

**Joint Legislative Committee on Performance
Evaluation and Expenditure Review (PEER)**

Report to
the Mississippi Legislature



Medical Care for State Inmates: The Department of Corrections' Contract Management and Its Provision of Specialty Medical Care

From January 1, 2007, through May 31, 2007, the Department of Corrections and its contractor, Wexford Health Services, did not ensure that all inmates received timely access to quality medical care, as follows:

- Regarding routine medical care, during the period of review, MDOC and Wexford did not ensure that all state inmates received timely access to the sick call process and two-year dental prophylaxis within the intervals established by the medical services contract and by national correctional standards for medical care.
- MDOC's current contract with Wexford does not address chronic medical care; therefore, MDOC cannot ensure that Wexford develops and implements a system of quality chronic medical care for the state's inmates.
- Regarding mental health care, MDOC does not require that Wexford keep mental health records organized separately from inmates' other medical records, a condition that could affect continuity of care.

Also, medical records for the review period do not contain documentation that MDOC and Wexford provided timely specialty medical care to all state inmates needing such care.

Concerning medical staffing, during the review period, Wexford's staffing levels were not in compliance with contract requirements. Also, MDOC did not require Wexford to submit documentation of the professional credentials of all medical staff.

Neither MDOC nor Wexford has an effective quality assurance process for contract compliance and Wexford does not assure confidentiality and security in the transport of inmates' medical records and medications from one correctional facility to another.

Regarding MDOC's FY 2007 medical expenditures, MDOC spent approximately \$42.8 million for inmate medical care in FY 2007, approximately \$1.1 million more than it would have expended for Wexford's turnkey proposal to provide comprehensive medical services to inmates and approximately \$2.8 million more than its FY 2007 appropriation for medical services.

December 11, 2007

PEER: The Mississippi Legislature's Oversight Agency

The Mississippi Legislature created the Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER Committee) by statute in 1973. A joint committee, the PEER Committee is composed of seven members of the House of Representatives appointed by the Speaker and seven members of the Senate appointed by the Lieutenant Governor. Appointments are made for four-year terms with one Senator and one Representative appointed from each of the U. S. Congressional Districts. Committee officers are elected by the membership with officers alternating annually between the two houses. All Committee actions by statute require a majority vote of four Representatives and four Senators voting in the affirmative.

Mississippi's constitution gives the Legislature broad power to conduct examinations and investigations. PEER is authorized by law to review any public entity, including contractors supported in whole or in part by public funds, and to address any issues that may require legislative action. PEER has statutory access to all state and local records and has subpoena power to compel testimony or the production of documents.

PEER provides a variety of services to the Legislature, including program evaluations, economy and efficiency reviews, financial audits, limited scope evaluations, fiscal notes, special investigations, briefings to individual legislators, testimony, and other governmental research and assistance. The Committee identifies inefficiency or ineffectiveness or a failure to accomplish legislative objectives, and makes recommendations for redefinition, redirection, redistribution and/or restructuring of Mississippi government. As directed by and subject to the prior approval of the PEER Committee, the Committee's professional staff executes audit and evaluation projects obtaining information and developing options for consideration by the Committee. The PEER Committee releases reports to the Legislature, Governor, Lieutenant Governor, and the agency examined.

The Committee assigns top priority to written requests from individual legislators and legislative committees. The Committee also considers PEER staff proposals and written requests from state officials and others.

PEER Committee
Post Office Box 1204
Jackson, MS 39215-1204

(Tel.) 601-359-1226
(Fax) 601-359-1420
(Website) <http://www.peer.state.ms.us>

The Mississippi Legislature

Joint Committee on Performance Evaluation and Expenditure Review

PEER Committee

SENATORS
MERLE FLOWERS
Vice Chair
GARY JACKSON
Secretary
SAMPSON JACKSON
DEAN KIRBY
EZELL LEE
LYNN POSEY
RICHARD WHITE



Post Office Box 1204
Jackson, Mississippi 39215-1204

Max K. Arinder, Ph. D.
Executive Director

TELEPHONE:
(601) 359-1226

FAX:
(601) 359-1420

www.peer.state.ms.us

REPRESENTATIVES
HARVEY MOSS
Chair
WILLIE BAILEY
ALYCE CLARKE
DIRK DEDEAUX
JOEY HUDSON
WALTER ROBINSON
RAY ROGERS

OFFICES:
Woolfolk Building, Suite 301-A
501 North West Street
Jackson, Mississippi 39201

December 11, 2007

Honorable Haley Barbour, Governor
Honorable Amy Tuck, Lieutenant Governor
Honorable Billy McCoy, Speaker of the House
Members of the Mississippi State Legislature

On December 11, 2007, the PEER Committee authorized release of the report entitled **Medical Care for State Inmates: The Department of Corrections' Contract Management and Its Provision of Specialty Medical Care.**

A handwritten signature in cursive script that reads "Harvey Moss".

Representative Harvey Moss, Chair

This report does not recommend increased funding or additional staff.

Table of Contents

Letter of Transmittal	i
Executive Summary	ix
Introduction	1
Authority	1
Scope and Purpose.....	1
Method	2
Background	5
How the Department of Corrections Provided Medical Services to Inmates Prior to FY 2007	5
In-House Provision of Services and Contract with the University of Mississippi Medical Center	6
Contract with Correctional Medical Services, Inc.	6
Decision to Seek a New Contractor in 2005.....	6
The Current Medical Services Contract and the State's Assumption of Increased Risk	8
Risks to Inmates.....	9
Financial Risks to the State.....	10
Access to Medical Care Provided by Wexford.....	11
Routine Medical Care for Inmates.....	11
Chronic Medical Care for Inmates.....	26
Mental Health Care for Inmates.....	33
Wexford's and MDOC's Provision of Specialty Medical Care	37
No Written Timeliness Standards for Monitoring the Status of Inmates' Specialty Care Cases	38
No Effective Method for Tracking Inmates through the Specialty Care Process	49
Operational Issues: MDOC and Wexford.....	52
Issues with Medical Staffing.....	52
Issues with Quality Assurance for Contract Compliance and Recordkeeping.....	61
MDOC's FY 2007 Medical Expenditures	68

Table of Contents (continued)

Recommendations	72
Appendix A: Population Sizes, Calculated Sample Sizes, and Actual Sample Sizes, for all Three Parent Facilities Combined, January 1, 2007, through May 31, 2007	77
Appendix B: Compliance Rates and Ranges for all Three Parent Facilities Combined, January 1, 2007, through May 31, 2007	78
Appendix C: Compliance Percentages for Inmate Intake, by Parent Facility	79
Appendix D: Compliance Percentages for Sick Call Triage, by Parent Facility	80
Appendix E: Compliance Percentages for Sick Call 7-Day Physician Visit, by Parent Facility	81
Appendix F: Compliance Percentages for 2-Year Dental Prophylaxis, by Parent Facility	82
Appendix G: Compliance Rates and Ranges for Chronic Care, for all Three Parent Facilities Combined.....	83
Appendix H: Compliance Percentages for Chronic Care 6-Month Visit, by Parent Facility	84
Appendix I: Compliance Percentages for Chronic Care 6-Month Physician Referral Notation, by Parent Facility.....	85
Appendix J: Compliance Percentages for Chronic Care Medication Treatment Plan, by Parent Facility.....	86
Appendix K: 2007 1 st and 2 nd Quarter Staffing Levels, by Parent Facility	87

Table of Contents (continued)

Appendix L:	Number of Licensed, Registered, or Certified Medical Staff Employed by Wexford at the Three Parent Facilities Combined, as of October 29, 2007.....	90
Agency Response	91

List of Exhibits

1.	Summary of Wexford’s Compliance with Standards for Routine Medical Care at the Three Parent Correctional Facilities, January 1 through May 31, 2007.....	13
2.	Summary of Wexford’s Performance Regarding Chronic Medical Care at the Three Parent Correctional Facilities, January 1 through May 31, 2007.....	28
3.	Flow Chart of Specialty Care Process from Consult Request to Appointment Scheduled for Timeliness of Specialty Care	39
4.	Number of Days Between Wexford’s Completion of Consult and Specialty Care Appointment.....	41
5.	Number of Days Between Wexford’s Completion of Consult and Submission to MDOC’s Office of Specialty Care	42
6.	Number of Days Between Receipt and Review of Consult Request by MDOC’s Office of Specialty Care.....	44
7.	Number of Days Between MDOC’s Review of Consult Request and Appointment Date	45
8.	Summary of Wexford’s Staffing of MDOC Parent Facilities, January-June 2007	54
9.	Liquidated Damages Recommended by the MDOC Chief Medical Officer for Staffing Shortages between January 1, 2007, and June 30, 2007.....	61
10.	Percentages of Medical Records PEER Considered to be Indeterminate for the Period January 1, 2007, through May 31, 2007	66
11.	Comparison of Covered Medical Services, Responsibilities, and Costs of the Turnkey and Combination Models for Providing Inmate Medical Care, FY 2007.....	69

Medical Care for State Inmates: The Department of Corrections' Contract Management and Its Provision of Specialty Medical Care

Executive Summary

Introduction

To address legislative concerns regarding the Mississippi Department of Corrections' (MDOC's) management of state inmates' medical care, including management of the contract with Wexford Health Sources, Inc., and the department's own provision of specialty medical care, PEER reviewed the following areas of concern:

- the risk to the state related to both hidden costs and care for inmates associated with the Department of Corrections' decision to change the scope of services that had traditionally been required of its medical services contractors;
- whether the contractor, Wexford Health Sources, met minimum standards for routine medical care as set out in the contract with MDOC for medical care provided to state inmates;
- MDOC's assurance of the provision of chronic care, including mental health care;
- MDOC's provision of specialty medical care; and,
- MDOC's and Wexford's operational issues while providing inmate medical care.

The review focuses on whether MDOC's current medical services program complies with accepted standards promulgated to assure the quality of medical care provided to persons under control of the state's correctional system, including assurance of timely and appropriate access to health care providers and services.

PEER sampled inmates' medical records dated between January 1, 2007, and May 31, 2007, and limited the review to the medical records of inmates housed at one of the three main correctional facilities (Central Mississippi Correctional Facility [CMCF], South Mississippi Correctional Institution [SMCI], and Mississippi State Penitentiary [MSP]), hereafter referred to as the "parent facilities."

MDOC's Contract for Inmate Medical Services

In July 2005, MDOC's previous medical services provider, Correctional Medical Services, informed the department that it did not wish to be considered for renewal of its contract ending June 30, 2006, thereby necessitating that the department move forward with a search for a new medical services provider.

Following departmental evaluations of responses to a request for proposals, the Department of Corrections entered into a contract with Wexford Health Sources, Inc., in June 2006 for FY 2007 through FY 2009 for a total of \$94,312,523. The contract requires that Wexford meet all national standards (the American Correctional Association [ACA] and the National Commission on Correctional Health Care [NCCHC]) for inmate medical care.

The contract between MDOC and Wexford includes inmate medical services for the three major correctional facilities, the eleven satellite facilities (also known as regional facilities), seventeen community work centers, three male restitution centers, and the Governor's Mansion work site. The contract with Wexford does not include the state's private correctional facilities or county regional correctional facilities. Inmates are transported to one of the three parent facilities for medical care.

The type of contract MDOC entered into with Wexford is for a "combination" model for delivery of medical services to inmates. Under this model, the contractor assumes responsibility for medical care rendered inside institutions, with the correctional agency taking responsibility for important functions such as specialty care rendered outside of the correctional institutions and utilization review. This enables the correctional agency to manage the care given to the inmates, but exposes the correctional agency to additional financial and managerial risks, as the agency becomes responsible for providing certain forms of care.

In entering into the current agreement with Wexford, the department has assumed for the state an increased risk, as

the department is now required to bear directly a greater share of the responsibility for delivering medical care to inmates. As the state assumes greater responsibility and control over the delivery of services, it has more opportunities for both controlling expenses and better managing the delivery of care. However, the state must ensure that quality specialty medical care is provided to inmates and that this care can be rendered to inmates in a manner that will not overly extend the state's financial resources.

Access to Medical Care Provided by Wexford

Based on PEER's compliance review with medical service contract standards, from January 1, 2007, through May 31, 2007, the Department of Corrections and its contractor, Wexford Health Services, did not ensure that all inmates received timely and adequate access to quality medical care.

To determine the quality of medical care state inmates received from January 1 through May 31, 2007, PEER reviewed samples of medical records at each of the three parent facilities for compliance with standards of the medical services contract with Wexford and for compliance with accepted national standards regarding routine and chronic care, including mental health care.

Routine Medical Care for Inmates

During the period of review, MDOC and its contractor Wexford did not ensure that all state inmates received timely access to the sick call process and two-year dental prophylaxis within the intervals established by the medical services contract and by national correctional standards for medical care. Wexford did comply with applicable standards for the medical care component of the inmate intake process.

According to MDOC's medical services contract with Wexford Health Sources, Wexford is responsible for all routine medical care for state inmates at the three parent correctional facilities.

PEER analyzed the following areas of routine medical care during the period of review:

- the medical care component of the inmate intake process;
- the sick call process; and,
- the two-year dental prophylaxis.

According to the contract, Wexford must ensure timely access to routine medical care by meeting at least an 85% compliance rate for the three medical services contract areas listed above. Failure to meet at least an 85% compliance rate could subject Wexford to predetermined contractual financial penalties, hereafter referred to as liquidated damages, as dictated by the contract.

Exhibit A, page xiii, summarizes Wexford's compliance with standards at CMCF, SMCI, and MSP for routine medical care. As shown in the exhibit, during the period of review, Wexford complied substantially with contract standards and national correctional standards in regard to ensuring that state inmates received adequate access to health care upon intake into the state correctional system. However, Wexford did not ensure that all inmates had timely access to medical care through the sick call process in accordance with contract requirements and national correctional standards. Also, Wexford did not document whether all inmates had a dental prophylaxis every two years in accordance with contract requirements.

Chronic Medical Care for Inmates

MDOC's current contract with Wexford does not address the issue of chronic care. Thus MDOC cannot ensure that Wexford develops and implements a system of quality chronic medical care for the state's inmates.

Although Wexford provides chronic care to inmates, since MDOC's medical services contract with Wexford does not address chronic care, MDOC does not audit chronic care for the same 85% compliance rate as the other medical areas and does not assess liquidated damages regarding chronic care. Therefore, in assessing Wexford's performance in providing chronic care, PEER used Wexford's policies and procedures, MDOC's policies and procedures, and national standards as the compliance standards.

PEER assessed Wexford's compliance with providing timely access to quality chronic care for state inmates in the correctional system for the following areas:

- chronic care visit at least every six months;
- notation in the medical records of scheduling a follow-up chronic care visit in six months; and,
- a medication treatment plan for each inmate under chronic care.

Exhibit A: Summary of Wexford's Compliance with Standards for Routine Medical Care at the Three Parent Correctional Facilities, January 1 through May 31, 2007

	<i>Meets 85% compliance rate for inmate intake standard?</i>	
Inmate Intake	Yes	No
Inmates' understanding of access to medical care	√	
Inmates receive initial health assessment within <i>one month</i> of intake	√	
Inmates receive initial dental screening within <i>7 calendar days</i> of intake	√	
Inmates receive dental exam within <i>one month</i> of intake	√	
Psychiatric/mental health screening within <i>5 calendar days</i> of intake	√	
Sick Call		
Inmates' sick call triaged within <i>24 hours</i>		√
Inmates receive a physician visit within <i>7 calendar days</i>		√
2 Year Dental Prophylaxis		
Documentation of inmates' receipt of a dental prophylaxis <i>at least every 2 years</i>		√

SOURCE: PEER analysis of MDOC's inmate medical records.

Exhibit B, page xiv, summarizes Wexford's performance regarding chronic care at CMCF, SMCI, and MSP. As shown in the exhibit, during the period of review, Wexford did not comply with its own policies and procedures regarding timely access to chronic care and proper documentation of all chronic care follow-up referrals. However, Wexford did comply with documentation of a medication treatment plan requirement.

Exhibit B: Summary of Wexford’s Performance Regarding Chronic Medical Care at the Three Parent Correctional Facilities, January 1 through May 31, 2007

Chronic Care 6 Month Visit	<i>Compliance rates*</i>
Inmates receive a chronic care visit <i>at least every 6 months</i>	59%
Chronic Care Physician Referral Notation	
Physicians notate a referral for a chronic care follow-up visit <i>within 6 months</i> of the inmates’ previous chronic care visit	76%
Chronic Care Medication Treatment Plan	
Physicians develop and notate a medication treatment plan for chronic care inmates	85%

*MDOC’s medical services contract with Wexford did not address chronic medical care, although Wexford does provide chronic care services to the three parent correctional facilities.

SOURCE: PEER analysis of MDOC’s inmate medical records.

Mental Health Care for Inmates

MDOC does not require that Wexford keep mental health records organized separately from the inmates’ other medical records, a condition that could affect continuity of care.

Wexford staff do not consistently file mental health records with records for chronic care. Critical mental health information may be overlooked by medical personnel due to their inability to locate such information within the inmates’ medical records.

Also, for both chronic and mental health care, MDOC has not required Wexford to develop an effective system-wide method of managing inmates’ appointments or maintaining uniform log sheets. As a result, MDOC cannot assure continuity of care.

Wexford's and MDOC's Provision of Specialty Medical Care

Inmates' medical records from January 1, 2007, through May 31, 2007, do not contain documentation that MDOC and its contractor Wexford provided timely specialty medical care to all state inmates needing such care.

According to MDOC's medical services contract with Wexford, Wexford and MDOC share responsibility for providing inmates with access to specialty medical care. As of July 1, 2006, Wexford is responsible for providing the following specialty care: optometry, radiology, dialysis, audiology, and care for sexually transmitted diseases, HIV/AIDS, and tuberculosis. MDOC is financially responsible for all other specialty care services for state inmates off site and is responsible for oversight of the utilization review process for specialty care for all state inmates.

PEER reviewed MDOC's and Wexford's implementation of their respective responsibilities for inmates' specialty medical care from January 1, 2007, through May 31, 2007, and concluded that MDOC and Wexford did not document timeliness of specialty care for all inmates during that period because neither Wexford nor MDOC has established written timeliness standards for monitoring consult requests. Also, neither Wexford nor MDOC has implemented an effective method of tracking inmates through the specialty care process.

Operational Issues: MDOC and Wexford

During PEER's review of inmate medical records to determine the quality of medical care state inmates received, PEER identified operational issues that also affect quality of care:

- medical staffing;
- quality assurance and recordkeeping; and,
- MDOC's medical expenditures.

PEER also compared MDOC's FY 2007 medical costs under the contract with Wexford to the correctional system's FY 2006 costs for medical care.

Issues with Medical Staffing

For the period of review, PEER noted the following deficiencies in the medical staffing of the correctional facilities:

- **Wexford’s medical staffing levels were not in compliance with the contract requirements.** Neither MDOC nor Wexford could ensure appropriate and timely access to quality medical care for state inmates because of staff shortages.
- **MDOC did not require Wexford to submit documentation of all licensures, certifications, and registrations of all medical staff to MDOC for review.** Without providing any type of oversight, MDOC relied on Wexford to ensure that its medical personnel were properly licensed, certified, or registered in the state of Mississippi. As a result, during the period of review at least five individuals without proper credentials provided medical care to inmates.
- **Neither MDOC nor Wexford ensured sufficient orientation/training of temporary medical staff.** Although Wexford has an orientation program in place for newly hired full-time medical staff, MDOC did not require in contract that Wexford provide temporary nursing staff (“agency nurses”) with basic orientation relative to provision of medical care in a correctional environment.

PEER also determined that MDOC has not collected liquidated damages for Wexford’s failure to meet staffing requirements of the contract. Although as of June 30, 2007, the MDOC Chief Medical Officer had recommended assessment of over \$1 million in liquidated damages, of which \$931,310 was incurred due to staffing shortages, MDOC management has not formally assessed or collected any liquidated damages from Wexford to recoup state funds paid for staffing that was not provided.

Issues with Quality Assurance for Contract Compliance and Recordkeeping

During the period of review, neither MDOC nor Wexford had a quality assurance program for contract compliance in place that ensured timely access and continuity of medical care through accurate and appropriate medical recordkeeping. The major areas of concern associated with quality assurance and medical recordkeeping are as follows.

- **Neither MDOC nor Wexford has an effective quality assurance process.** Wexford does not have a quality assurance plan in place that ensures that the MDOC Health Service Administrator receives accurate medical compliance data from Wexford's databases to use in conducting compliance audits. Also, MDOC did not establish in its contract with Wexford a formal audit methodology that utilizes confidence levels and compliance ranges and includes all contracted medical service areas. Therefore, MDOC cannot ensure that all state inmates receive timely access to quality medical care.
- **Significant percentages of inmates' medical records lack critical medical information.** Wexford does not have a quality assurance program in place that ensures that all medical records are accurate and can be used to make timely decisions in regard to state inmates' medical care.
- **Wexford does not assure confidentiality in the transport of inmates' medical records.** Wexford does not ensure that all medical records and medications are sealed at the time of inmate transport from one correctional facility to another.

