of the CQI reporting for diabetic inmates, the listing of inmates and lab results were verified. HIV data is researched weekly and validated by receipt of the lab results. There are specialists who depend upon the validity of tests to offer care suggestions. Tele-medical conferences are conducted every Tuesday to discuss and question labs and viral load levels.

In addition, on a weekly basis, medical contractors managing Hepatitis C patients are questioned and corrections are made related to missing information or faulty data that was submitted for approval for anti-viral therapy. That data is on a lab report which is faxed for our review prior to the presentation. Every month, data submitted for review related to HIV testing, dialysis, ER reports, etc. are challenged and reviewed. Pregnancy information submitted by the contractors is reviewed daily/weekly. This includes testing for STD, HIV, Hepatitis, and urine pregnancy testing using the Bio-Reference Laboratory and the electronic record. The State Venereal Disease Research Laboratory (VDRL) is tracked by OIHS internal auditors using the state's listing of inmates. The contractor enters the data received so that most of the infectious disease information is not that of the medical contractor, but a laboratory entity. We continue to monitor the contractor's requests, receipts and actions, if required, of those lab test results.

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[3] **Auditor's Comment:** DPSCS' response indicates actions that are taken related to various service delivery problems. Specifically, while the response cites monitoring of some aspects of the contractor's medical service delivery system, our review noted that OIHS did not ensure all service delivery reports required by the medical service contract were received. Additionally, for those reports received the response indicated that information on the reports was reviewed, but we noted that OIHS did not ensure the information contained on the reports was reliable. However, the DSPCS' response does indicate that OIHS would create a spreadsheet to track and summarize its monitoring efforts.

Furthermore, follow-up audits related to sick call and medication management were conducted by the state, and documentation of the efforts of the contractor to correct medication management was submitted to the legislative auditors.

Finally, serious incident reporting is part of the quarterly CQI submission under risk management. Any other serious incident requirements more than reporting are followed up by the regional agency's on-site contract monitor.

To achieve full compliance in this area, effective May 2010, OIHS will create an Excel spreadsheet to track and summarize the above-referenced practices.

Finding #9 – A timely independent review should be conducted of the adequacy of care rendered subsequent to each inmate death.

Auditor status determination – In Progress.

We agree. A physician reviewer is an essential component of the death review process. However, given that the Department only has one physician provider for an inmate population of 23,000 inmates, some additional steps were taken to alert the DPSCS Medical Director of those incidents of death that required a more urgent review. In the current process, the site level's master's degree nurses review the case to participate in the 72 hour death review on site. They have served to alert the DPSCS Medical Director about deviations from standards of care and have also achieved a more timely review.

The Department has recently completed the hiring of an additional master's level nurse, part time, who has been trained in mortality review to assist in the identification of cases that require more immediate input. In addition, an administrative nursing review is conducted by other nursing staff who will also alert the mortality review nurses of cases requiring their immediate input. Although those deaths that were related to terminal illnesses, homicide, overdose, and expected deaths related to unstable chronic conditions are important, the priority of cases that are unexpected, suspicious, or deviations from the standards, will be given to the master's level nurse for input more expeditiously.

To achieve full compliance in this area, OIHS believes that with the ability to fill the nursing FTE, we will soon be able to respond to these reviews in a more timely manner.

Finding #12 – Actions should be taken to address contractor reported weaknesses in coordination.

Auditor status determination – In Progress.

We agree. Early on, the Department identified the need for multi-vendor meetings for opportunities to identify, separate from the individual contractor meetings, systemic or individual issues that created barriers to providing contracted services. There are regional multi-vendor CQI, Pharmacy, Access to care and MAC meetings. DPSCS hosts quarterly multi-vendor meetings, quarterly multi-vendor CQI meetings; monthly Infection Control multi-vendor meetings, and multi-vendor death reviews.

The medical contractor, as custodian for the medical records, has met with vendors and corrected problems related to schedule conflicts for clinics with paper record access issues. The missed appointment issue for contractors was improved upon significantly. Lab issues for mental health audits were conducted and shared with the vendor responsible for lab test completion. There is documentation of multi-vendor electronic medical record meetings to resolve the issue related to the medical record.

Emergency room documentation is submitted by the contractor concurrent to the event and is reviewed monthly as part of the minutes as a report with the UM vendor, and submitted to the auditing team. The medical contractor has intermittently submitted documentation challenging the percentages, and the OIHS and UM vendor review prevailed. We agree that the secondary care documentation submitted by the UM peer review vendor may not have been standardized as necessary to meet the original goal of the OIHS.

To meet full compliance, in the new RFP, secondary care, as it relates to peer reviews, has been modified from the current requirements and will only apply to specialists assigned to clinics on a regular basis. This level of peer review is more consistent with community standards and will be monitored for full compliance. Additionally, Medical and UM services are being combined into one contract.

Respectfully,

Philip Pié,
Deputy Secretary
Programs and Services

c: G. Lawrence Franklin, Deputy Secretary for Administration
Thomasina Hiers, Assistant Secretary/Chief of Staff
Susan D. Dooley, Director of Financial Services
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