MDOC's FY 2007 Medical Expenditures

MDOC spent approximately \$42.8 million for inmate medical care in FY 2007, approximately \$1.1 million more than it would have expended for Wexford's turnkey proposal to provide comprehensive medical services to inmates and approximately \$2.8 million more than its FY 2007 appropriation for medical services.

In addition to paying Wexford approximately \$30 million for providing routine medical care, the department incurred expenses of approximately \$12.8 million for providing specialty medical care for inmates. By opting to use the combination model of service delivery, the department expended approximately \$42.8 million, or \$1.1 million more than it would have if the department had accepted Wexford's turnkey proposal.

MDOC's FY 2007 appropriation bill included spending authority for \$40,011,620 to operate the department's medical services program. In spending approximately \$42.8 million on medical services, the department exceeded its FY 2007 spending authority by approximately \$2.8 million.

According to staff of the Department of Finance and Administration, as of October 3, 2007, MDOC had exceeded its total FY 2007 spending authority by approximately \$5.2 million, with \$2.8 million of that amount attributable to medical services. To cover the \$5.2 million that it overspent during FY 2007, the department used a portion of its FY 2008 appropriation. This practice violates MISS. CODE ANN. Section 27-104-25 (1972), which states that an agency may pay a claim from a prior fiscal year if the claim is presented within one year, if the claim does not cause the agency to exceed its prior year's appropriation bill, and if sufficient funds remain in the current year's allotment—i. e., appropriation amount—to pay the claim. Because the department had a balance of \$1.7 million remaining from its FY 2007 appropriation, the department did not have sufficient funds remaining to offset the \$5.2 million that it overspent in FY 2007.

Recommendations

1. The Mississippi Department of Corrections staff should seek to amend the department's medical services contract to require Wexford to:
 - use a uniform method (such as a date stamp) by which qualified personnel document the date of receipt of inmates' sick call requests and the date on which such sick call requests are triaged. Documentation should include verification by the initials or signature of the person receiving the request or conducting triage;
 - document the required two-year dental prophylaxis in an inmate's dental records;
 - provide a system of chronic medical care for inmates, incorporating standards of the American Correctional Association and National Commission on Correctional Health Care for inmates' chronic medical care;
 - establish in writing acceptable time frames for submitting specialty consult requests to MDOC's Office of Specialty Care. For those consult requests that fall outside the acceptable time frame, Wexford should include notations on the inmate's medical record regarding the status of the request and an explanation of the delay;

- segregate mental health records within an inmate's medical records by use of a separate tab;
 - develop and utilize a uniform management information system for logging chronic and mental health care, including, at a minimum, inmate name and number, facility location, date, type of condition;
 - design and implement a computerized management information system that allows staff at all of the correctional facilities the capability to track and monitor inmates' chronic care and mental health appointments;
 - submit to MDOC for review and final approval the names of all potential medical staff, accompanied by evidence of professional licensure, certification, and/or registration prior to their employment; and,
 - secure all health records in sealed boxes and all medications in sealed envelopes prior to the transfer of inmates among correctional facilities. Also, the contract should require Wexford health care staff and MDOC transportation officers to sign off on the transfer record that lists all the medications the inmate has en route, the number of pills en route, and the number of doses en route. Upon arrival at the receiving correctional facility, Wexford health care staff should inventory the contents of the inmate's medication envelope to ensure that the contents reconcile with those listed on the transfer record.
2. The Mississippi Department of Corrections staff should ensure that Wexford conducts triage seven days a week at all correctional facilities as is presently required in the contract.
 3. The Mississippi Department of Corrections staff should develop and adhere to written timeliness standards for monitoring the actions that the department should take during the portion of the specialty care process that is within the parameters of the department's responsibility. For example, MDOC should establish an acceptable time frame for reviewing consult requests upon receipt from the contractor and scheduling specialty appointments and surgeries. Then, for those consult requests that fall outside the acceptable time frame, MDOC should

include notations on the inmate's medical record regarding the status of the request and an explanation of the delay.

4. MDOC should create a management information system accessible to medical and dental providers and directors at Central Mississippi Correctional Facility, South Mississippi Correctional Institution, and Mississippi State Penitentiary. This system should incorporate action standards for the completion, submission, receipt, and review of consult requests and the scheduling of appointments and surgeries, and should trigger an alert to responsible personnel if the status of an inmate's case is not checked within a reasonable time frame, as established by Wexford and MDOC in their timeliness standards. These standards should account for the possibility of Wexford's or MDOC's need to obtain additional information before making decisions regarding the request and the response time needed for such, as well as the department's prioritization of requests.
5. Wexford should periodically provide MDOC staff with documentation of its formal recruitment plan to attract and retain appropriately licensed health care staff.
6. MDOC should require Wexford to develop a strategy for ensuring that all agency nurses employed at one of the state's correctional facilities receive basic orientation regarding provision of medical care in a correctional environment prior to assuming their duties.
7. For purposes of ensuring compliance with contractual requirements, MDOC should require Wexford to design and implement a verifiable management information system that ensures that reports submitted by Wexford to MDOC accurately reflect information recorded on source documents--e. g., sick call logs, chronic care logs.
8. MDOC should ensure that Wexford provides all necessary medical services and maintains all medical record documentation as required in its inmate medical services contract with the department. Also, in order to determine Wexford's compliance with contract provisions, MDOC should develop a formal audit methodology that includes appropriate statistical sampling to allow the department to extrapolate the sample results to the entire population.

9. MDOC should make formal demand to Wexford for the collection of liquidated damages provided for in the contract for failing to adhere to contractual requirements.
10. The State Auditor should investigate the department's overspending of its FY 2007 medical services appropriation and consider taking any necessary collection actions against MDOC personnel.

For More Information or Clarification, Contact:

PEER Committee
P.O. Box 1204
Jackson, MS 39215-1204
(601) 359-1226
<http://www.peer.state.ms.us>

Representative Harvey Moss, Chair
Corinth, MS 662-287-4689

Senator Merle Flowers, Vice Chair
Olive Branch, MS 662-349-3983

Senator Gary Jackson, Secretary
Kilmichael, MS 662-262-9273

Medical Care for State Inmates: The Department of Corrections' Contract Management and Its Provision of Specialty Medical Care

Introduction

Authority

In response to a legislative request, the PEER Committee reviewed the Mississippi Department of Corrections' (MDOC's) management of its current medical services contract and its provision of specialty medical care. The Committee acted in accordance with MISS. CODE ANN. Section 5-3-51 et seq. (1972).

Scope and Purpose

To address legislative concerns regarding MDOC's management of state inmates' medical care, including management of the contract with Wexford Health Sources, Inc., and the department's own provision of specialty medical care, PEER reviewed the following areas of concern:

- the risk to the state related to both hidden costs and care for inmates associated with the Department of Corrections' decision to change the scope of services that had traditionally been required of its medical services contractors;
- whether the contractor, Wexford Health Sources, Inc., met minimum standards for routine medical care as set out in the contract with MDOC for medical care provided to state inmates at Central Mississippi Correctional Facility, South Mississippi Correctional Institution, and the Mississippi State

Penitentiary (see complete list of all facilities covered by the contract with Wexford, page 5);

- MDOC's assurance of the provision of chronic medical care, including mental health care;
- MDOC's provision of specialty medical care; and,
- MDOC's and Wexford's operational issues while providing inmate medical care (e. g., staffing, quality assurance, recordkeeping, and MDOC's medical expenditures).

The review focuses on whether MDOC's current medical services program complies with accepted standards promulgated to assure the quality of medical care provided to persons under control of the state's correctional system, including assurance of timely and appropriate access to health care providers and services.

In view of ongoing litigation concerning state inmates in Unit 32 of the Mississippi State Penitentiary, PEER did not include as part of its review sample (see following section) any inmates who were housed in Unit 32 between January 1, 2007, and May 31, 2007.

Method

PEER reviewed medical records dated between January 1, 2007, and May 31, 2007, because January 1, 2007, was the first date Wexford Health Sources became subject to liquidated damage assessments by MDOC for noncompliance with contract standards.

PEER utilized a statistical sampling method to test for compliance with minimum contract standards for inmates' medical care. PEER limited the review to the medical records of inmates housed at one of the three parent facilities (Central Mississippi Correctional Facility, South Mississippi Correctional Institution, and the Mississippi State Penitentiary) because the majority of state inmates are held in one of these facilities. The number of records refers to inmate medical visits, not individual inmates, since some inmates could have had multiple visits.

In collecting data for this review, PEER used the contractor's log sheets as source data, chose an appropriate sampling technique, and calculated sample sizes, yielding distinct sample sizes for each category.

PEER utilized systematic random sampling, which is a preferred method for obtaining a representative sample

from a population. This method provides for the selection of records in such a way that all have an equal probability of being included in the sample.

From the log sheets, PEER determined the total number of records in each population for newly admitted inmates, sick calls, dental, psychiatric referrals, chronic care, and specialty care. (See Appendix A , page 77, for the totals, along with the associated sample sizes.)

PEER then calculated the sample sizes for each population based upon:

- a +/-5% level of precision (i. e., error, the amount PEER is willing to accept that the projected level of compliance either overstates or understates the actual level of compliance);
- a 95% confidence level (the amount of confidence PEER has that the actual level of compliance falls within the confidence interval); and,
- a 50% expected deviation rate (expected variability within the population). A deviation rate of 50% is the most conservative rate possible, which requires a greater number of records to be sampled in order to generalize the results of the sample to the entire population.

PEER used an accepted formula and published tables for determining sample sizes for research activities. For chronic care, PEER did not obtain the sample size needed to maintain a 5% level of precision due to inmate movement, which had resulted in corresponding movement of medical records. The actual sample size for chronic care records yielded a 6% level of precision.

PEER then divided the population for each key area by the sample size to determine the interval size (k). PEER randomly selected an integer between 1 and k to determine a starting point, and then every kth record was selected for review. PEER collected medical data from a total of 1,341 records.

Also, PEER:

- analyzed contractual standards relative to national standards (i. e., those of the National Commission on Correctional Health Care [NCCHC] and the American Correctional Association [ACA]) to develop evaluation criteria;
- calculated compliance rates for each sample, where appropriate; and,

- compared compliance rates with the evaluation criteria.

Because MDOC is responsible for most of the specialty medical care services, Wexford's compliance rates for this category are not applicable. PEER reviewed and collected data from a random sample of specialty care records to calculate the timeliness of the specialty care process (from completion of the consult by Wexford to scheduling of appointments by MDOC).

PEER also reviewed and analyzed MDOC's financial data related to medical services costs for fiscal years 2006 and 2007.

Background

The contract between MDOC and Wexford includes the three major correctional facilities, the eleven satellite facilities (also known as regional facilities), seventeen community work centers, three male restitution centers, and the Governor's Mansion work site. The contract with Wexford does not include the state's private correctional facilities and county regional correctional facilities.

For medical care, inmates are transported to one of the three major correctional facilities (hereafter referred to as "parent facilities"). They are:

- the Central Mississippi Correctional Facility (CMCF), located in Pearl;
- the South Mississippi Correctional Institution (SMCI), located in Leakesville; and,
- the Mississippi State Penitentiary (MSP), located in Parchman.

How the Department of Corrections Provided Medical Services to Inmates Prior to FY 2007

Inmates are not eligible for Medicaid services, so the department must use its own resources to provide medical care to inmates.

Persons bound over to the custody of the Mississippi Department of Corrections become the state's responsibility for care and maintenance, including medical services. Inmates are not eligible for Medicaid services, so the department must use its own resources to provide medical care to inmates (see MISS. CODE ANN. Section 47-5-901 [1972]).

Medical care has been a significant issue in Mississippi's correctional system. A component of the well-known litigation regarding conditions of confinement, *Gates v. Collier*, dealt with medical services at the Mississippi State Penitentiary at Parchman in the early 1980s. See *Gates v. Collier*, 501 F. 2d 1291 (5 Cir, 1974), for an overview of the substantive conditions that gave rise to the litigation.

In-House Provision of Services and Contract with the University of Mississippi Medical Center

Mississippi's health services for inmates have evolved since the *Gates* litigation. For many years, the department opted to provide medical services through the use of physicians and staff employed by the Department of Corrections. Cases that required more demanding or specialized care were directed to hospital facilities such as the University of Mississippi Medical Center in Jackson and MDOC paid for the inmate's care.

In July 1998, the department chose to contract out its medical services to the University of Mississippi Medical Center. This arrangement operated much like one with a Health Maintenance Organization, with the Department of Corrections paying a capitation for inmates served.

Contract with Correctional Medical Services, Inc.

In July 2005, CMS (MDOC's previous medical services contractor) informed the department that it did not wish to be considered for renewal of its contract ending June 30, 2006.

The department's relationship with the University of Mississippi Medical Center terminated June 30, 2003, when the Department of Corrections selected a new health service provider, Correctional Medical Services, Inc. (CMS). In July 2005, CMS informed the department that it did not wish to be considered for renewal of its contract ending June 30, 2006, thereby necessitating that the department move forward with a search for a new medical services provider.

Decision to Seek a New Contractor in 2005

Prior to CMS's decision regarding renewal of its contract, the department considered the potential for several service delivery options. Documents obtained from the Department of Corrections show that the senior staff of the agency weighed the strengths and weaknesses of returning to a model of service delivery under which the agency would employ physicians and other medical service providers. This is the approach the department had used prior to 1998. During the years in which CMS managed medical services for the agency, the department's staff monitored complaints and concerns about quality and timeliness of care under the contract. Consequently, the department had accumulated considerable knowledge of the strengths and weaknesses associated with a so-called "turnkey" system under which the department pays a

capitated rate for services and the contractor assumes responsibility for the complete range of medical services rendered to inmates. While not a formal needs assessment in the strictest sense, the department had collected information upon which it could base an assessment of the strengths and weaknesses of these two models of service delivery.

In preparing an RFP (request for proposals) for interested bidders, the department considered a third option for service delivery. In recent years, many correctional systems have experimented with another model for service delivery. Under this model, a contractor assumes responsibility for medical care rendered inside institutions, with the correctional agency taking responsibility for important functions such as specialty medical care rendered outside of the correctional institutions and utilization review. This enables the correctional agency to manage the care given to the inmates, something lacking in the “turnkey” approach, but exposes the correctional agency to additional financial and managerial risks, as the agency becomes responsible for providing certain forms of care.

Following departmental evaluations, the Department of Corrections entered into a contract with Wexford Health Sources in June 2006 for FY 2007 through FY 2009 for a total of \$94,312,523.

In the fall of 2005, the Department of Corrections began the process of seeking a new medical services contractor. The department prepared a request for proposals that required all interested parties to appear before representatives of the department for a bidders’ conference on November 27, 2005. Responses to the RFP were due January 27, 2006. The Department of Corrections received three comprehensive proposals from interested firms. Procedures employed by the department met the Personal Service Contract Review Board’s requirements for competitive procurement.

Following departmental evaluations, the Department of Corrections entered into a contract with Wexford in June 2006 for FY 2007 through FY 2009 for a total of \$94,312,523. The contract requires that Wexford meet all national standards (those of the American Correctional Association [ACA] and the National Commission on Correctional Health Care [NCCHC]) for inmate medical care.

The Current Medical Services Contract and the State's Assumption of Increased Risk

The Department of Corrections' new service delivery model gives it more control over the provision of medical services to inmates, but increases the risks associated with service delivery.

The contract itself raised questions regarding increased risk to the state, particularly risks to inmates and financial risks to the state. The Department of Corrections' new service delivery model gives it more control over the provision of medical services to inmates, but increases the risks associated with service delivery. The risk to inmates is that of possible delays in specialty medical care (due to the referral process for specialty care, which is not included in the current contract; see page 38).

In making decisions about a new contract for inmate health care, the department was faced with a clear problem regarding costs of services, because turnkey contracts such as the one with CMS are becoming more expensive.

Wexford also provided an alternative bid for providing turnkey services, the cost of which would have been approximately \$41.7 million per year.

As a case in point, the successful bidder, Wexford, also provided an alternative bid for providing turnkey services similar to those provided by CMS. The capitated rate for such would have been \$7.98 per inmate day. Based on an inmate count of 14,300, the cost of this contract would have been approximately \$41.7 million per year. This is evidence of the considerable increase in costs associated with providing comprehensive care under a turnkey program, which contributed to the department's decision to rely on a different model of service delivery.

While costs for providing a turnkey approach to correctional medicine are increasing, such programs give the state little control over ways to improve efficiency or effectiveness in delivering health care services to the inmate population. The Department of Corrections found itself in the position of having to assume predictable, yet considerable, known financial risks through a turnkey approach or assume for itself increasing and unquantifiable financial risk associated with providing specialized care in exchange for the possibility that it could manage timely, quality services better than a turnkey contractor.

PEER's review of the contract showed that, in entering into the current agreement with Wexford, the department has assumed for the state an increased risk, as the department is now required to bear directly a greater share of the responsibility for delivering medical care to inmates. As the state assumes greater responsibility and control over the delivery of services, it has more opportunities for both controlling expenses and better managing the delivery of

care. But this responsibility carries with it an increased risk to the state. The state must ensure that quality specialty medical care is provided to inmates and that this care can be rendered to inmates in a manner that will not overly extend the state's financial resources.

As stated above, PEER noted at least two potential risks, based on the contract, of which the department and the Legislature must be aware:

- risks to inmates; and
- financial risks to the state.

Risks to Inmates

In its review of the contract, PEER determined that the process for referring inmates for specialty medical care, and the provision of specialty care, which is not included in the current contract with Wexford, could impact the timeliness of specialty care.

In determining risks associated with inmate health care, PEER reviewed the procedures for referrals to offsite care and interviewed Wexford and MDOC staff about off-site care for inmates. The main concern was whether inmates were receiving timely medical care when referred for specialty care. Based on interviews conducted with Wexford staff, a review of MDOC specialty referral procedures, and a brief observation of Wexford staff, the vendor appeared to be following contract terms for referrals for off-site care; however, this report includes a determination of MDOC's fulfillment of the contract terms based on a sample of specialty care records. (See pages 37 through 51 for discussion.)

The current contract calls for MDOC to approve or deny specialty care referrals, schedule the appointments, transport the inmates to the appointments, and negotiate with off-site providers.

In the previous contract with CMS, the vendor was responsible for specialty care, including referrals of inmates, scheduling of appointments, and negotiating contracts with off-site providers. The current contract initially included a clause for the vendor to pay transportation costs, but the contract was amended to state that MDOC would provide transportation. The current contract calls for MDOC to approve or deny specialty care referrals, schedule the appointments, transport the inmates to the appointments, and negotiate with off-site providers.

This report addresses specialty medical care cases between January 1, 2007, and May 31, 2007, to determine whether MDOC provided timely specialty medical care.

Additionally, PEER would note that the provision of both routine and chronic medical care through a contractor, while not constituting a new risk assumed by the state under this contract, does pose issues for the quality of care for inmates. The department must properly oversee the provision of these services to ensure that inmates are receiving the care to which they are entitled.

Financial Risks to the State

The contract also raised questions regarding financial risks to the state. By contracting with Wexford for approximately \$30 million per year for inmate medical care (excluding specialty care), MDOC avoided approximately \$11.7 million in costs that would have been incurred under a contract with the lowest turnkey bidder (which included specialty medical care in its contract proposal); however, the department provided no projections of the amount that could be saved by providing specialty medical care outside the contract, which could have resulted in the need for an additional infusion of general funds to cover inmate medical costs.

The department's ability to manage care ultimately plays a critical role in whether the state has benefited from the changed service model and has realized, at worst, costs no greater than the state would have incurred under a turnkey program.

Ultimately, this created some uncertainty regarding the total amount that would be spent on inmate health care, thereby creating a risk that the state might have to spend more to render inmate medical care than the department had anticipated. The department's ability to manage care ultimately plays a critical role in whether the state has benefited from the changed service model and has realized, at worst, costs no greater than the state would have incurred under a turnkey program.

In this report, PEER analyzed MDOC's financial records to determine whether MDOC spent more funds than anticipated to cover inmate medical costs. (See pages 68 through 71 for discussion.)

Access to Medical Care Provided by Wexford

Based on PEER's compliance review with medical service contract standards, from January 1, 2007, through May 31, 2007, the Department of Corrections and its contractor, Wexford Health Services, did not ensure that all inmates received timely and adequate access to quality medical care.

To determine the quality of medical care state inmates received from January 1 through May 31, 2007, at Central Mississippi Correctional Facility, South Mississippi Correctional Institution, and the Mississippi State Penitentiary, PEER reviewed medical records at each of the three parent facilities for compliance with standards of the medical services contract with Wexford and for compliance with accepted national standards for correctional institutions regarding routine, specialty, and chronic medical care, including mental health care.

Routine Medical Care for Inmates

During the period of review, MDOC and its contractor Wexford did not ensure that all state inmates received timely access to the sick call process and two-year dental prophylaxis within the intervals established by the medical services contract and by national correctional standards for medical care. Wexford did comply with applicable standards for the medical care component of the inmate intake process.

According to the terms of the contract, routine medical care consists of any non-emergent medical care than can be completed on-site at one of the three parent facilities without consulting a specialist.

According to MDOC's medical services contract with Wexford Health Sources, Wexford is responsible for all routine medical care for state inmates at the three parent correctional facilities (i. e., Central Mississippi Correctional Facility, South Mississippi Correctional Institution, and the Mississippi State Penitentiary). According to the terms of the contract, *routine medical care* consists of any non-emergent medical care than can be completed on-site at one of the three parent facilities without consulting a specialist.

PEER analyzed the following areas of routine medical care during the period of review:

- the medical care component of the inmate intake process;
- the sick call process; and,

- the two-year dental prophylaxis.

According to the contract, Wexford must ensure inmates timely access to routine medical care by meeting at least an 85% compliance rate for specified medical service areas.

According to the contract, Wexford must ensure timely access to routine medical care by meeting at least an 85% compliance rate for the three medical services contract areas listed above. Failure to meet at least an 85% compliance rate could subject Wexford to predetermined contractual financial penalties, hereafter referred to as liquidated damages, as dictated by the contract.

Exhibit 1, page 13, summarizes Wexford's compliance with standards at CMCF, SMCI, and MSP for routine medical care. Appendix B, page 78, summarizes the compliance rates and ranges for all three parent facilities combined for PEER's review of routine medical care of inmates.

The following sections include discussions of each of the compliance issues.

Medical Care Component of the Inmate Intake Process

During the period of review, Wexford Health Sources complied substantially with contract standards and national correctional standards in regard to ensuring that state inmates received adequate access to health care upon intake into the state correctional system.

Once an inmate is convicted and sentenced to a state correctional facility, he or she must go through the intake process at Central Mississippi Correctional Facility (CMCF) in Pearl before being sent to another state facility. According to the contract, Wexford is responsible for the medical component of the inmate intake process for all new inmates in the state correctional system. This process includes:

- distribution and collection of a form that explains how the inmate is to receive access medical care that he or she may need. The inmate must sign this "access to medical care understanding form" as evidence of understanding the medical care access process;
- a comprehensive health assessment, which is a physician's examination of the inmate's current physical condition and medical history, within one month of intake;
- a dental screening within seven calendar days of intake;
- a dental exam within one month of intake; and,

- a mental health screening within five calendar days of intake.

Exhibit 1: Summary of Wexford's Compliance with Standards for Routine Medical Care at the Three Parent Correctional Facilities, January 1 through May 31, 2007

	<i>Meets 85% compliance rate for inmate intake standard?</i>	
Inmate Intake	Yes	No
Inmates' understanding of access to medical care	√	
Inmates receive initial health assessment within <i>one month</i> of intake	√	
Inmates receive initial dental screening within <i>7 calendar days</i> of intake	√	
Inmates receive dental exam within <i>one month</i> of intake	√	
Psychiatric/mental health screening within <i>5 calendar days</i> of intake	√	
Sick Call		
Inmates' sick call triaged within <i>24 hours</i>		√
Inmates receive a physician's visit within <i>7 calendar days</i>		√
2 Year Dental Prophylaxis		
Documentation of inmates' receipt of dental prophylaxis <i>at least every 2 years</i>		√

SOURCE: PEER analysis of MDOC's inmate medical records.

Appendix C, page 79, includes compliance percentages by parent facility for inmate intake.

Between the review period of January 1, 2007, and May 31, 2007, the contract required Wexford to meet an 85% compliance rate for all medical care areas addressed in the

contract. However, beginning July 1, 2007, the contract requires Wexford to meet a 90% compliance rate for all medical areas addressed in the contract.

Beginning July 1, 2007, the contract requires Wexford to meet a 90% compliance rate for all medical areas addressed in the contract.

PEER reviewed Wexford's compliance with applicable standards of the contract and with national standards for the medical component of the inmate intake process. PEER reviewed a sample of 313 inmate medical records from the review period, distributed as follows: 99 records from CMCF, 118 records from SMCI, and 96 records from MSP.

Intake: Inmates' Understanding of Access to Medical Care

For the period reviewed, a random sample of inmates' medical records yielded an 88% compliance rate for Wexford regarding instruction of new state inmates on how to obtain access to medical care. Based upon a confidence level of 95% and an acceptable error rate of 5%, the actual compliance rate for the entire population of inmates would range between 83% and 93%.

According to MDOC's medical services contract with Wexford, Wexford is responsible for instructing all new state inmates on how to obtain access to medical care at the parent facilities. At the time of intake, inmates sign and date a form stating that they have been made aware of and understand how to obtain necessary medical care should he or she need it during incarceration.

Wexford met the required compliance percentage for inmates' understanding of access to medical care.

Of the 313 inmate medical records sampled from the review period, 274 records (88%) included a signed, dated form indicating the inmate's understanding of access to medical care. Based on a 95% confidence level yielded by the sample, the actual rate would fall between 83% and 93%.

Because MDOC's contract with Wexford requires a compliance rate of at least 85%, Wexford met the required compliance percentage for inmates' understanding of access to medical care. PEER did not locate any indeterminate records for inmate understanding of access to medical care. For the purpose of this review, PEER defined an *indeterminate* record as a record that did not contain enough information for PEER to determine either compliance or noncompliance with contract standards.

Intake: Initial Inmate Health Assessment

For the period reviewed, a random sample of inmates' medical records yielded a 100% compliance rate for Wexford regarding new state inmates receiving an initial health assessment within one month of intake. Based upon a confidence level of 95% and

an acceptable error rate of 5%, the actual compliance rate for the entire population of inmates would range between 95% and 100%.

According to MDOC's medical services contract with Wexford, Wexford is responsible for ensuring that all new inmates receive a health assessment within one month of intake.

Wexford met the required compliance percentage for initial inmate health assessment.

The National Commission on Correctional Health Care (NCCHC) defines a health assessment as, "the process whereby the health status of an individual is evaluated, including questioning the patient regarding symptoms." According to NCCHC standards, a health assessment includes a review of the screening results, a recording of vital signs, additional data needed to complete the medical history, a physical examination, laboratory tests for communicable diseases, and initiation of immunizations when appropriate.

PEER found that all 313 inmate medical records sampled from the review period included documentation that Wexford had completed an inmate initial health assessment within one month of intake. PEER did not locate any indeterminate records for initial inmate health assessment.

Intake: Inmate Dental Screening within Seven Calendar Days

For the period reviewed, a random sample of inmates' medical records yielded a 97% compliance rate for Wexford regarding new state inmates receiving an initial dental screening within seven calendar days of intake. Based upon a confidence level of 95% and an acceptable error rate of 5%, the actual compliance rate for the entire population of inmates would range between 92% and 100%.

According to MDOC's medical services contract with Wexford, Wexford is responsible for conducting a dental screening of each new inmate within seven calendar days of intake. The American Correctional Association (ACA) defines a dental screening as a visual assessment of the teeth and gums by a dentist or health care staff trained by a dentist. The National Commission on Correctional Health Care (NCCHC) defines a dental screening as a visual observation of the teeth and gums, and notation of any obvious or gross abnormalities requiring immediate referral to a dentist.

Of the 313 inmate medical records sampled from the review period, 305 records (97%) included documentation of an inmate initial dental screening within seven calendar days of intake. Based upon a confidence level of 95% and an acceptable error rate of 5%, the actual compliance rate

for the entire population of inmates would range between 83% and 93%.

Wexford met the required compliance percentage for inmate dental screenings within seven calendar days of intake.

Because MDOC's contract with Wexford requires a compliance rate of at least 85%, Wexford met the required compliance percentage for inmate dental screenings within seven calendar days of intake. PEER did not locate any indeterminate records for inmate dental screenings within seven days.

Intake: Initial Inmate Dental Exam within One Month

For the period reviewed, a random sample of inmates' medical records yielded a 99.7% compliance rate for Wexford regarding new state inmates receiving an initial dental exam within one month of intake. Based upon a confidence level of 95% and an acceptable error rate of 5%, the actual compliance rate for the entire population of inmates would range between 95% and 100%.

According to MDOC's medical services contract with Wexford, Wexford is responsible for conducting a dental examination of each new inmate within one month of intake. ACA defines a dental examination as an examination by a licensed dentist that includes a dental history, exploration, and charting of teeth, examination of the oral cavity, and x-rays. NCCHC defines a dental examination as taking or reviewing the patient's oral history, an extraoral head and neck examination, charting teeth, and examination of hard and soft tissue of the oral cavity with a mouth mirror, explorer and adequate illumination.

Wexford met the required compliance percentage for providing an initial inmate dental exam within one month of intake.

Of the 313 inmate medical records sampled from the review period, 312 (99.7%) included documentation of an inmate initial dental exam within one month of intake. Based upon a confidence level of 95% and an acceptable error rate of 5%, the actual compliance rate for the entire population of inmates would range between 95% and 100%.

Because MDOC's contract with Wexford requires a compliance rate of at least 85%, Wexford met the required compliance percentage for providing an initial inmate dental exam within one month of intake. PEER did not locate any indeterminate records for documentation of an initial inmate dental exam within one month of intake.

Intake: Initial Inmate Mental Health Screening within Five Calendar Days

For the period reviewed, a random sample of inmates' medical records yielded a 98% compliance rate for Wexford regarding new state inmates receiving an initial mental health screening within

five days of intake. Based upon a confidence level of 95% and an acceptable error rate of 5%, the actual compliance rate for the entire population of inmates would range between 93% and 100%.

According to MDOC's medical services contract with Wexford, Wexford is responsible for ensuring that all inmates receive a mental health assessment within five calendar days of intake.

Wexford met the required compliance percentage for providing an initial inmate mental health screening within five days of intake.

During a mental health assessment Wexford evaluates an inmate's mental stability at the time of intake. Wexford conducts the mental health screening in two parts. The first part is a psychiatric screening that addresses any history an inmate might have had regarding psychiatric care. The second part of the mental health screening is a suicide potential screening that helps determine the likelihood of the inmate's committing suicide.

Of the 313 inmate medical records sampled from the review period, 307 (98%) had documentation of an initial mental health screening within five calendar days of intake.

Because MDOC's contract with Wexford requires a compliance rate of at least 85%, Wexford met the required compliance percentage for providing an initial inmate mental health screening within five days of intake. PEER did not locate any indeterminate records for initial mental health screenings within five days of intake.

Sick Call Process for Inmates

During the period of review, Wexford Health Sources did not ensure that all inmates had timely access to medical care through the sick call process in accordance with contract requirements and national correctional standards.

According to MDOC's medical services contract with Wexford, Wexford is responsible for providing sick call at CMCF, SMCI, and MSP.

***Triage* is the sorting and classifying of inmates' health requests to determine priority of need and the proper place for health care to be rendered.**

According to the National Commission on Correctional Health Care (NCCHC), *sick call* is the evaluation and treatment of an ambulatory patient in a clinical setting, either on- or off-site, by a qualified health care professional. NCCHC standards dictate that each inmate have the opportunity to request health care assistance on a daily basis and should be triaged within twenty-four hours. NCCHC standards also state that *daily* means seven days a week, including holidays. *Triage* is defined by NCCHC as the sorting and classifying of inmates' health requests to determine priority of need and the proper place for health care to be rendered.

When an inmate at one of the three parent facilities becomes ill, he or she must first submit a sick call request form for all non-emergent medical needs into a locked drop box in the facility's housing or dining area, the contents of which are picked up daily by nursing staff. The inmate's sick call request form must then be triaged by a nurse trained in triage within twenty-four hours.

After a nurse triages the sick call request form, the nurse must determine whether the inmate should see a physician for a condition that cannot be treated by over-the-counter medications. If the inmate needs to see a physician for a condition that exceeds the nurse's ability to treat the condition, then the inmate must have a physician visit within seven calendar days of the original complaint.

At satellite facilities for which Wexford provides medical care, the staff of each facility fax sick call requests to Wexford medical staff at the assigned parent facility. Wexford medical staff then visit the satellite facility once a week (for female inmates) or once every two weeks (for male inmates) to respond to sick call requests. If an inmate at a satellite facility needs to see a physician, the MDOC staff transports that inmate to the assigned parent facility. Although such a situation as described is rare, PEER's sample of inmate medical records for routine care could possibly have included inmates from satellite facilities that were transported to a parent facility for medical care.

PEER reviewed Wexford's compliance with the following components of the sick call process:

- triage within twenty-four hours of the inmate's submitting a sick call request; and,
- for those inmates who need to see a physician, examination by a physician within seven days of the inmate's submission of a sick call request.

PEER reviewed Wexford's compliance with applicable standards of the contract and with national standards for the sick call process. PEER reviewed a sample of 365 inmate medical records from the review period regarding the inmate sick call process.

Sick Call: Triage within Twenty-Four Hours

For the period reviewed, a random sample of inmates' medical records yielded a 33% compliance rate for Wexford's documenting that inmates' sick call requests were triaged within twenty-four hours. Based upon a confidence level of 95% and an acceptable

error rate of 5%, the actual compliance rate for the entire population of inmates would range between 28% and 38%.

According to MDOC's medical services contract with Wexford, "a licensed nurse trained in triage will conduct sick call triage each day at times that are coordinated with Facility staff." Both Wexford policy and procedure and the medical services contract state that sick call requests will be triaged within twenty-four hours.

Wexford did not meet the required compliance percentage for triage of sick call requests within twenty-four hours of when sick call forms are gathered.

Of the 365 inmate medical records sampled from the review period, 122 (33%) contained documentation that inmates' sick call request forms had the triage dates stamped or written on by Wexford staff within twenty-four hours of the dates of submission. Of the remaining inmate records in the sample, 214 (59%) did not comply with the contract and national standards and 29 inmate medical records (8%) were indeterminate. PEER considered records to be indeterminate in cases in which inmates had re-entered the system and their old medical records did not follow, sick call forms were missing dates, or medical records were missing. Appendix D, page 80, contains a facility-by-facility breakdown of the twenty-four-hour triage compliance percentages.

Based upon a confidence level of 95% and an acceptable error rate of 5%, the actual compliance rate for the entire population of inmates would range between 28% and 38%. Because MDOC's contract with Wexford requires a compliance rate of at least 85%, Wexford did not meet the required compliance percentage for triage of sick call requests within twenty-four hours of when sick call forms are gathered.

Wexford may be delaying access to medical attention to those inmates who are determined through triage to need a physician's care.

Even if PEER considered the 8% of indeterminate medical records as compliant, Wexford still would only have a 41% compliance rate. Including the indeterminate medical records, based on a 95% confidence level yielded by the sample, the actual rate would fall between 36% and 46%.

In addition to violating the terms of the contract, by not ensuring that inmates' sick call requests are triaged within twenty-four hours, Wexford may be delaying access to medical attention to those inmates who are determined through triage to need a physician's care.

Wexford's practices for documenting triage of an inmate sick call request do not ensure that medical assessment of the request has actually occurred and that it occurred within the time frame required by the contract.

In order for Wexford, MDOC, or a third party such as PEER to determine whether Wexford is complying with

requirements of the contract for triage of inmate sick call requests within twenty-four hours, Wexford staff must document that they performed triage on the sick call request within the required time frame.

Regarding the procedure for receiving sick call forms and documenting triage, MDOC's contract with Wexford states:

Non-emergent health care (sick call) requests shall be triaged within twenty-four (24) hours. . . .

If the sick call request (SCR) form is date-stamped (which is required), that date is deemed the official triage date. If the SCR form is not date-stamped, then the date the inmate originated the complaint (i.e., the date he/she writes on the SCR form) is the date used and is compared to the date signed at the bottom of the SCR form as the reference date the inmate was seen by the healthcare staff.

The contract allows the use of the date the inmate writes on the sick call form (which, of course, is subject to error) as the baseline from which to measure the twenty-four-hour window for triage. The contract states that the date stamped on the request is to be the date of triage, but does not specify that a nurse or person in any specified position of authority is to conduct the triage prior to stamping the form. The contract also does not require that a nurse or person in any specified position of authority sign the form attesting that he or she has triaged the request. The only confirmation that triage has occurred is that if a member of Wexford's nursing staff actually refers the inmate to a physician's care, a note is made in another portion of the patient's medical record.

The current procedure does not hold any individual accountable for ensuring that sick call triage is an analytical process that actually occurs and that it occurs within the required time frame.

Further, the terms of the contract allow those sick call requests without the date stamp indicating triage to use the date written on the form by the inmate as the date of triage. When PEER inquired, Wexford staff noted that they do not have formal, written policies and procedures for sick call triage other than the requirements of the contract and the ACA and NCCHC standards.

The above-described procedure does not provide primary evidence of compliance with the twenty-four hour triage requirement of the contract. A date stamped on the sick call request form does not necessarily indicate that triage has actually occurred because the form does not require a signature and no written policy or procedure assigns responsibility to a specified position of authority. Thus no individual is held accountable for ensuring that triage is an

analytical process that actually occurs and that it occurs within the required time frame. Also, the contract allows those forms without stamped dates to default to the date of the request as the “date used” for triage.

Because Wexford staff are inconsistent in their methods of recording dates of triage at the three facilities, when inmates or staff transfer between facilities, it may be difficult to determine what occurred when during the triage process.

Compounding this problem is the fact that Wexford staff are inconsistent in their methods of recording dates of triage at the three facilities. Staff at CMCF write dates on some sick call forms and date-stamp some forms. SMCI staff write the date of triage on all the sick call forms, and MSP staff date-stamp the date of receipt of the sick call form, then write the date of triage on the sick call form. (MSP’s practice does not comply with the contract language.) Thus, when inmates or staff transfer between facilities, it may be difficult to determine what occurred when during the triage process. Also, as noted in the previous subsection, PEER had to classify 8% of the inmate sick call requests within the sample of inmate records as indeterminate records because sick call forms were missing the dates or the forms themselves were missing.

This condition has occurred because the contract does not specify a procedure for sick call triage that can be audited. The contract language does not require attestation or confirmation that triage has occurred. Also, Wexford has not implemented quality assurance methods to assure MDOC that triage is actually taking place and within the required time frame by a licensed nurse trained in triage. Wexford’s procedures for sick call triage consist only of copies of the ACA and NCCHC standards.

Because of the above-noted problems, it would be difficult for Wexford, MDOC, or a third party such as PEER to determine whether Wexford is complying with requirements of the contract for triage of inmate sick call requests within twenty-four hours. Also, inmates needing a physician’s care might be delayed in receiving that care.

Unlike the other two parent facilities, for those inmate sick call requests submitted on Fridays or Saturdays, Wexford staff at CMCF do not comply with the contract requirement for daily triage of inmates’ sick call requests within twenty-four hours.

At CMCF, Wexford managers have not required those nursing staff who are trained in triage to be present and perform this function seven days a week.

As noted previously, according to MDOC’s medical services contract with Wexford, “a licensed nurse trained in triage will conduct sick call triage each day at times that are coordinated with Facility staff.” Both Wexford policy and procedure and the medical services contract state that sick call requests will be triaged within twenty-four hours.

According to nursing staff at South Mississippi Correctional Institution and Mississippi State Penitentiary,

triage is conducted daily, including weekends. However, according to nursing staff at Central Mississippi Correctional Facility, triage of sick call requests is conducted five days a week; CMCF does not triage on the weekends. Wexford staff collect sick call requests from inmates seven days a week, but sick call requests submitted on Friday, Saturday, or Sunday are not triaged until Monday.

Wexford may be delaying access to medical attention to those CMCF inmates who are determined through triage to need a physician's care.

This condition has occurred because Wexford managers have not required those nursing staff who are trained in triage to be present and perform this function seven days a week.

In addition to violating the terms of the contract, because Wexford does not ensure that inmates' sick call requests are triaged within twenty-four hours, Wexford may be delaying access to medical attention to those inmates who are determined through triage to need a physician's care.

Sick Call: Physician Visit within Seven Days

For the period reviewed, a random sample of inmates' medical records yielded a 53% compliance rate for Wexford's ensuring that inmates who are determined through triage to need a physician's or mid-level practitioner's care receive such care within seven calendar days of submitting the sick call request. Based upon a confidence level of 95% and an acceptable error rate of 5%, the actual compliance rate for the entire population of inmates would range between 48% and 58%.

According to MDOC's medical services contract with Wexford, Wexford is responsible for assuring that those inmates who are determined through triage to need a physician's care receive such care within seven days. The medical services contract states:

...when necessary, a referral shall be made for the inmate to be evaluated by the physician or mid-level practitioner within seven (7) calendar days of the original compliant.

Of the 365 inmate medical records sampled from the review period, 192 (53%) contained documentation of inmates' receiving a physician's visit within seven calendar days of the original sick call request. Of the remaining inmate medical records in the sample, 116 (32%) did not comply with contract standards and 57 (15%) inmate medical records were indeterminate. PEER considered records to be indeterminate in cases in which inmates' sick call request forms had a signature but no date of the physician's visit (i. e., PEER could not determine whether

these inmates actually received a physician visit within the seven-calendar-day window). See Appendix E, page 81, for a facility-by-facility breakdown of the seven-day physician visit compliance percentages.

Wexford did not meet the required compliance percentage for assuring that those inmates who are determined through triage to need a physician's care receive such care within seven days.

Based upon a confidence level of 95% and an acceptable error rate of 5%, the actual compliance rate for the entire population of inmates would range between 48% and 58%. Because MDOC's contract with Wexford requires a compliance rate of at least 85%, Wexford did not meet the required compliance percentage for assuring that those inmates who are determined through triage to need a physician's care receive such care within seven days.

Even if PEER considered the 15% of indeterminate medical records as compliant, Wexford still would only have a 68% compliance rate. Including the indeterminate medical records, based on a 95% confidence level yielded by the sample, the actual rate would fall between 63% and 73%. PEER notes that MDOC's contract with Wexford includes a clause stating that beginning July 1, 2007, Wexford must meet at least a 90% compliance rate for all medical areas addressed in the medical services contract.

Wexford's delays may be allowing some inmates' medical conditions to decline and create the need for specialty care.

One cause for this condition could be Wexford's rate of at least 59% noncompliance with the requirement for triage of inmates' sick call request within twenty-four hours (see previous subsection).

In addition to violating the terms of the contract, by not assuring that those inmates who are determined through triage to need a physician's care receive such care within seven calendar days, Wexford's delays may be allowing some inmates' medical conditions to decline and create the need for specialty care.

Dental Prophylaxis for Inmates Every Two Years

During the period of review, Wexford Health Sources did not document that all inmates had a dental prophylaxis every two years in accordance with contract requirements.

In addition to new inmates' initial dental screenings and dental examinations previously discussed, MDOC's medical services contract with Wexford makes Wexford responsible for providing all inmates with a routine dental prophylaxis (i.e., a dental cleaning intended to remove plaque, calculus, and stains in order to help prevent dental disease) no less than once every two years. The contract requires Wexford to maintain a record of each inmate's dental care.

To determine Wexford's rate of compliance with this contract requirement, PEER reviewed a sample of 187 inmate dental records within the medical records of inmates who had entered the system between January 1, 2005, and May 31, 2005, who are still in the system and should have received a two-year dental prophylaxis between January 1, 2007, and May 31, 2007.

For the period reviewed, a random sample of inmate dental records yielded a 41% compliance rate for Wexford's ensuring of this two-year dental prophylaxis. Based upon a confidence level of 95% and an acceptable error rate of 5%, the actual compliance rate for receiving a two-year dental prophylaxis for the entire population of inmates would range between 36% and 46%.

PEER's initial review of the sample of 187 inmate dental records for documentation of the two-year dental prophylaxis yielded an extremely low compliance rate (40 records, or 21%) because very few records contained a notation evidencing a two-year dental prophylaxis. In subsequent interviews with the MDOC Dental Director and several dentists who provided dental care at the three parent facilities, PEER was told that, in practice, if a dentist provided *any* type of dental care to an inmate on a visit (e.g., filling a cavity), that the dentist also performed a prophylaxis at the same visit and considered it to fulfill the requirement for the two-year prophylaxis. However, the Dental Director and dentists acknowledged that dentists did not consistently note this prophylaxis in the inmate's dental record.

Wexford did not meet the required compliance percentage for inmates receiving a dental prophylaxis at least once every two years.

Although the failure to note performing a prophylactic procedure in the dental records would be considered a weakness in documentation in the practice of a health care profession, PEER gave credit for the two-year visits in these cases, which increased the number of compliant records to 76 (41%). Of the remaining dental records in the sample, 97 (52%) did not comply with contract standards and 14 dental records (7%) were indeterminate. PEER considered records to be indeterminate in cases in which inmates' initial dental prophylaxis date was missing in the dental records. (PEER could not determine whether these inmates actually received a dental prophylaxis visit within the two-year window.) Based upon a confidence level of 95% and an acceptable error rate of 5%, the actual compliance rate for receiving a two-year dental prophylaxis for the entire population of inmates would range between 36% and 46%.

See Appendix F, page 82, for a facility-by-facility breakdown of the two-year dental prophylaxis visit compliance percentages.

Even if PEER considered the 7% of indeterminate dental records as compliant, Wexford still would only be at a 48% compliance rate. Including the indeterminate dental records, based on a 95% confidence level and an acceptable error rate of 5%, the actual compliance rate for the entire population of inmates for compliance with the two-year prophylaxis requirement would fall between 43% and 53%, at best.

By not ensuring that inmates receive a dental prophylaxis at least once every two years, Wexford is delaying inmate access to preventive dental care, which could result in more advanced problems such as extreme tooth decay or gum disease.

Because MDOC's contract with Wexford requires a compliance rate of at least 85%, Wexford did not meet the required compliance percentage for inmates receiving a dental prophylaxis at least once every two years. PEER notes that MDOC's contract with Wexford includes a clause stating that beginning July 1, 2007, Wexford must meet at least a 90% compliance rate for all medical areas addressed in the medical services contract.

In addition to violating the terms of the contract, by not ensuring that inmates receive a dental prophylaxis at least once every two years, Wexford is delaying inmate access to preventive dental care, which could result in more advanced problems such as extreme tooth decay or gum disease. Such conditions could result in the need to see a specialist such as an oral surgeon and ultimately cost the state more money for specialty care.

Because of dentists' inconsistent documentation of two-year prophylaxis in inmates' dental records, MDOC and Wexford cannot ensure that inmates receive the preventive dental care required by the contract.

As noted above, the MDOC Dental Director and dentists practicing at the three parent correctional facilities stated that if an inmate received any type of dental care, that the dentist also performed a prophylaxis at the same visit. Wexford considered these visits to fulfill the requirement for the inmate's two-year prophylaxis. However, the Dental Director and dentists acknowledged that dentists did not consistently note this prophylaxis in the inmate's dental record.

Should a facility experience turnover in dental staff or should an inmate transfer to another facility, failure to document the two-year dental prophylaxis could disrupt the continuity of dental care for that inmate.

Because the dentists do not consistently document that inmates receiving other forms of dental care also receive their two-year prophylaxis at the same visit, Wexford cannot prove to MDOC that this service is being rendered consistently. Should a facility experience turnover in dental staff or should an inmate transfer to another facility, the failure to document the two-year dental prophylaxis could disrupt the continuity of dental care for that inmate.

Chronic Medical Care for Inmates

MDOC's current contract with Wexford does not address the issue of chronic care. Thus MDOC cannot ensure that Wexford develops and implements a system of quality chronic medical care for the state's inmates.

The American Correctional Association defines *chronic care* as health care provided over a long period to those patients who suffer from long-term health conditions or illnesses.

The American Correctional Association defines *chronic care* as health care provided over a long period to those patients who suffer from long-term health conditions or illnesses. NCCHC defines a *chronic illness* as a condition that affects an individual's well being for an extended interval, usually at least six months, and generally is not curable, but can be managed to provide optimum functioning within any limitations the condition imposes on the individual. NCCHC states, "A proactive [chronic care] program exists that provides care for special needs patients who require close medical supervision or multidisciplinary care."

According to MDOC policy, Wexford is to hold ongoing chronic care clinics for asthma, diabetes, hypertension, human immunodeficiency virus (HIV), seizures, and tuberculosis. MDOC requires that the vendor schedule inmates for the appropriate chronic care clinic when a chronic disease process is identified.

By failing to include in the contract with Wexford formal contract standards, requirements, and a quality assurance plan for chronic care, MDOC cannot monitor Wexford's performance in providing quality chronic care to ensure that inmates receive quality health care for chronic care conditions.

However, MDOC does not address the chronic care area within the medical services contract. Specifically, MDOC does not spell out exactly how chronic care clinics are to be conducted, such as what type of documentation is to be kept within the medical record for each chronic care clinic visit, what type of information must be submitted to MDOC for review, how that information will be sent and within what time frames, how often MDOC requires the contractor to re-evaluate each chronic care patient by condition, and what type of basic treatment plans each chronic care condition must include.

By failing to include in the contract with Wexford formal contract standards, requirements, and a quality assurance plan for chronic care, MDOC cannot monitor Wexford's performance in providing quality chronic care to ensure that inmates receive quality health care for chronic care conditions.

Appendix G, page 83, shows the overall compliance rates for Wexford for chronic care for all three parent facilities combined.

PEER's Sample of Inmate Medical Records for Chronic Care

During the period of review, Wexford Health Sources did not comply with its own policies and procedures regarding timely access to chronic care and proper documentation of all chronic care follow-up referrals. However, Wexford did comply with the documentation of a medication treatment plan requirement.

Since MDOC's medical services contract with Wexford does not address chronic care, PEER used Wexford's policies and procedures, MDOC's policies and procedures, and national standards as the compliance standards for this portion of the review.

According to MDOC's medical services contract with Wexford, MDOC conducts random quarterly compliance audits of inmates' intake, sick call, dental, and mental health care administered by Wexford. However, since MDOC's medical services contract with Wexford does not address chronic care, MDOC does not audit chronic care for the same 85% compliance rate as the other medical areas and does not assess liquidated damages regarding chronic care. Therefore, in assessing Wexford's performance in providing chronic care, PEER used Wexford's policies and procedures, MDOC's policies and procedures, and national standards as the compliance standards.

PEER assessed Wexford's compliance with providing timely access to quality chronic care for state inmates in the correctional system for the following areas:

- chronic care visit at least every six months (see explanation of this standard in the following subsection);
- notation in the medical records of scheduling a follow-up chronic care visit in six months; and,
- a medication treatment plan for each inmate under chronic care.

In reviewing chronic care, PEER sampled a combined total of 254 inmate medical records from the three parent correctional facilities. See page 3 for a discussion of the level of precision in the sample for chronic care.

Exhibit 2, page 28, summarizes Wexford's performance regarding chronic care at CMCF, SMCI, and MSP. The following sections include discussions of each of the chronic care issues reviewed.

Exhibit 2: Summary of Wexford’s Performance Regarding Chronic Medical Care at the Three Parent Correctional Facilities, January 1 through May 31, 2007

Chronic Care 6 Month Visit	<i>Compliance rates*</i>
Inmates receive a chronic care visit <i>at least every 6 months</i>	59%
Chronic Care Physician Referral Notation	
Physicians notate a referral for a chronic care follow-up visit <i>within 6 months</i> of the inmates’ previous chronic care visit	76%
Chronic Care Medication Treatment Plan	
Physicians develop and notate a medication treatment plan for chronic care inmates	85%

*MDOC’s medical services contract with Wexford did not address chronic medical care, although Wexford does provide chronic care services to the three parent correctional facilities.

SOURCE: PEER analysis of MDOC’s inmate medical records.

Chronic Care: Physician’s Visit At Least Every Six Months

For the period reviewed, a random sample of inmates’ medical records yielded a 59% compliance rate¹ for Wexford’s ensuring that state inmates received a chronic care physician’s visit at least once every six months. Based upon a confidence level of 95% and an acceptable error rate of 6%, the actual compliance rate for the entire population of inmates would range between 53% and 65%.

As stated previously, MDOC’s medical services contract with Wexford does not establish any chronic care standards or requirements. Wexford requires in its own policies and procedures for the management of chronic care that the physician conduct an assessment every

¹ As noted on page 26, MDOC’s medical services contract with Wexford did not address chronic medical care, although Wexford does provide chronic care services to the three parent correctional facilities.

ninety days to determine the need for continued chronic care services. MDOC requires in its policies and procedures that inmates with chronic conditions be seen at least annually. Thus PEER sampled inmates' medical records to assess whether inmates were seen by a physician for chronic care every six months, the midpoint between Wexford's requirement of every ninety days (in its own policies and procedures) and MDOC's policy of an annual physician's visit.

Failure to monitor inmates' chronic health conditions appropriately could subject the state to increased medical expenses due to the need for specialty care that might otherwise have been unnecessary if the inmates had been treated in a timely manner.

Of the 254 inmate medical records sampled from the review period, 150 (59%) included documentation of the inmate's receiving a chronic care visit at least once every six months. Of the remaining records in the sample, 49 (19%) did not fall within the six-month time frame for re-evaluating an inmate's chronic medical condition and 55 records (22%) were indeterminate.

PEER classified records as indeterminate if they did not contain sufficient information for PEER to determine compliance or noncompliance. Of the 55 records that PEER classified as indeterminate for the six-month chronic care visits, 50 were missing all chronic care information; therefore, PEER could not determine whether these inmates actually received chronic care, although the inmates' names appear on the chronic care logs as being seen. These 5 records should not have been a part of PEER's sample, but due to Wexford's recording errors, these records were put on the chronic care logs instead of the mental health logs, so PEER considered the records indeterminate. See Appendix H, page 84, for a facility-by-facility breakdown of the percentages for providing inmates with a chronic care visit at least every six months.

Based upon a confidence level of 95% and an acceptable error rate of 6%, the actual compliance rate for the entire population of inmates would range between 53% and 65%.

Even if PEER considered the 22% of indeterminate medical records as compliant, Wexford would have only 81% compliance. Including the indeterminate records, based on a 95% confidence level yielded by the sample, the actual compliance rate would fall between 75% and 87%.

By not ensuring that inmates receive a chronic care visit at least once every six months, Wexford is not only violating its own timeliness standards for chronic care, but it is failing to ensure the continuity of medical care needed to help prevent inmates' chronic conditions from becoming worse. Failure to monitor chronic health conditions appropriately could subject the state to increased medical expenses due to the need for specialty care that might otherwise have been unnecessary if the inmates had been treated in a timely manner.

Chronic Care: Physician Referral for Six-Month Follow-up Visits

For the period reviewed, a random sample of inmates' medical records yielded a 76% compliance rate² for documentation of a Wexford physician referring inmates for follow-up visits for chronic care at least once every six months. Based upon a confidence level of 95% and an acceptable error rate of 6%, the actual compliance rate for the entire population of inmates would range between 70% and 82%.

As stated previously, MDOC's medical services contract with Wexford does not establish any chronic care standards or requirements. PEER sampled inmates' medical records to assess whether inmates under chronic medical care were scheduled for six-month follow-up visits because six months is the midpoint between Wexford's requirement of a chronic care visit every ninety days (in its own policies and procedures) and MDOC's policy of an annual physician's visit.

Of the 254 inmate medical records sampled from the review period, 193 (76%) included documentation of a physician's chronic care referral at least within six months of the last scheduled chronic care visit. Of the remaining records in the sample, 44 (17%) did not contain documentation that a physician had referred the inmate for a chronic care follow-up visit within six months of the last scheduled chronic care visit and 17 records (7%) were indeterminate.

By not ensuring that all inmates are being properly referred for chronic care follow-up visits in a timely manner, Wexford is failing to ensure continuity of care should an inmate transfer from one facility to another.

PEER classified records as indeterminate if they did not contain sufficient information for PEER to determine compliance or noncompliance. Of the 17 records that PEER classified as indeterminate for scheduling of the six-month follow-up visits for chronic care, 12 were missing chronic care information and PEER could not determine whether a physician had referred the inmate for a chronic care follow-up visit within at least six months of the last scheduled chronic care visit. These 5 records should not have been a part of PEER's sample, but due to Wexford's recording errors, these records were put on the chronic care logs instead of the mental health logs, so PEER considered the records to be indeterminate. Appendix I, page 85, contains for a facility-by-facility breakdown of the percentages for physician referral for chronic care at least within six months of the last scheduled chronic care visit.

² As noted on page 26, MDOC's medical services contract with Wexford did not address chronic medical care, although Wexford does provide chronic care services to the three parent correctional facilities.

Based upon a confidence level of 95% and an acceptable error rate of 6%, the actual compliance rate for the entire population of inmates would range between 70% and 82%.

Even if PEER considered the 7% indeterminate medical records as compliant, Wexford would have an 83% compliance rate. Including the determinate records, based on a 95% confidence level yielded by the sample, the actual compliance rate would fall between 77% and 89%.

By not ensuring that all inmates are being properly referred for chronic care follow-up visits in a timely manner, Wexford is failing to ensure continuity of care should an inmate transfer from one facility to another. The physician at the next facility should be able to open the chronic care file and determine when the inmate's last chronic care visit was scheduled and when the next chronic care scheduled visit is needed. Otherwise, the possibility exists that inmates could fail to get a follow-up visit because the physician failed to schedule a referral and document such in the medical records.

Chronic Care: Treatment Plans

For the period reviewed, a random sample of inmates' medical records yielded an 85% compliance rate³ for Wexford's documentation of prescribing a medication treatment plan for each inmate under chronic care. Based upon a confidence level of 95% and an acceptable error rate of 6%, the actual compliance rate for the entire population of inmates would range between 79% and 91%.

As noted previously, MDOC'S medical services contract with Wexford does not establish any chronic care standards and requirements. However, ACA and NCHC standards require that inmates under chronic medical care have a treatment plan.

ACA defines *treatment plan* as a series of written statements that specify the particular course of therapy and the roles of medical and non-medical personnel in carrying it out and states: "A written treatment plan is required for offenders requiring close medical supervision, including chronic and convalescent care."

³ As noted on page 26, MDOC's medical services contract with Wexford did not address chronic medical care, although Wexford does provide chronic care services to the three parent correctional facilities.

NCCHC standards state:

The treatment plan includes at a minimum:

- *The frequency of the follow-up for medical evaluations and adjustment of treatment modality;*
- *The type and frequency of diagnostic testing and therapeutic regimes; and*
- *When appropriate, instructions about diet, exercise, adaptation to the correctional environment, and medication.*

Because the management of each chronic care condition differs to some extent, PEER focused on the two most common treatment areas mentioned in the national standards for inmates diagnosed with chronic conditions. The first area was frequency of follow-up visits, which is addressed on page 30. The second area was the administration of medications used to keep chronic conditions under control.

Of the 254 inmate medical records sampled from the review period, 217 (85%) included documentation of a physician-developed medication treatment plan. Of the remaining records in the sample, 22 (9%) did not include such documentation and 15 records (6%) were indeterminate.

Ensuring that all chronic care inmates have a medication treatment plan for each chronic condition helps in keeping chronic medical conditions controlled and could reduce the number of specialty care visits.

PEER classified records as indeterminate if they did not contain sufficient information to be reviewed. Of the 15 records that PEER classified as indeterminate for the medication treatment plans, 10 were missing chronic care information and PEER could not determine whether a medication treatment plan had been developed. The other 5 records should not have been a part of PEER's sample, but due to Wexford's recording errors, these records were put on the chronic care logs instead of the mental health logs, so PEER considered the records to be indeterminate. Appendix J, page 86, contains a facility-by-facility breakdown of the percentages for documentation of physicians developing a medication treatment plan for inmates with chronic conditions.

Based upon a confidence level of 95% and an acceptable error rate of 6%, the actual compliance rate for the entire population of inmates would range between 79% and 91%.

If including the 6% of indeterminate records as compliant, based on a 95% confidence level yielded by the sample, the actual compliance rate would fall between 85% and 97%.

Ensuring that all chronic care inmates have a medication treatment plan for each chronic condition helps in keeping chronic medical conditions controlled and could reduce the number of specialty care visits.

Mental Health Care for Inmates

No Segregation of Mental Health Records

MDOC does not require that Wexford keep mental health records organized separately from inmates' other medical records, a condition that could affect continuity of care.

MDOC policy states, "It is the policy of the Mississippi Department of Corrections (MDOC) that the Medical Provider maintains accurate and timely medical records that reflect the provisions of care to inmate patients."

For the review period, mental health records maintained by Wexford were not auditable because they were mixed together with regular medical records at CMCF, SMCI, and MSP, which made it difficult to analyze contract compliance with any level of confidence. Due to the degree of movement of inmates from one facility to another, PEER could not determine whether this recordkeeping problem is present at all three parent correctional facilities.

Critical mental health information may be overlooked by medical personnel due to their inability to locate such information within the medical records.

According to MDOC's Mississippi State Prison Approved Chart Order outline, all mental health records should be kept with those for chronic care because mental health is a specific area of chronic care. However, PEER identified during the medical records audit that Wexford staff do not consistently file mental health records with those for chronic care. Instead, mental health records were mixed with the regular medical records in the progress notes section of the medical records and psychiatric notes were mixed with other physician's orders.

As a result, PEER could not determine which records were mental health and which were medical. Neither MDOC nor Wexford can audit the mental health records with any level of confidence for contract compliance when records are not uniformly kept in one area.

As an example of the problems mixed medical records can create, PEER requested mental health professionals at CMCF and SMCI to search inmate medical records for mental health referral forms, medications prescribed to inmates, and inmates' next mental health appointment within the medical records. The mental health professionals at CMCF and SMCI had trouble finding and

identifying the mental health information PEER requested from the medical records.

By MDOC not requiring Wexford to maintain a separate mental health section within the regular medical records, neither MDOC nor Wexford can ensure continuity of mental health care from one facility to the next. Critical mental health information may be overlooked by medical personnel due to their inability to locate such information within the medical records. As a result, an inmate may not receive the proper medical care.

Lack of System-Wide Management of Some Chronic and Mental Health Care Documents

For chronic and mental health care, MDOC has not required Wexford to develop an effective system-wide method of managing inmates' appointments or maintaining uniform log sheets. As a result, MDOC cannot assure continuity of care.

Because MDOC may transfer inmates between facilities, or inmates may leave and re-enter the correctional system, consistency among facilities is important in maintaining some of the medical care management information and documents for inmates. This is particularly important for inmates under chronic or mental health care, as follow-up and continuity of care are especially significant factors in these inmates' overall health.

PEER found problems in the managing of appointments for inmates under chronic or mental health care. Also, Wexford staff at the three parent facilities do not maintain uniform log sheets for chronic and mental health care.

No System-Wide Method of Managing Inmates' Chronic and Mental Health Care Appointments

MDOC has not required Wexford to develop an effective system-wide method of managing the appointments of inmates under chronic or mental health care. As a result, MDOC cannot assure continuity of care for inmates under chronic or mental health care, especially if inmates transfer between facilities.

ACA standards state, "Continuity of care is required from admission to transfer or discharge from the facility, including referral to community based providers, when indicated." NCCHC standards state, "The facility ensures that inmates receive diagnostic and other health services ordered by clinicians."

MDOC has not required in contract that Wexford implement a formal system for tracking inmates' chronic

care physician visits and mental health psychiatric visits to ensure continuity of care from one facility to another. Wexford currently uses a process for keeping records of chronic care and mental health appointments that varies between the facilities.

At both CMCF and MSP, Wexford staff record chronic care and mental health appointment dates in a spreadsheet and sort them to determine which inmates are due to see the chronic care physician or the mental health professional on a specific day.

Because MDOC has not required Wexford to implement an effective method of managing appointments for chronic or mental health care, the potential exists that inmates might not be scheduled for follow-up, which is an important component of chronic or mental health care.

At SMCI, Wexford staff keep chronic care appointments on a paper calendar log to determine which inmates need to see the chronic care physician on a specific date. Also, SMCI uses adhesive notes in the medical record to show the date of the next scheduled chronic care visit. Wexford staff put mental health appointments on a calendar to determine when to schedule psychiatric follow-up appointments.

PEER believes that a method such as a formal management information system for managing appointments and tracking inmates through chronic and mental health care could help assure continuity of care and could most likely be accomplished with MDOC's existing resources.

Because MDOC has not required Wexford to implement an effective method of managing appointments for chronic or mental health care, the potential exists that inmates might not be scheduled for follow-up, which is an important component of chronic or mental health care, and Wexford cannot ensure continuity of care for inmates transferred between facilities.

No System-Wide Method of Keeping Chronic and Mental Health Care Logs

MDOC has not required Wexford to ensure continuity of care by maintaining uniform log sheets for all chronic care and mental health inmate medical records.

According to MDOC policy, Wexford must keep log sheets on-site for all health care performed at the facility. However, Wexford does not use uniform log sheets at all three parent facilities that tracks the same information for chronic care and mental health care.

Wexford staff at the facilities keep logs for chronic care and mental health care, with the exception of SMCI. Wexford staff at SMCI did not have any mental health logs for the period of the review.

By not maintaining uniform log sheets, Wexford cannot ensure continuity of care from one facility to another. Inmates are frequently transferred from one facility to another and should be ensured of having the same level of care at all parent facilities. Since the log sheets represent the source data of all inmate medical visits into a clinic, the log sheets should be uniform and record the same medical information. This process would also allow MDOC to audit the log sheets for continuity of care from one facility to the next.

Wexford's and MDOC's Provision of Specialty Medical Care

Inmates' medical records from January 1, 2007, through May 31, 2007, do not contain documentation that MDOC and its contractor Wexford provided timely specialty medical care to all state inmates needing such care.

According to MDOC's medical services contract with Wexford Health Sources, Wexford and MDOC share responsibility for providing inmates with access to specialty medical care. As of July 1, 2006, Wexford is responsible for providing the following specialty care: optometry, radiology, dialysis, audiology, and care for sexually transmitted diseases, HIV/AIDS, and tuberculosis. MDOC is financially responsible for all other specialty care services for state inmates off site and is responsible for oversight of the utilization review process for specialty care for all state inmates.

Wexford and MDOC share responsibility for providing inmates with access to specialty medical care.

MDOC created the Office of Specialty Care within the Office of Medical Compliance in response to its increased responsibility for specialty medical care for inmates. The Office of Specialty Care employs licensed practical nurses (LPNs) as Specialty Care Coordinators (SCCs). These SCCs are responsible for receiving, reviewing, and evaluating consult requests from Wexford physicians. SCCs are also responsible for requesting additional information from Wexford physicians, discussing consult requests with the Chief Medical Officer or designee (i. e., a physician consultant), and scheduling all appointments and surgeries.

PEER reviewed MDOC's and Wexford's implementation of their respective responsibilities for inmates' specialty medical care from January 1, 2007, through May 31, 2007. PEER concluded that MDOC and Wexford did not document timeliness of specialty care for all inmates during that period because:

- neither Wexford nor MDOC has established written timeliness standards for monitoring consult requests; and,
- neither Wexford nor MDOC has implemented an effective method of tracking inmates through the specialty care process.

No Written Timeliness Standards for Monitoring the Status of Inmates' Specialty Care Cases

Process for Specialty Medical Care

According to MDOC's contract with Wexford, the contractor is responsible for requesting specialty medical care consults for inmates. MDOC is responsible for reviewing and evaluating these consult requests and scheduling appointments with specialists.

In the case of an inmate who needs specialty medical care, the inmate submits a sick call request, through triage is referred to a health care professional (i. e., a physician, nurse practitioner, or dentist) employed by Wexford at a parent correctional facility, then is seen by that health care professional. If the health care professional at the parent facility determines that the inmate's condition warrants review by a specialist (such as a cardiologist or ophthalmologist), the health care professional completes a specialty care consult form for the inmate.

Wexford's medical director or dental director signs the consult for approval and submits the form by fax to MDOC's Office of Specialty Care in Jackson. As noted previously, MDOC's Specialty Care Coordinators receive and review the consult requests and request any additional medical information needed. If no further information is needed, the SCCs discuss the consult requests with the Chief Medical Officer or designee, according to MDOC policy. Then, MDOC schedules the appointment for the inmate with a timeframe based upon the urgency of the medical condition. Wexford writes "urgent" on consult requests for inmates that need immediate attention. Otherwise, MDOC determines the urgency of the condition. MDOC schedules follow-up appointments or surgeries as needed.

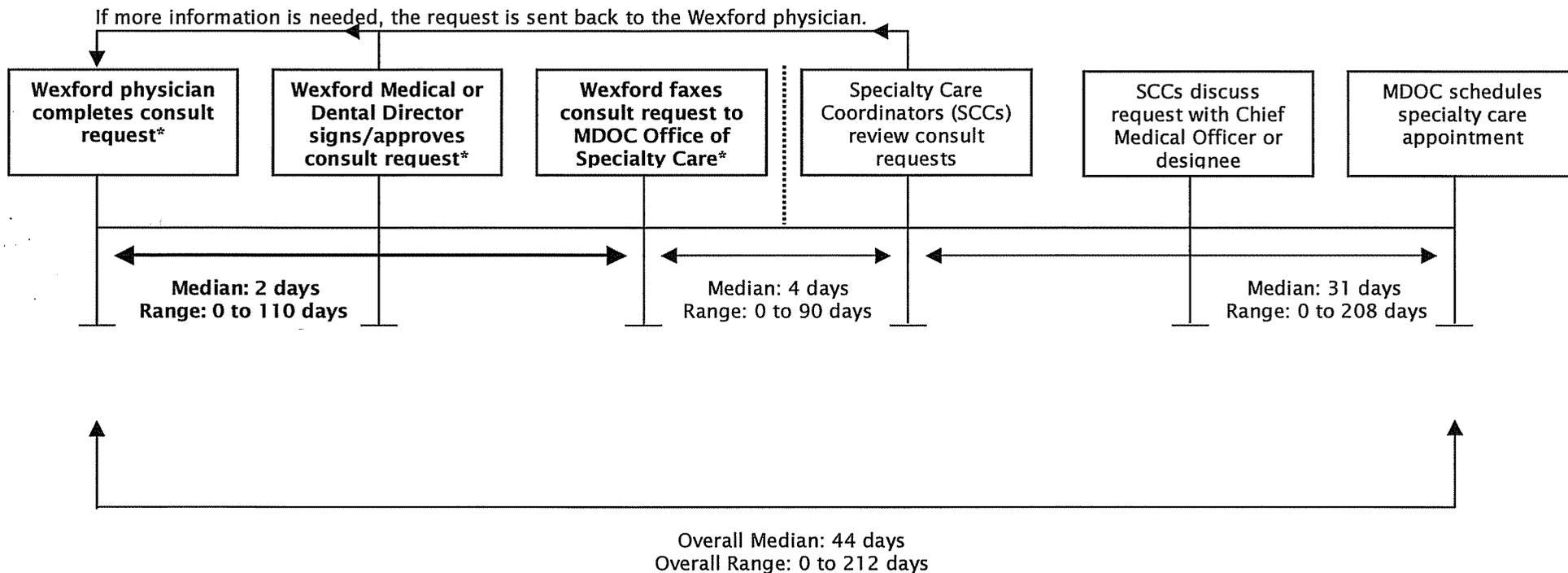
Exhibit 3, page 39, depicts the specialty care process from the point of the consult request to the scheduling of the appointment for specialty care.

PEER's Sample of Records Regarding the Specialty Care Process

During the period of review, for the cases in PEER's sample, MDOC scheduled 39 percent of appointments for specialty care within thirty days of Wexford's completion of the consult request.

To determine whether inmates at MDOC facilities received timely specialty medical care during the period of review,

Exhibit 3: Flow Chart of Specialty Care Process from Consult Request to Appointment Scheduled For Timeliness of Specialty Care



*Bold font represents Wexford's responsibility in the specialty care process.

SOURCE: Interview with MDOC's Chief Medical Officer, PEER analysis of MDOC's specialty care flow chart, and PEER analysis of specialty care cases.

PEER sampled 222⁴ medical records at MDOC headquarters in Jackson for inmates who received some type of specialty care between January 1, 2007, and May 31, 2007.

Results of PEER's Sample

As shown in Exhibit 4 on page 41, MDOC's Office of Specialty Care scheduled:

- 21 percent of appointments within 14 days of the consult being completed;
- 39 percent of appointments within 30 days of the consult being completed;
- 63 percent of appointments within 60 days of the consult being completed; and,
- 80 percent of appointments within 90 days of the consult being completed.

The remaining 20 percent of appointments not scheduled within 90 days of the consult being completed represent appointments for 41 inmates, for which 91 to 212 days elapsed before the inmate saw a specialist.

For the 20 percent of appointments not scheduled within 90 days of the consult being completed, from 91 to 212 days elapsed before the inmate saw a specialist.

As an example, a September 2006 surgery consult for an inmate with a large, painful hernia was not scheduled for an appointment until February 2007 (nearly five months after the consult request) and the inmate subsequently had surgery in April 2007.

PEER notes that these numbers represent all phases within the specialty care process (except for follow-up appointments or surgeries after the initial visit with a specialist). Subsequent discussions relate to individual phases within the specialty care process.

During the period of review, for the cases in PEER's sample, Wexford submitted 44 percent of consult requests to MDOC for approval within one day of completion.

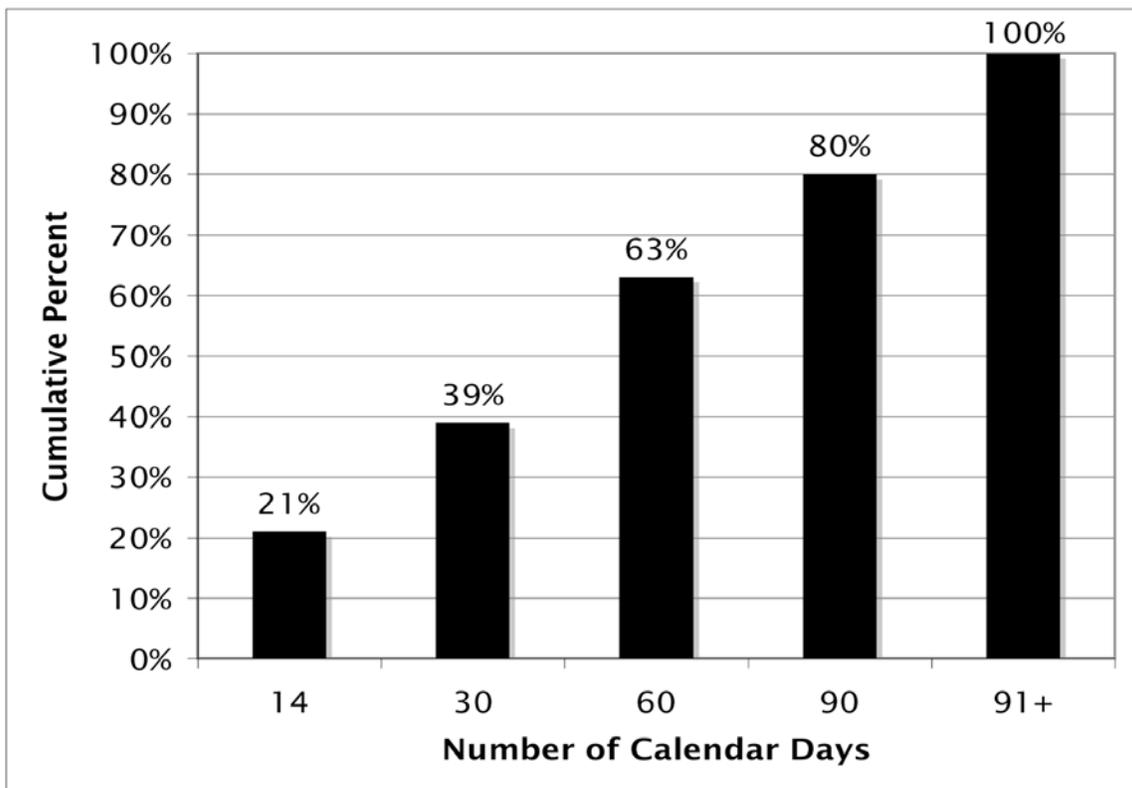
As shown in Exhibit 5 on page 42, Wexford submitted:

- 23 percent of consult requests on the same day of completion;

⁴ The 222 inmate medical records, or cases, sampled for this portion of PEER's review represent 211 individuals, with multiple specialty referrals for some individuals within the sample.

- 44 percent of consult requests within one day of completion;
- 54 percent of consult requests within 2 days of completion;
- 82 percent of consult requests within 7 days of completion;
- 93 percent of consult requests within 14 days of completion; and,
- 96 percent of consult requests within 30 days of completion.

Exhibit 4: Number of Days Between Wexford’s Completion of Consult and Specialty Care Appointment

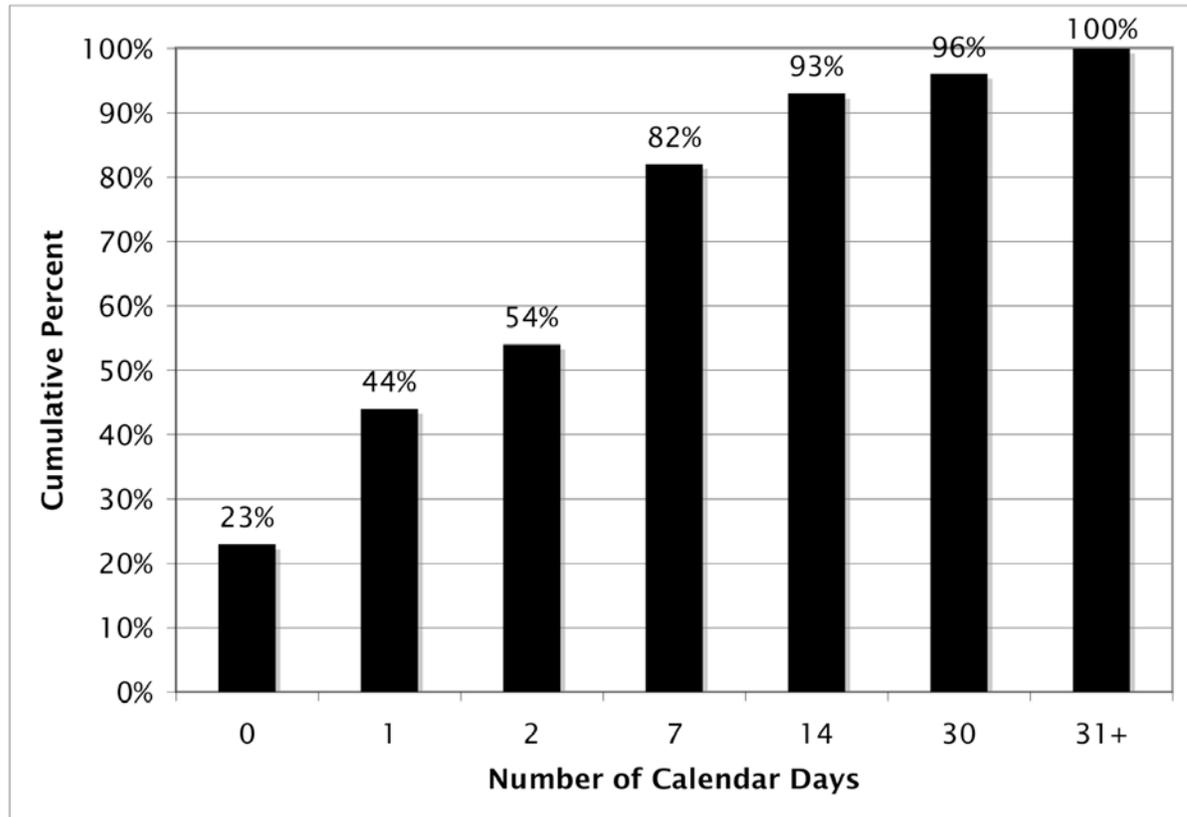


SOURCE: PEER analysis of MDOC specialty care files.

NOTE: Cumulative percentages show the percentage of consult requests that lie above or below the number of calendar days. For example, MDOC scheduled 21 percent of appointments within 14 calendar days of completion of the consult, as indicated in the chart.

The remaining 4 percent of consult requests not submitted within 30 days represent requests for 9 inmates, for which 35 to 110 days elapsed before Wexford submitted the consult request to MDOC.

Exhibit 5: Number of Days Between Wexford’s Completion of Consult and Submission to MDOC’s Office of Specialty Care



SOURCE: PEER analysis of MDOC specialty care files.

NOTE: Cumulative percentages show the percentage of consult requests that lie above or below the number of calendar days. For example, Wexford submitted 23 percent of consult requests on the same date of completion of the consult requests, as indicated by the “0” in the chart.

In one example, a December 2006 ophthalmology consult request marked “urgent” for an inmate with a presumed diagnosis of glaucoma was not signed and submitted to MDOC by the Site Medical Director until March 2007. The inmate was seen by the specialist in May 2007 and was recommended for surgery to remove cataracts.

During the period of review, for the cases in PEER's sample, MDOC reviewed 26 percent of consult requests within one day of receipt to determine whether the inmate required special care.

As shown in Exhibit 6 on page 44, MDOC reviewed:

- 14 percent of consult requests on the same day of receipt;
- 26 percent of consult requests within one day of receipt;
- 32 percent of consult requests within 2 days of receipt;
- 79 percent of consult requests within 7 days of receipt;
- 89 percent of consult requests within 14 days of receipt; and,
- 97 percent of consult requests within 30 days of receipt.

The remaining 3 percent of consult requests not reviewed within 30 days of receipt represent requests for 6 inmates, for which 31 to 90 days elapsed before MDOC reviewed the consult request.

For 6 inmates in PEER's sample, from 31 to 90 days elapsed before MDOC reviewed the consult request.

In one example, Wexford submitted a December 2006 cardiology consult request for an inmate with a presumed diagnosis of angina. MDOC reviewed and returned the request nearly ten weeks later, requesting additional information regarding what type of test was being requested. The inmate saw a cardiologist in late March and had a cardiac catheterization in late April 2007.

During the period of review, for the cases in PEER's sample, MDOC scheduled 49 percent of specialty appointments within thirty days of review.

As shown in Exhibit 7 on page 45, MDOC scheduled:

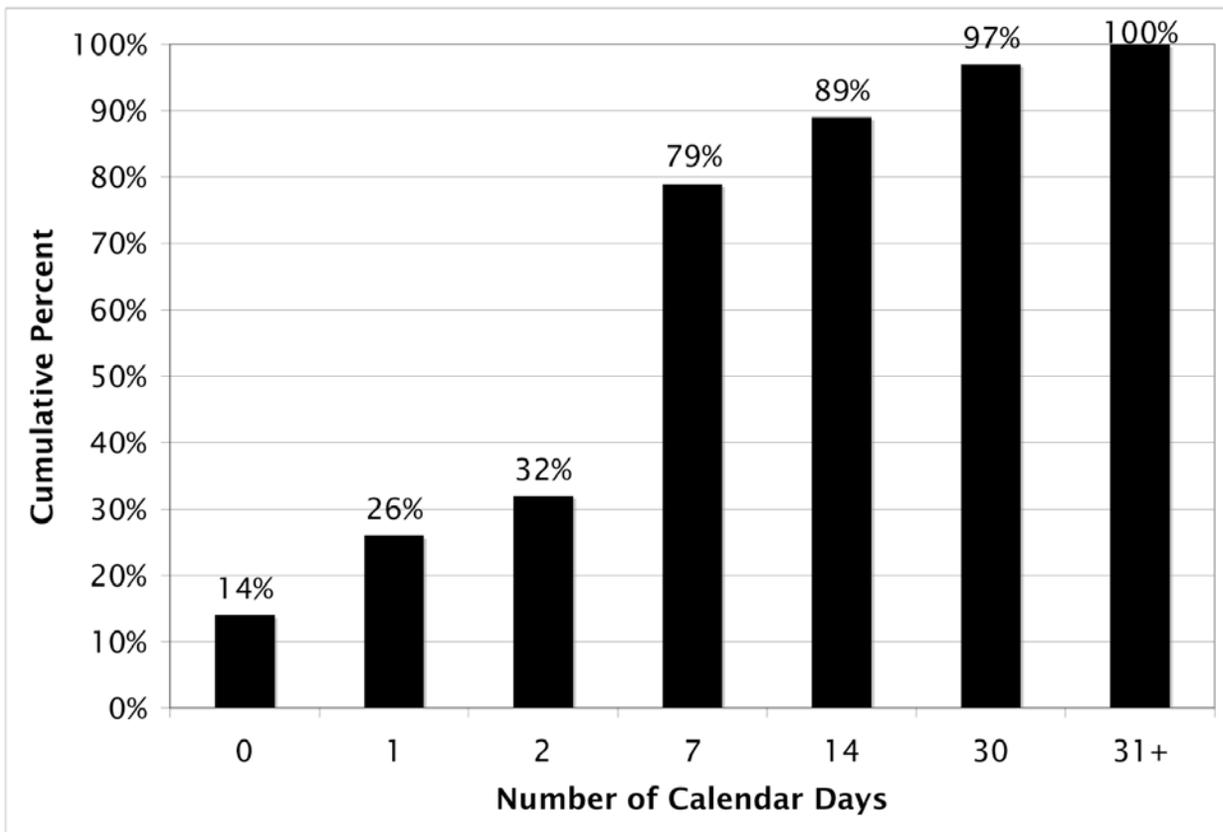
- 29 percent of appointments within 14 days of review;
- 49 percent of appointments within 30 days of review;
- 73 percent of appointments within 60 days of review; and,

- 87 percent of appointments within 90 days of review.

The remaining 13 percent of appointments not scheduled within 90 days of review represent appointments for 24 inmates, for which 95 to 208 days elapsed before the inmate saw a specialist.

As an example, MDOC reviewed a July 2006 urology consult request for an inmate with a painful scrotal mass. MDOC reviewed the request and scheduled a specialty appointment over four months later in November. The inmate was diagnosed with testicular cancer and had surgery in February.

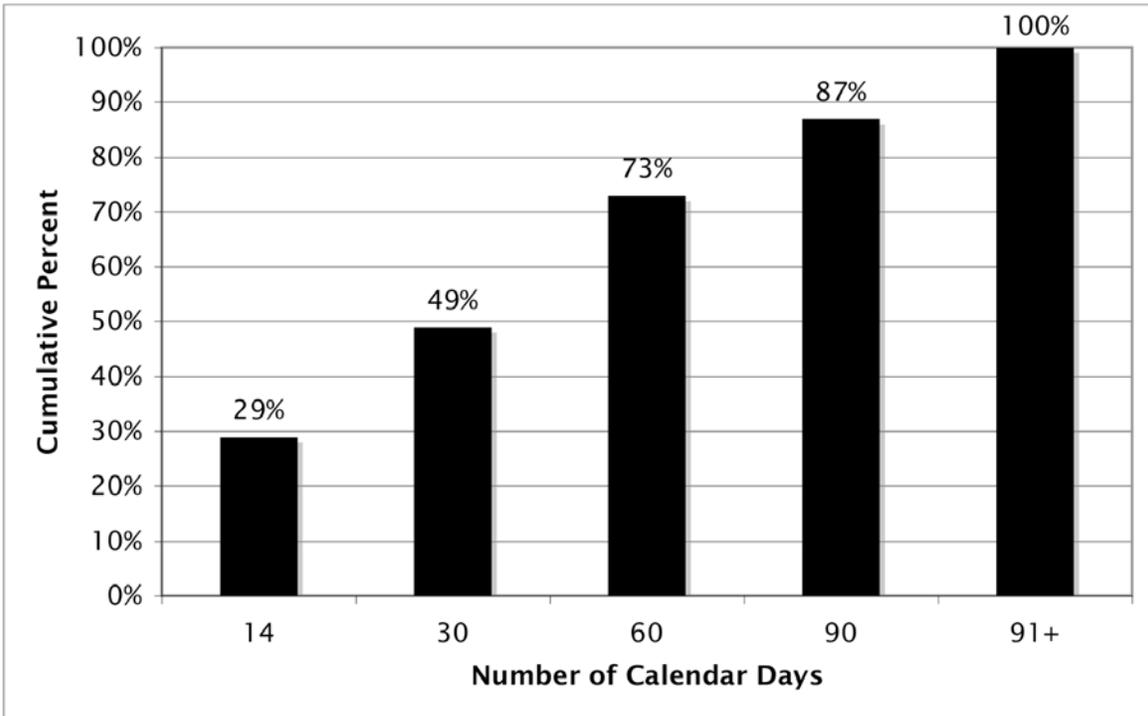
Exhibit 6: Number of Days Between Receipt and Review of Consult Request by MDOC’s Office of Specialty Care



SOURCE: PEER analysis of MDOC specialty care files.

NOTE: Cumulative percentages show the percentage of consult requests that lie above or below the number of calendar days. For example, MDOC reviewed 14 percent of consult requests on the same date of receipt of the requests, as indicated by the “0” in the chart.

Exhibit 7: Number of Days Between MDOC's Review of Consult Request and Appointment Date



SOURCE: PEER analysis of MDOC specialty care files.

NOTE: Cumulative percentages show the percentage of consult requests that lie above or below the number of calendar days. For example, MDOC scheduled 29 percent of consult requests within 14 calendar days of review of the requests, as indicated in the chart.

During the period of review, for the cases in PEER's sample, MDOC did not assure that all inmates were transported to their specialty care appointments.

During the period of review, for the cases in PEER's sample, seven inmates missed specialty medical care appointments due to MDOC's failure to transport inmates to their appointments. None of the seven records contained forms stating that the inmates had refused the appointments; therefore, MDOC was responsible for these inmates not being seen by specialists on their appointment dates.

As an example, one inmate with a fractured jaw after an alleged altercation four days earlier was referred for urgent specialty care with an oral surgeon on April 26,

2007. MDOC scheduled an appointment for the inmate on May 3 (over a week later), but did not transport the inmate to see the specialist on that date. MDOC rescheduled the appointment for May 8, but the inmate missed this appointment as well.

As mentioned previously, MDOC is responsible for the transportation of inmates to and from specialty care appointments. An inmate's health could be at an increased risk by missing an appointment with a specialist.

Significance of PEER's Sample Findings

PEER notes that several outliers appear in the charts on pages 41 through 45. Outliers are numbers that are much larger or smaller than most of the other numbers in the data set. For these charts, the outliers represent consult requests for inmates that took much longer to process than the other requests. For example, Wexford submitted the majority of consult requests to MDOC within 2 days of completion; however, for one inmate (i. e., one outlier), Wexford did not submit the consult for 110 days.

Wexford does not have a system in place to flag or identify consult requests that have not been approved by the medical or dental director and submitted to MDOC within an appropriate amount of time.

Also, MDOC does not have a system in place to flag or identify consult requests that have not been reviewed or scheduled for appointments within an appropriate amount of time.

As mentioned previously, the contract between Wexford and MDOC raised concerns as to whether inmates were receiving timely medical care when referred for specialty care. It is apparent that there are delays for some inmates in receiving specialty care services; however, the extent to which these delays increase the risks to inmates is unknown.

Neither Wexford nor MDOC has been able to assess the risks to inmates. Wexford does not have a system in place to flag or identify those consult requests, urgent or non-urgent, that have not been approved by the medical or dental director and submitted to MDOC within an appropriate amount of time. In turn, MDOC does not have a system in place to flag or identify those consult requests, urgent or non-urgent, that have not been reviewed or scheduled for appointments within an appropriate amount of time. The outliers mentioned above could represent inmates with severe conditions that could lead to otherwise avoidable surgeries and/or death if the inmate does not receive care from a specialist in a timely manner.

Lack of Timeliness Standards for Monitoring Consult Requests Hinders Accountability

MDOC's contract with Wexford does not include written timeliness standards for monitoring Wexford's submission of consult requests for specialty medical care. Also, MDOC has not established written timeliness standards for monitoring the department's actions on consult requests.

According to the Administrator for the University Clinical Associates of the University of Mississippi Medical Center and the Deputy Director/General Counsel of the Mississippi State Medical Association (MSMA), no criteria exist for measuring the expediency of processing consult requests (from completion to submission of consult requests). Also, according to the Deputy Director/General Counsel of the MSMA, no well-defined criteria are available to measure timely attention to inmates with specialty care needs. Each physician sets his/her own standards for determining the time frames of specialty care visits.

After MDOC determines that an inmate requires specialty care and contacts a specialist to make an appointment, neither MDOC nor Wexford can control the amount of time that the inmate must wait before seeing a specialist.

PEER acknowledges that after MDOC determines that an inmate requires specialty care and contacts a specialist to make an appointment, neither MDOC nor Wexford can control the amount of time that the inmate must wait before seeing a specialist. This span of time depends on factors such as number of physicians practicing and available in the specialty, the specialist's caseload and schedule, and availability of appointment times. However, to a certain extent, Wexford and MDOC could control the time frames for their respective responsibilities in the specialty medical care process prior to this point.

However, to a certain extent, Wexford and MDOC could control the time frames for their respective responsibilities in the specialty medical care process prior to this point.

PEER found that MDOC's contract with Wexford does not include timeliness standards for Wexford's submission of consult requests for specialty care, even though the timeliness of the initial phase of the specialty care process hinges on Wexford health care professionals' timeliness in submitting consult requests to MDOC. MDOC should have written standards in its contract with Wexford for monitoring actions that the contractor should take during the portion of the specialty care process that is within the parameters of the contractor's responsibility. For example, MDOC should require by contract that Wexford establish an acceptable time frame mutually agreeable to MDOC for the period from the physician's writing of a consult request until the submission of that request to MDOC. Then, if the amount of time for a consult request to reach MDOC falls outside the acceptable time frame specified in the contract, Wexford should take some sort of action on the request and include a notation in the medical record regarding the status of the request and an explanation for the delay.

No departmental policy or procedure states that MDOC should check the status of an inmate's specialty case after x number of days after receipt of the consult (or at other phases during the specialty care process) and include documentation in the medical record if the department has not contacted a specialist within that time frame.

Also, MDOC has not established written timeliness standards for the department's role in monitoring the specialty care process. No departmental policy or procedure states that MDOC should check the status of an inmate's specialty case after x number of days after receipt of the consult (or at other phases during the specialty care process) and include documentation in the medical record if the department has not contacted a specialist within that time frame. In particular, this becomes a factor in timeliness if MDOC requests additional information from the contractor during the utilization review process. MDOC staff state that they utilize informal time frame goals for their role in the specialty care process (i. e., one day for submission of consult and one day for review of consult). However, as shown in the previous subsection, actual time frames on record in the inmate cases in PEER's sample contradict this assertion. Obviously a high variance exists in the number of days between each phase of the specialty care process in some cases in the sample, but the inmate medical records contained no indication that the variance was attributable to any specific condition or situation.

As in the contract with Wexford, the department should have written timeliness standards in its own policies and procedures for monitoring the actions that the department should take within the parameters of the department's responsibility in specialty care. This could be accomplished in a relatively simple manner with an interface between off-the-shelf spreadsheet and database programs, possibly within resources already maintained by the department. Another alternative would be a formal information management system dedicated to management of inmates' specialty medical care (see following subsection). In either situation, the result should be a method that would incorporate action standards and would trigger an alert to responsible personnel if the status of an inmate's case is not checked within a time frame determined to be reasonable by the department. These standards for action should take into account the possibilities of Wexford's or MDOC's occasional need to obtain additional information before making decisions on the request and the response time needed for such, as well as the department's prioritization of requests.

Because of the absence in the contract of timeliness standards for monitoring specialty care, MDOC cannot hold Wexford accountable for any delays in the processing of consult requests for specialty care.

Because neither Wexford nor MDOC have implemented written timeliness standards for monitoring the status of specialty care cases, PEER questions whether some inmates received access to specialty medical care during the period of review in the most timely manner possible. According to the cumulative percentages related to PEER's sample of specialty medical care records (see discussion beginning on page 38), Wexford and MDOC appear to have provided timely access to specialty care for the majority of inmates. However, as described previously, specialty care for some inmates was delayed. Timeliness standards, along with an effective tracking system, might have provided PEER some determination as to the significance of these delays.

Because of the absence in the contract of timeliness standards for monitoring specialty care, MDOC cannot hold Wexford accountable for any delays in the processing of consult requests for specialty care. If MDOC could have ensured Wexford's timeliness in that portion of the specialty care process, timeliness of specialty care for inmates could have been at least somewhat improved. Also, any noncompliance by the contractor could be penalized by collection of liquidated damages.

No Effective Method for Tracking Inmates through the Specialty Care Process

Neither MDOC nor Wexford has developed an effective method of tracking inmates through the specialty medical care process by monitoring important dates and actions taken on the inmate's medical case. As a result, MDOC cannot assure timely specialty care for inmates.

In addition to not having timeliness standards for monitoring actions taken on specialty medical care, neither Wexford nor MDOC has an effective method of tracking information needed to ensure inmates' timely access to specialty care.

MDOC's staff uses a spreadsheet for monitoring specialty care, but this method has limited value because it does not contain all of the information needed for tracking inmates through the specialty medical care process.

NCCHC standards address the continuity of care during incarceration: "The facility ensures that inmates receive diagnostic and other health services ordered by clinicians." Further, ACA standards require, "Continuity of care is required from admission to transfer or discharge from the facility, including referral to community-based providers, when indicated." These standards are a part of the contract with Wexford and explain that it is MDOC's responsibility to monitor inmates' access to specialty care services as recommended by Wexford physicians.

MDOC staff state that they monitor specialty care by utilizing a spreadsheet that lists the consult date, receipt

date, and appointment date. However, this spreadsheet has limited value because it does not contain additional information needed for tracking, such as the type and severity of the medical condition, the date the consult was approved by the site medical director, the date on which MDOC reviewed the consult request, and date the inmate returned for follow-up care by a Wexford physician or an outside specialist. Also, because Wexford's physicians at CMCF, SMCI, and MSP and MDOC's specialty care staff do not have access to the same database of information, Wexford's physicians cannot adequately monitor the progress of inmates. This information also becomes critical in the event that the inmate is transferred to another correctional facility.

The following are examples of the lack of effective tracking of inmates under specialty medical care:

- In September 2006, a Wexford physician submitted a consult request for a specialty appointment with a neurosurgeon because of an inmate's symptomatic herniated discs. The physician e-mailed MDOC's Office of Specialty Care in March 2007 inquiring about the consult. MDOC responded that the inmate was "lost for follow-up" and that an appointment would be made immediately. The inmate had an MRI in March and saw a specialist in April.
- On April 13, 2007, MDOC's Office of Specialty Care received a consult request by a Wexford physician (optometrist) for a specialty appointment with an ophthalmologist for glaucoma. The physician followed up on the consult with MDOC on April 30, stating that the consult was sent "urgently" and that the inmate had "severe pain." MDOC responded that the inmate was scheduled for an appointment on May 15, 2007. The physician requested that the inmate be seen sooner and the appointment was rescheduled for May 7. The inmate was not transported to CMCF for housing/transport to the specialty appointment and was released from custody prior to the next scheduled appointment on June 1, 2007. PEER notes that there was no "urgent" indication on the consult request; however, if an effective tracking system had been in place, then this inmate might have been seen by a specialist before being released.

PEER believes that a method such as a formal information management system for tracking inmates through the specialty care process would be an effective way to assure

timely access to specialty medical care and could most likely be accomplished with MDOC's existing resources.

Without adequate data, neither Wexford nor MDOC can assess its own performance in providing timely access to specialty care.

Because neither Wexford nor MDOC has implemented an effective method of tracking inmates through specialty care, the potential exists for inmates to be "lost" within the specialty care process. Also, without adequate data, neither Wexford nor MDOC can assess its own performance in providing timely access to specialty care.

Operational Issues: MDOC and Wexford

During PEER's review of inmates' medical records to determine the quality of medical care state inmates received from January 1 through May 31, 2007, at the three parent correctional facilities, PEER identified operational issues that also affect quality of care:

- medical staffing;
- quality assurance and recordkeeping; and,
- MDOC's medical expenditures.

PEER also compared MDOC's FY 2007 medical costs under the contract with Wexford to the correctional system's FY 2006 costs for medical care.

Issues with Medical Staffing

While reviewing inmate medical records to determine quality of care, for the period of review PEER noted the following deficiencies in the medical staffing of the correctional facilities:

- Wexford's medical staffing levels were not in compliance with the contract requirements;
- MDOC did not require Wexford to submit documentation of all licensures, certifications, and registrations of all medical staff to MDOC for review; and,
- neither MDOC nor Wexford ensured sufficient orientation/training of temporary medical staff.

PEER also determined that MDOC has not collected liquidated damages for Wexford's failure to meet staffing requirements of the contract and thus has not recouped any of the state funds paid for staffing that was not provided.

Wexford's Noncompliance with Contract Requirements for Staffing Levels

During the period of review, Wexford's staffing levels did not comply with contract requirements. Therefore, neither MDOC nor Wexford could ensure appropriate and timely access to quality medical care for state inmates.

MDOC defines a *full-time equivalent* (FTE) as a unit of measure that is equal to one filled, full-time staff position. According to MDOC's contract with Wexford, Wexford is to maintain specified minimum full-time equivalent staffing levels at each of the three parent correctional facilities.

Each correctional facility's required minimum staffing level is different due to the fact that each correctional facility houses a different number of state inmates. The more state inmates a correctional facility houses, the higher the minimum required staffing level would need to be in order to provide medical care.

PEER reviewed Wexford's quarterly medical staffing reports for CMCF, SMCI, and MSP for the period of January 1, 2007, through June 30, 2007. The staffing reports show computations of medical staffing shortages and overages at each facility.

The overall minimum FTE staffing requirements include FTE requirements for several medical staff positions, including registered nurses, physicians, mental health professionals, and dentists. Exhibit 8, page 54, summarizes the contract staffing requirements for each facility for the first and second quarters of 2007, showing the required and actual FTEs and FTE shortages.

Wexford did not meet the contract's FTE staffing requirements at any of the three parent facilities for the first two quarters of calendar year 2007.

Appendix K, pages 87 through 89, shows the contract FTE requirements by staff position at each of the three parent facilities for the first two quarters of 2007, as well as the actual staffing FTEs by position.

As shown in Exhibit 8, in Appendix K, and discussed in the following subsections, Wexford did not meet the contract's FTE staffing requirements at any of the three parent facilities for the first two quarters of 2007 (January 1 through June 30).

Exhibit 8: Summary of Wexford's Staffing of MDOC Parent Facilities, January-June 2007

First Quarter of 2007 (January-March)

Facility	FTEs Required by Contract	Actual FTEs	Shortage
CMCF	67.00	58.49	8.51
SMCI	39.00	37.45	1.55
MSP	97.30	71.09	26.21

Second Quarter of 2007 (April-June)

Facility	FTEs Required by Contract	Actual FTEs	Shortage
CMCF	67.00	61.50	5.50
SMCI	39.00	36.71	2.29
MSP	97.30	85.40	11.90

SOURCE: PEER analysis of MDOC's quarterly reports for January-June 2007.

Wexford did not meet the contract requirements for FTE staffing at CMCF for the first two quarters of 2007 (January 1 through June 30, 2007).

According to MDOC's contract with Wexford, CMCF should have an overall minimum medical staffing FTE of 67.0. During the first quarter of 2007 (January through March), CMCF had an actual medical staffing FTE of 58.49, with an overall medical staffing shortage of 8.51 FTE.

During the first two quarters of 2007, Wexford's actual RN staffing level at CMCF was approximately half of the RN staffing level required by the medical services contract.

The chief medical FTE staffing shortage area for the first quarter at CMCF was Registered Nurse (RN) staffing. The medical services contract required 16.0 FTEs and Wexford had an actual RN staffing FTE of 9.0. Wexford's RN staffing FTE was approximately half of the required RN FTE staffing level in the medical services contract.

During the second quarter of 2007 (April through June), CMCF did improve upon its medical staffing FTE from the first quarter, but still did not meet the contract's required overall minimum medical staffing FTE of 67.0. CMCF had an overall actual second quarter medical staffing level of

61.50, with an overall medical staffing shortage of 5.50 FTE.

The major problem area in the second quarter continued to be RN staffing. The required FTE for RN staffing was 16.0, while CMCF had an actual FTE staffing level of 8.0 during the second quarter. See Appendix K, page 87, for a complete breakdown of the required and actual staffing levels at CMCF during the review period.

In addition to noncompliance with medical staffing FTE requirements of the contract, during this period Wexford could not ensure that all state inmates at CMCF received timely, adequate access to medical care.

Wexford did not meet the contract requirements for FTE staffing at SMCI for the first two quarters of 2007 (January 1 through June 30, 2007).

According to MDOC's contract with Wexford, SMCI should have an overall minimum medical staffing FTE of 39.0. During the first quarter of 2007, SMCI had an actual medical staffing FTE of 37.45, with an overall medical staffing shortage of 1.55 FTEs.

During the first two quarters of 2007, Wexford's actual Mental Health Professional (MHP) staffing level at SMCI was less than half of the MHP staffing level required by the medical services contract.

The chief medical staffing shortage area for the first quarter at SMCI was Mental Health Professional (MHP) staffing. The medical services contract required 2.0 FTEs and Wexford had actual MHP staffing FTE of .75. Wexford's Mental Health Professional FTE staffing level was less than half of the required staffing level in the medical services contract.

During the second quarter of 2007, SMCI had an actual FTE staffing level of 36.71, with an overall medical staffing shortage of 2.29 FTEs.

The major problem area during the second quarter continued to be MHP staffing. The required FTE for MHP staffing was 2.0 while SMCI had an actual FTE staffing level of .90 during the second quarter. See Appendix K, page 88, for a complete breakdown of the required and actual staffing levels at SMCI during the review period.

In addition to noncompliance with FTE medical staffing requirements of the contract, during this period Wexford could not ensure that all state inmates at SMCI received timely, adequate access to medical care.

Wexford did not meet the contract requirements for FTE staffing at MSP for the first two quarters of 2007 (January 1 through June 30, 2007).

According to MDOC's contract with Wexford, MSP should have an overall minimum medical staffing FTE of 97.30. During the first quarter of 2007, MSP had an actual medical staffing FTE of 71.09, with an overall first quarter FTE staffing shortage of 26.21 FTE.

MSP had several staffing shortage areas for the first quarter at MSP. These included RN staffing, LPN staffing and dental staffing. The required FTE for RNs during the first quarter was 16.0, while Wexford actually had 8.5. The required FTE for LPNs for the first quarter was 27.0, while Wexford had 15.60. The required FTE for dentists during the first quarter was 3.50, while Wexford had 2.0.

During the first two quarters of 2007, Wexford's actual RN and LPN staffing levels at MSP were below the respective staffing levels required by the medical services contract.

During the second quarter of 2007, MSP had an actual second quarter staffing level of 85.40, with an overall second quarter FTE staffing shortage of 11.90 FTE.

The major problem area was RN and LPN staffing, along with physician staffing. MSP corrected the first quarter dental staffing shortage by the second quarter and was fully staffed in that area. The required FTE for RN staffing was 16.0, while MSP had an actual FTE staffing level of 11.60 during the second quarter. The required FTE for LPN staffing was 27.0, while MSP had an actual LPN staffing level of 21.50. The required FTE for physician staffing was 4.0, while MSP had 3.0 during the second quarter. See Appendix K, page 89, for a complete breakdown of the required and actual staffing levels at MSP during the review period.

In addition to noncompliance with FTE medical staffing requirements of the contract, during this period Wexford could not ensure that all state inmates at MSP received timely, adequate access to medical care.

No Verification of Licensure

Without providing any type of oversight, MDOC relied on Wexford to ensure that its medical personnel were properly licensed, certified, or registered in the state of Mississippi. As a result, during the period of review at least five individuals without proper credentials provided medical care to inmates.

Regarding licensure, certification, or registration of medical staff for correctional facilities, NCCHC standards state:

All health care personnel who provide services to inmates are appropriately

credentialed according to the licensure, certification, and/or registration requirements of the state.

ACA standards state:

All professional staff comply with applicable state and federal licensure, certification, or registration requirements. Verification of current credentials and job descriptions should be kept on file at the facility.

MDOC does not require Wexford to submit any verification to MDOC that the individuals employed by Wexford are appropriately licensed, certified, or registered.

MDOC's contract with Wexford requires Wexford to confirm that all the required registrations, licenses, and credentials are active, unrestricted, and in good standing for professionals contracted or engaged by Wexford to provide services at CMCF, SMCI, and MSP. The contract also requires Wexford to verify with the state licensure board the status of every physician, nurse, or other personnel requiring a license to practice his or her profession prior to contracting with or employing a health care professional to work in one of the three parent facilities. However, MDOC does not require Wexford to submit any verification to MDOC that the individuals employed by Wexford are appropriately licensed, certified, or registered.

The five individuals employed without proper credentials during the review period included three radiology technicians, one pharmacy technician, and one dental assistant.

PEER verified the license, certification, or registration of 314 Wexford employees at CMCF, SMCI, and MSP as of October 24, 2007, for sixteen different position titles. These positions included physicians, physician assistants, psychiatrists, dentists, dental assistants, nurse practitioners, nurses, pharmacy technicians, x-ray technicians, radiology technicians, and emergency medical technologists. Of the 314 positions reviewed, five (1.59%) were not licensed, certified or registered as required by state law. The five positions included three radiology technicians, one pharmacy technician, and one dental assistant. See Appendix L, page 90, for a breakdown of licensed, registered, and certified staff at the three parent facilities.

As a result of MDOC's failure to verify licensures, registrations, and certifications, during the period of review Wexford employed medical staff without proper credentials to provide medical care to state inmates.

Insufficient Orientation/Training of Temporary Nursing Staff

Although Wexford has an orientation program in place for newly hired full-time medical staff, MDOC did not require in contract that Wexford provide temporary nursing staff with basic orientation relative to provision of medical care in a correctional environment.

NCCHC standards state, “All health staff receive an immediate basic orientation and all full-time staff complete a formal in-depth orientation to the health services program.”

NCCHC defines *basic orientation* as orientation provided on the first day of employment to include information needed for the health staff member to function safely in the institution. NCCHC defines *in-depth orientation* as orientation provided to fully familiarize the health staff member with the health services delivery system at the facility and it focuses on the similarities as well as the differences between providing health care in the community and in the correctional setting.

Wexford’s policy and procedures state, “Wexford requires that all newly employed health service staff be oriented to the facility and their job responsibilities, beginning at the time of their employment.” Wexford requires all of its employees to receive basic training on the first day of employment that includes information such as security procedures and the emergency response plan. Within ninety days of employment, Wexford employees receive in-depth training that includes topics such as inmate classification and age- and health-specific needs of an inmate population.

During the period of review, CMCF utilized agency nurses without any orientation or training in providing health care in a correctional environment.

Although Wexford provides both basic and in-depth orientation and training for its newly hired full-time employees, agency nurses do not receive the same type of training regarding the correctional environment. “Agency nurses” work for other employers and are assigned to Wexford on an as-needed basis when staffing shortages occur. Agency nurses work varying schedules and may only work one day at a facility.

During the period of review, Central Mississippi Correctional Facility was the only facility that utilized agency nurses. According to the Director of Nursing at CMCF, the agency nurses utilized by CMCF during that period worked without any orientation or training in providing health care in a correctional environment.

MDOC did not require in the contract with Wexford, or through its departmental policies and procedures, that all

agency nurses receive basic orientation regarding provision of medical care in a correctional environment. This could result in a decrease in the quality of inmate care because the agency nurses are not familiar with the inmates and type of care they need. Also, this practice could present a security risk to inmates and staff.

No Collection of Liquidated Damages for Staffing Shortages

Although as of June 30, 2007, the MDOC Chief Medical Officer had recommended assessment of over \$1 million in liquidated damages, of which \$931,310 was incurred due to staffing shortages, MDOC management has not formally assessed or collected any liquidated damages from Wexford to recoup state funds paid for staffing that was not provided.

According to MDOC's Chief Medical Officer, MDOC monitors Wexford staffing levels through staffing reports submitted to the MDOC Chief Medical Officer by the MDOC Health Service Administrator (HSA). The HSA acts as a liaison between Wexford and the MDOC Chief Medical Officer. The HSA is responsible for compiling staffing reports by using Wexford's Employee Register Report, Vacancy Report, and Bi-weekly Hours Report and submitting the specified staffing reports upon request of the Chief Medical Officer. The HSA also assists with compliance monitoring of the contractor's medical staff.

The MDOC Commissioner ultimately has the responsibility of formally assessing and collecting all staffing liquidated damages.

Upon reviewing the staffing reports for each quarter, the MDOC HSA may recommend liquidated damages that may be assessed and submits these recommendations to the MDOC Chief Medical Officer for review. The Chief Medical Officer prepares quarterly reports that include staffing level shortages at the three parent facilities and submits the quarterly reports to the MDOC Commissioner for review. The MDOC Commissioner ultimately has the responsibility of formally assessing and collecting all staffing liquidated damages.

MDOC extended Wexford a grace period for the first six months of the medical services contract (July 1, 2006, through December 31, 2006). This was intended as a transition period for Wexford and to allow MDOC to monitor Wexford's staffing shortages, providing feedback to Wexford management to allow the contractor to correct staffing shortages before becoming subject to liquidated damages.

According to MDOC's contract with Wexford, MDOC was able to formally assess and collect liquidated damages for noncompliance with contract requirements as of January 1, 2007. As of June 30, 2007, the Chief Medical Officer had recommended \$1,152,810 in liquidated damages for noncompliance with contract standards. Of this total,

\$931,310 was related to staffing shortages. Exhibit 9 on page 61 contains a breakdown by facility and by quarter of staffing liquidated damages due to staffing shortages that were recommended to MDOC management between January 1, 2007, and June 30, 2007.

Because of the method specified in contract for assessing liquidated damages due to staffing shortages, actual staffing shortages at the facilities could be even greater than those reflected in the quarterly reports.

Because of the method specified in contract for assessing liquidated damages due to staffing shortages, actual staffing shortages at the facilities could be even greater than those reflected in the quarterly reports (see Exhibit 8, page 54). As noted on page 53, in the contract, MDOC set minimum required FTE staffing levels for each parent facility by medical position. If Wexford falls below the medical services contract specified minimum staffing level, then Wexford is subject to liquidated damages. The current assessment method for liquidated damages in the contract allows Wexford to have a position vacant for ninety days before Wexford must reimburse MDOC for that position. The MDOC Chief Medical Officer recommends liquidated damages for staffing based on the standard hourly rate for the vacant position in excess of ninety days that the position remained vacant. The recommended liquidated damages are calculated on a quarterly basis.

Because MDOC's contract does not require that MDOC recommend staffing liquidated damages on a daily basis, Wexford is allowed to keep a staffing position paid for by MDOC open for 89 days without having to have an individual in the position providing any type of medical care.

Because MDOC management has not formally assessed and collected the MDOC Chief Medical Officer's recommended staffing liquidated damages from the contractor, Wexford is not being held accountable for noncompliance with contract standards in regard to maintaining adequate levels of qualified staff to provide medical services to state inmates. Also, MDOC has not recouped state funds paid for staffing that was not provided.

Exhibit 9: Liquidated Damages Recommended by the MDOC Chief Medical Officer for Staffing Shortages between January 1, 2007, and June 30, 2007

	Central Mississippi Correctional Facility	South Mississippi Correctional Institution	Mississippi State Penitentiary	Total Staffing Liquidated Damages
1 st Quarter Staffing Liquidated Damages Recommended	\$148,709.74	\$46,512.49	\$298,908.82	\$494,131.05
2 nd Quarter Staffing Liquidated Damages Recommended	\$143,651.07	\$45,493.87	\$248,034.02	\$437,178.96
Total Staffing Liquidated Damages January-June 2007	\$292,360.81	\$92,006.36	\$546,942.84	\$931,310.01

SOURCE: MDOC's first and second quarter staffing reports for 2007.

Issues with Quality Assurance for Contract Compliance and Recordkeeping

During the period of review, neither MDOC nor Wexford had a quality assurance program for contract compliance that ensured timely access and continuity of medical care through accurate and appropriate medical recordkeeping.

ACA defines *quality assurance* as:

. . .a formal, internal monitoring program that uses standardized criteria to ensure quality and consistency. The program identifies opportunities for improvement, develops improvement strategies, and monitors their effectiveness.

A major part of a correctional quality assurance program is ensuring that accurate medical records are maintained at all correctional facilities.

While reviewing inmate medical records in order to determine the overall quality of medical care, PEER identified several operational issues associated with the way medical records are maintained at the three parent correctional facilities. PEER also noted a lack of overall quality assurance programs in place at both MDOC and Wexford. The major areas of concern associated with quality assurance and medical recordkeeping include:

- neither MDOC nor Wexford has an effective quality assurance process;

- significant percentages of inmates' medical records lack critical medical information; and,
- no assurance of confidentiality exists in the transport of inmates' medical records.

No Effective Quality Assurance Programs for Contract Compliance

MDOC has not included a formal quality assurance program in the Wexford medical services contract to ensure that Wexford is held accountable for meeting established contract compliance standards.

Under the Wexford medical services contract, Wexford is responsible for meeting certain compliance standards for medical care as discussed on pages 11 through 25. In order to monitor contract compliance, MDOC requires Wexford to submit electronically daily, weekly, monthly and/or quarterly reports for specified medical areas within the medical services contract, such as inmate intake, sick call, dental, and mental health reports. However, MDOC did not require in contract that Wexford develop a quality assurance program that ensures that all reports submitted are accurate, correct, and contain all medical information needed to determine contract compliance.

PEER reviewed the overall quality assurance process for both Wexford and MDOC to determine whether either has an acceptable means of ensuring that all state inmates receive adequate and timely access to medical care.

Wexford's Quality Assurance

Wexford does not have a quality assurance plan in place that ensures that the MDOC Health Service Administrator receives accurate medical compliance data from Wexford's databases to use in conducting compliance audits.

According to MDOC's contract with Wexford, Wexford is required to submit medical reports to MDOC within the time periods specified in contract. However, Wexford does not have a quality assurance program that ensures MDOC that the information submitted by Wexford is accurate.

ACA standards require that "a system of documented internal reviews be developed and implemented by the health authority." Both ACA and NCCHC standards, as well as MDOC's policies and procedures, designate the contractor as the "health authority." ACA standards also require eleven items to be documented as part of internal reviews.

PEER noted three necessary elements of quality assurance not included by Wexford to ensure quality of data submitted to MDOC Health Service Administrators at the three parent facilities. These elements include:

- collecting, trending, and analyzing of data combined with planning, intervening, and reassessing;
- evaluating defined data, which would result in more effective access, improved quality of care, and better utilization of resources; and,
- on-site monitoring of health service outcomes on a regular basis.

Following are two notable examples of Wexford's lack of quality assurance during the review period.

- PEER noted missing mental health log sheets at SMCI. Wexford did not have any mental health logs between January 1, 2007, and May 31, 2007, for mental health. Without source data, Wexford cannot assure MDOC that all required mental health care is performed in a timely manner.
- PEER requested all electronic databases between January 1, 2007, and May 31, 2007, for sick call and chronic care at CMCF, SMCI, and MSP. The sick call database submitted by Wexford to the MDOC Health Service Administrator at SMCI showed a total of 2,820 sick call requests at SMCI during this period. However, PEER reviewed the Wexford logs and found 8,308 sick calls were actually submitted during this period--66% more than was reported in the Wexford database. Also, the sick call database submitted by Wexford to the MDOC Health Service Administrator at CMCF showed a total of 4,033 sick call requests. PEER reviewed the Wexford logs and found 6,349 sick call requests were submitted during this period--36% more than was reported in the Wexford database.

As a result of Wexford's not having a quality assurance program in place that ensures accurate and correct data is being submitted, MDOC is not able to monitor with any degree of assurance the contractor's compliance for timely access with requirements for medical care for sick call, dental, mental health, and other medical areas.

Also, the possibility exists that Wexford could submit data that it as the vendor wants MDOC to audit for compliance purposes, while omitting data that does not comply with

contract standards, NCCHC standards, or ACA standards and therefore possibly subject to liquidated damages.

MDOC's Quality Assurance

MDOC did not establish in its contract with Wexford a formal audit methodology that utilizes confidence levels and compliance ranges and includes all contracted medical service areas. Therefore, MDOC cannot ensure that all state inmates receive timely access to quality medical care.

Under MDOC's contract with Wexford, MDOC uses a randomized audit methodology for monitoring contract compliance. However, MDOC relies entirely on Wexford databases submitted for all required medical compliance information established in contract, instead of reviewing all the source data such as medical logs at each facility. As stated on page 62, these databases submitted by Wexford do not go through a system of quality controls or checks for accuracy by Wexford and thus should not be considered reliable sets of data.

MDOC relies entirely on Wexford's databases submitted for all medical compliance information required by contract, instead of reviewing source data such as medical logs at each facility.

From these Wexford databases, MDOC picks every fifth inmate name up to a maximum of fifty inmates per audit area (e. g., sick call, dental, mental health). MDOC reviews the medical records of the selected inmates and measures the compliance components established in contract to determine whether Wexford is meeting contract requirements. As noted previously, each facility must meet at least an 85% compliance percentage per audit area. If a facility falls below the 85% compliance rate, then the contractor is subject to liquidated damages.

PEER determined the following problems with the audit methodology of MDOC.

- MDOC has not established an audit plan that incorporates confidence levels of assurance into the compliance audit and thus cannot be sure of any of the audit results.
- MDOC relies on Wexford to submit databases to develop a sample pool, which is not a reliable source of data because no quality assurance program exists for Wexford's databases.
- MDOC only audits fifty medical records per audit area and thus cannot ensure that a representative sample is being performed.
- MDOC does not audit every medical service provided by Wexford, such as chronic care. As noted on page 26, chronic care is not even

addressed in the medical services contract. Thus MDOC cannot ensure all inmates receive timely access to medical care.

As a result of not having a formal audit methodology, MDOC cannot accurately make contract compliance decisions with any level of confidence nor is MDOC able ensure that Wexford is providing all state inmates with timely access to quality medical care. Also, MDOC is not able to assess liquidated damages accurately for failure to meet contract compliance standards, because MDOC does not know if the data received from Wexford is even accurate. Therefore, money owed to the state for Wexford's failure to meet contract compliance may not be assessed and collected.

Significant Percentages of Indeterminate Medical Records

Wexford does not have a quality assurance program in place that ensures that all medical records are accurate and can be used to make timely decisions in regard to state inmates' medical care.

As discussed on pages 11 through 36 of this report, PEER reviewed medical records for routine care and chronic care at CMCF, SMCI, and MSP between January 1, 2007, and May 31, 2007. As part of the chronic care review, PEER attempted to review the inmates' medical records for mental health care, but was unable to due to missing mental health record information (e. g., missing mental health referral dates, medication dates, and mental health logs). Also, of the mental health records PEER did attempt to audit, the mental health records were mixed with regular medical records, making it difficult to determine which records were for mental health care and which records were routine medical care records.

PEER noted numerous inmate medical records that were missing critical medical information needed to make timely medical care decisions.

Wexford does not have a quality assurance program in place that ensures that physicians, nurses, dentists, and psychiatrists are properly documenting all critical medical information in inmates' medical records. PEER noted numerous inmate medical records that were missing critical medical information such as appointment dates, facility locations, times, physician signatures, chronic care treatment plans, chronic care follow-up visit notations, two-year dental prophylaxis notations, and other information needed to make timely medical care decisions.

As a result of not having a quality assurance program in place that ensures that all medical records are properly documented with critical information needed to make medical decisions, Wexford cannot ensure that inmates are receiving adequate and timely access to medical care. Exhibit 10, page 66, illustrates the percentage of

indeterminate records for each medical area PEER reviewed during the period of January 1, 2007, through May 31, 2007.

Exhibit 10: Percentages of Medical Records PEER Considered to be Indeterminate for the Period January 1, 2007, through May 31, 2007

	Central Mississippi Correctional Facility	South Mississippi Correctional Institution	Mississippi State Penitentiary
Inmate intake	0%	0%	0%
Sick call 24 hour triage	3.2%	2.5%	14.9%
Sick call 7 day physician visit	19.4%	4.2%	22.1%
2-Year dental prophylaxis	5.9%	14.6%	4.2%
Chronic care visit within 6 months	26.5%	18.6%	18.6%
Physician notation of referral for chronic care visit within 6 months	14.2%	1.7%	2.0%
Notation of chronic care medication treatment plan	14.2%	1.7%	0%

SOURCE: PEER analysis of MDOC and Wexford indeterminate records.

Transportation of and Controlled Access to Medical Records

Wexford does not maintain confidentiality of inmates' medical records by ensuring that all medical records and medications are sealed at the time of inmate transport from one correctional facility to another.

Regarding transportation of and controlled access to medical records, MDOC policy states:

It is the policy of the Mississippi Department of Corrections (MDOC) to ensure responsibility of all at MDOC and its contract workers the confidentiality of all inmate medical records. When an inmate is transported to a medical/surgical specialist or transferred to another location, all medical documentation will be sealed in an envelope marked CONFIDENTIAL HEALTH INFORMATION.

NCCHC standards state:

The confidentiality of a patient's written or electronic health record, as well as verbally conveyed health information, is maintained. If health records are transported by non-health staff, the records are sealed.

Inmates in the state correctional system are frequently transferred from one correctional facility to another correctional facility during their time of incarceration. Whenever an inmate leaves one facility and is transferred to another facility, the inmate's medical records and all current medications must follow the inmate.

Under the department's current system, both MDOC and Wexford are breaching confidentiality of medical records, which is in direct violation of both agency policy and national standards.

When the department transfers an inmate from one facility to another, Wexford medical personnel at the transferring facility complete an American Correctional Association (ACA) intra-system transfer form which lists all of the inmate's current medications, the dosages, the last time the medication was taken by the inmate, and the amount of medication being transferred. The transfer form also lists the current medical conditions of the inmate. Once the inmate arrives at the facility to which he or she is being transferred, medical personnel at the receiving facility review the inmate's medical records and take custody of any medications.

Contrary to MDOC policies, Wexford medical personnel do not place and seal inmates' medical records and medications in boxes or envelopes prior to an inmate's transfer to another facility. MDOC security officers typically carry inmates' medical records without any type of special packaging and protective seal. In addition, medications for inmates being transferred are transported in mesh bags with no security measures to ensure that the contents of the bags are not tampered with or lost.

Under the department's current system, both MDOC and Wexford are breaching confidentiality of medical records, which is in direct violation of both agency policy and national standards. Also, by failing to secure all medical records and medications, the possibility exists that health record information could be shared or lost in route. Also, medications could be lost, stolen, or sold on the bus in route to the facility to which the inmate is being transported.

MDOC's FY 2007 Medical Expenditures

MDOC spent approximately \$42.8 million for inmate medical care in FY 2007, approximately \$1.1 million more than it would have expended for Wexford's turnkey proposal to provide comprehensive medical services to inmates and approximately \$2.8 million more than its FY 2007 appropriation for medical services.

As noted on page 7, in contemplating the provision of inmate medical services for future years, the Department of Corrections considered three possible models for providing medical care to inmates:

- providing all medical care to inmates through use of state employees;
- contracting with a provider for comprehensive medical care ("turnkey" approach), with the department having only oversight responsibilities; and,
- a combination of the two, with a contractor assuming responsibility for medical care rendered inside institutions and the department having responsibility for specialty care rendered outside of institutions.

As stated on page 8, although Wexford submitted a turnkey proposal in the amount of \$41.7 million per year, the department chose the combination approach and entered into a contract with Wexford to provide routine medical care for approximately \$30 million for FY 2007. (Exhibit 11, page 69, shows a comparison of the covered medical services, responsibilities, and costs of Wexford's turnkey and combination models.) The department based financial terms of the contract on an inmate per diem rate and an estimated average daily population of 14,300 inmates in FY 2007. MDOC's FY 2007 actual average daily population for the facilities for which Wexford provides medical care was 13,758.

As shown in Exhibit 11, MDOC's actual expenditures for inmate medical care for FY 2007 were approximately \$42.8 million. In addition to paying Wexford approximately \$30 million for providing routine medical care, the department incurred expenses of approximately \$12.8 million for providing specialty medical care for inmates. By rejecting Wexford's turnkey proposal and opting to use the combination model, the department expended approximately \$42.8 million, or about \$1.1 million more than it would have if the department had accepted Wexford's turnkey proposal.

Exhibit 11: Comparison of Covered Medical Services, Responsibilities, and Costs of the Turnkey and Combination Models for Providing Inmate Medical Care, FY 2007

Service Model	Wexford's Responsibilities		MDOC's Responsibilities		Total Cost (in millions) *
	Services	Subtotal (in millions)*	Services	Subtotal (in millions)*	
Wexford's Turnkey Proposal	All medical services including inpatient hospitalization, outpatient services, utilization review, and medical claims	\$41.7	None		\$41.7
Current Contract with Wexford (Combination Model)	All basic services for routine, chronic, dental, and some specialty care services**	\$30.0	Some specialty care,*** inpatient hospitalization, outpatient services, utilization review, and medical claims	\$12.8	\$42.8
	<i>Difference</i> \$11.7			<i>Difference</i>	\$1.1

*Dollar amounts are approximate, rounded amounts for FY 2007.

**According to the contract, Wexford must provide the following specialty care through its chronic care clinics: optometry, radiology, dialysis, audiology, and care for sexually transmitted diseases, HIV/AIDS, and tuberculosis.

***According to the contract, MDOC is financially responsible for all other specialty care services for state inmates off site.

Terms According to Contract:

Routine Care--consists of any non-emergent medical or dental care than can be completed on-site at one of the three parent facilities without consulting a specialist.

Chronic Care--consists of any non-emergent medical care, including mental health care, that can be treated on site. The ACA defines this type of care as health care provided over a long period to those patients who suffer from long-term health conditions or illnesses. The NCCHC defines a chronic illness as a condition that affects an individual's well-being for an extended interval, usually at least six months, and generally is not curable, but can be managed to provide optimum functioning within any limitations the condition imposes on the individual.

Specialty Care--consists of any medical care that requires a specialist (such as a cardiologist or ophthalmologist) and may be completed on- or off-site, depending on whether Wexford or MDOC is responsible for treatment.

SOURCE: DFA, MDOC, and State Personnel Board records.

MDOC's FY 2007 appropriation bill had included spending authority for \$40,011,620 to operate the department's medical services program. In spending \$42.8 million on medical services, the department exceeded its FY 2007 spending authority by approximately \$2.8 million, as shown below:

\$ 30 million*	amount MDOC spent for contract with Wexford for routine inmate medical care
+12.8 million	amount MDOC spent beyond the contract for inmate specialty medical care
\$42.8 million	total amount MDOC spent in FY 2007 for inmate medical care
-40.0 million	amount of MDOC's spending authority for inmate medical care
\$2.8 million	amount by which MDOC's inmate medical care expenditures exceeded FY 2007 spending authority

*Dollar amounts are approximate, rounded amounts for FY 2007.

The department either underestimated the costs of specialty care or failed to monitor specialty care expenses during FY 2007.

The department either underestimated the costs of specialty care or failed to monitor specialty care expenses associated during FY 2007.

According to staff of the Department of Finance and Administration, as of October 3, 2007, MDOC had exceeded its total FY 2007 spending authority by approximately \$5.2 million, with \$2.8 million of that amount attributable to medical services. To cover the \$5.2 million that it overspent during FY 2007, the department used a portion of its FY 2008 appropriation. This practice violates MISS. CODE ANN. Section 27-104-25 (1972), which states that an agency may pay a claim from a prior fiscal year if the claim is presented within one year, if the claim does not cause the agency to exceed its prior year's appropriation bill, and if sufficient funds remain in the current year's allotment—i. e., appropriation amount—to pay the claim. Because the department had a balance of \$1.7 million remaining from its FY 2007 appropriation, the department did not have sufficient funds remaining to offset the \$5.2 million that it overspent in FY 2007.

MDOC's Deputy Commissioner for Administration and Finance told PEER that the law required the department to pay the medical expenses of state inmates. Thus, although a portion of these expenditures caused the department to

exceed its FY 2007 spending authority, the department paid these expenditures with its FY 2008 funds to satisfy this legal obligation. PEER knows of no provision of law that exempts MDOC from statutes proscribing the conditions under which deficit spending may occur.

PEER knows of no provision of law that exempts MDOC from statutes proscribing the conditions under which deficit spending may occur.

Since MDOC has violated state law governing FY 2007 expenditures with lapsed money, the department has reduced its available budgeted funds by at least \$3.5 million for FY 2008. Thus, MDOC may not have sufficient funding to procure all necessary services and supplies for its programs without a deficit appropriation for FY 2009 or violating the law for paying FY 2008 expenditures with FY 2009 funds.

At this time, PEER is not certain as to whether there will be other claims for services rendered for the department in FY 2007. Strictly speaking, CODE Section 27-104-25 (1972) would require vendors of such services to proceed against the executive director of the agency or the business manager for the amounts incurred in excess of the agency's spending authority. While not mentioned in the section, PEER does not believe that this law would preclude the Legislature from approving a deficit appropriation during the 2008 session to pay the additional expenses incurred in FY 2007. Funds expended contrary to law should still be the subject of an investigation by the State Auditor with possible action following to recover any funds expended in violation of law.

Recommendations

Amendments to Inmate Medical Services Contract

1. The Mississippi Department of Corrections staff should seek to amend the department's medical services contract to require Wexford to:
 - use a uniform method (such as a date stamp) by which qualified personnel document the date of receipt of inmates' sick call requests and the date on which such sick call requests are triaged. Documentation should include verification by the initials or signature of the person receiving the request or conducting triage;
 - document the required two-year dental prophylaxis in an inmate's dental records;
 - provide a system of chronic medical care for inmates, incorporating standards of the American Correctional Association and National Commission on Correctional Health Care for inmates' chronic medical care;
 - establish in writing acceptable time frames for submitting specialty consult requests to MDOC's Office of Specialty Care. For those consult requests that fall outside the acceptable time frame, Wexford should include notations on the inmate's medical record regarding the status of the request and an explanation of the delay;
 - segregate mental health records within an inmate's medical records by use of a separate tab;
 - develop and utilize a uniform management information system for logging chronic and mental health care, including, at a minimum, inmate name and number, facility location, date, type of condition;
 - design and implement a computerized management information system that allows staff at all of the correctional facilities the capability to track and monitor inmates' chronic care and mental health appointments;

- submit to MDOC for review and final approval the names of all potential medical staff, accompanied by evidence of professional licensure, certification, and/or registration prior to their employment; and,
- secure all health records in sealed boxes and all medications in sealed envelopes prior to the transfer of inmates among correctional facilities. Also, the contract should require Wexford health care staff and MDOC transportation officers to sign off on the transfer record that lists all the medications the inmate has en route, the number of pills en route, and the number of doses en route. Upon arrival at the receiving correctional facility, Wexford health care staff should inventory the contents of the inmate's medication envelope to ensure that the contents reconcile with those listed on the transfer record.

Routine Medical Care for Inmates

2. The Mississippi Department of Corrections staff should ensure that Wexford conducts triage seven days a week at all correctional facilities as is presently required in the contract.

Specialty Medical Care for Inmates

3. The Mississippi Department of Corrections staff should develop and adhere to written timeliness standards for monitoring the actions that the department should take during the portion of the specialty care process that is within the parameters of the department's responsibility. For example, MDOC should establish an acceptable time frame for reviewing consult requests upon receipt from the contractor and scheduling specialty appointments and surgeries. Then, for those consult requests that fall outside the acceptable time frame, MDOC should include notations on the inmate's medical record regarding the status of the request and an explanation of the delay.
4. MDOC should create a management information system accessible to medical and dental providers and directors at Central Mississippi Correctional Facility, South Mississippi Correctional Institution, and

Mississippi State Penitentiary. This system should incorporate action standards for the completion, submission, receipt, and review of consult requests and the scheduling of appointments and surgeries, and should trigger an alert to responsible personnel if the status of an inmate's case is not checked within a reasonable time frame, as established by Wexford and MDOC in their timeliness standards. These standards should account for the possibility of Wexford's or MDOC's need to obtain additional information before making decisions regarding the request and the response time needed for such, as well as the department's prioritization of requests.

Issues with Medical Staffing

5. Wexford should periodically provide MDOC staff with documentation of its formal recruitment plan to attract and retain appropriately licensed health care staff.
6. MDOC should require Wexford to develop a strategy for ensuring that all agency nurses employed at one of the state's correctional facilities receive basic orientation regarding provision of medical care in a correctional environment prior to assuming their duties.

Issues with Quality Assurance for Contract Compliance and Recordkeeping

7. For purposes of ensuring compliance with contractual requirements, MDOC should require Wexford to design and implement a verifiable management information system that ensures that reports submitted by Wexford to MDOC accurately reflect information recorded on source documents--e. g., sick call logs, chronic care logs.
8. MDOC should ensure that Wexford provides all necessary medical services and maintains all medical record documentation as required in its inmate medical services contract with the department. Also, in order to determine Wexford's compliance with contract provisions, MDOC should develop a formal audit methodology that includes appropriate statistical sampling to allow the department to extrapolate the sample results to the entire population.

MDOC's FY 2007 Medical Expenditures

9. MDOC should make formal demand to Wexford for the collection of liquidated damages provided for in the contract for failing to adhere to contractual requirements.
10. The State Auditor should investigate the department's overspending of its FY 2007 medical services appropriation and consider taking any necessary collection actions against MDOC personnel.

Appendix A: Population Sizes, Calculated Sample Sizes, and Actual Sample Sizes, for all Three Parent Facilities Combined, January 1, 2007, through May 31, 2007

	Population Size	Calculated Sample Size	Actual Sample Size	Non-Audited Visit Records
Newly Admitted Inmates	1,575	314	313	1
Sick Calls	25,945	365	365	0
Dental	373	187	187	0
Psychiatric Referrals*	893	298	Non-audited	298
Specialty Care**	1,580	316	222	94
Chronic Care***	3,120	342	254	88
Total	33,486	1,822	1,341	481

*Because the mental health visit records with psychiatric referral information were combined with the regular medical visit record information, PEER concluded that the medical records with this visit information were not auditable.

**The sample size for specialty care was reduced due to excluding emergency room visits and follow-up specialty care appointments.

***The sample size for chronic care was reduced due to the movement of inmates and the transfer of inmates to a facility that was not one of the three parent facilities.

NOTE: The number of medical care visit records for each category is greater than the number of inmates represented, since this number includes multiple visits of some inmates.

SOURCE: PEER analysis of MDOC inmates' medical records.

Appendix B: Compliance Rates and Ranges for all Three Parent Facilities Combined, January 1, 2007, through May 31, 2007

Inmate Intake

	Documentation of Medical Service Process	Initial Health Assessment	Initial Dental Screening	Dental Exam	Psychiatric/Mental Health Screening
Sample Size	313	313	313	313	313
# in Compliance	274	313	305	312	307
Compliance Rate	88%	100%	97%	99.7%	98%
Error Rate	5%	5%	5%	5%	5%
Range of Compliance	83-93%	95-100%	92-100%	95-100%	93-100%

Sick Call

	Triage	7-day
Sample Size	365	365
# in Compliance	122	192
Indeterminate Records	21	57
Compliance Rate	33%	53%
Compliance Rate (best case)*	41%	68%
Error Rate	5%	5%
Range of Compliance	28-38%	48-58%
Range of Compliance (best case)*	36-46%	63-73%

Dental Prophylaxis

Sample Size	187
# in Compliance	40
Indeterminate Records	14
Compliance Rate	41%
Compliance Rate (best case)*	48%
Error Rate	5%
Range of Compliance	36-46%
Range of Compliance (best case)*	43-53%

*Includes all indeterminate records as if they were compliant.

NOTE: The number of medical care visit records for each category is greater than the number of inmates represented, since this number includes multiple visits of some inmates.

SOURCE: PEER analysis of MDOC inmates' medical records.

Appendix C: Compliance Percentages for Inmate Intake, by Parent Facility

	Inmates' Understanding of Access to Medical Care	Initial Health Assessment within One Month of Intake	Initial Dental Screening within 7 Calendar Days of Intake	Dental Exam within One Month of Intake	Psychiatric/ Mental Health Screening within 5 Days of Intake
Central Mississippi Correctional Facility	84%	100%	98%	100%	96%
South Mississippi Correctional Institution	92%	100%	97%	100%	100%
Mississippi State Penitentiary	86%	100%	97%	99%	98%
Overall Compliance Percentage	88%	100%	97%	99.7%	98%

NOTES: All intake of state inmates into the state correctional system occurs at Central Mississippi Correctional Facility. Inmates are then transferred to other state, regional, and private facilities. The table above shows a breakdown of the compliance percentages for the inmates' medical records that were reviewed at each parent facility during the review period of January 1, 2007, through May 31, 2007.

The MDOC/Wexford medical services contract requires an 85% compliance rate for all inmate intake medical service requirements between January 1, 2007, and June 30, 2007.

SOURCE: PEER analysis of MDOC inmates' medical records.

Appendix D: Compliance Percentages for Sick Call Triage, by Parent Facility

	Central Mississippi Correctional Facility	South Mississippi Correctional Institution	Mississippi State Penitentiary	Overall Compliance Percentage for All 3 Parent Facilities
Sick Call Triage Compliance	38%	36%	29%	33%
Sick Call Triage Noncompliance	59%	62%	56%	59%
Sick Call Triage Indeterminate	3%	2%	15%	8%
Total	100%	100%	100%	100%

NOTES: Sick call triage is the screening and classification of inmates' health care concerns to determine the priority of need and the appropriate level of intervention.

The MDOC/Wexford medical services contract requires an 85% compliance rate between January 1, 2007, and June 30, 2007. In order to be considered compliant, the sick call request must be picked up daily from the inmates and triaged within twenty-four hours of the receipt.

Indeterminate records are records that PEER could not determine as being either compliant or noncompliant. These records existed because inmates re-entered the system and old records did not follow them, lack of dates on sick call forms, and/or inmate medical records could not be located at the time of review.

SOURCE: PEER analysis of MDOC inmates' medical records.

Appendix E: Compliance Percentages for Sick Call 7-Day Physician Visit, by Parent Facility

	Central Mississippi Correctional Facility	South Mississippi Correctional Institution	Mississippi State Penitentiary	Overall Compliance Percentage for All 3 Parent Facilities
Sick Call 7-Day Compliance	49%	66%	45%	53%
Sick Call 7-Day Noncompliance	32%	30%	33%	32%
Sick Call 7-Day Indeterminate	19%	4%	22%	15%
Total	100%	100%	100%	100%

NOTES: If an inmate’s medical condition warrants seeing a physician and the inmate cannot be treated by a nurse, then the inmate is required to see a physician within seven calendar days of the original sick call complaint.

The MDOC/Wexford medical services contract requires an 85% compliance rate for seven-day physician visits between January 1, 2007, and June 30, 2007.

Indeterminate records are records that PEER could not determine as being either compliant or noncompliant. These records existed because inmates re-entered the system and old records did not follow them, lack of dates on sick call forms, and/or inmate medical records could not be located at the time of review.

SOURCE: PEER analysis of MDOC inmates’ medical records.

Appendix F: Compliance Percentages for 2-Year Dental Prophylaxis, by Parent Facility

	Central Mississippi Correctional Facility	South Mississippi Correctional Institution	Mississippi State Penitentiary	Overall Compliance Percentage for All 3 Parent Facilities
2 Year Dental Prophylaxis Compliance	60%	27%	31%	41%
2 Year Dental Prophylaxis Noncompliance	34%	58%	65%	52%
2 Year Dental Prophylaxis Indeterminate	6%	15%	4%	7%
Total	100%	100%	100%	100%

NOTE: Every two years an inmate is required by the medical services contract to have a dental prophylaxis. A dental prophylaxis is a basic dental cleaning performed by the dentist.

MDOC/Wexford medical services contract requires an 85% compliance rate for two-year dental prophylaxis visits between January 1, 2007, and June 30, 2007.

Indeterminate records are records that PEER could not determine as being either compliant or noncompliant. These records existed because of a lack of dates for initial dental prophylaxis on dental forms.

SOURCE: PEER analysis of MDOC inmates' medical records.

Appendix G: Compliance Rates and Ranges for Chronic Care, for all Three Parent Facilities Combined

	Visits	Treatment Plan	6-month Follow-up
Sample Size	254	254	254
# in Compliance	150	217	193
Indeterminate Records	55	15	17
Compliance Rate	59%	85%	76%
Compliance Rate (best case)*	81%	91%	83%
Error Rate	6%	6%	6%
Range of Compliance	53-65%	79-91%	70-82%
Range of Compliance (best case)*	75-87%	85-97%	77-87%

*Includes all indeterminate records as if they were compliant.

SOURCE: PEER analysis of MDOC inmates' medical records.

Appendix H: Compliance Percentages for Chronic Care 6-Month Visit, by Parent Facility

	Central Mississippi Correctional Facility	South Mississippi Correctional Institution	Mississippi State Penitentiary	Overall Compliance Percentage for All 3 Parent Facilities
Chronic Care 6-Month Visit Compliance	47%	76%	61%	59%
Chronic Care 6-Month Visit Noncompliance	27%	5%	21%	19%
Chronic Care 6-Month Visit Indeterminate	26%	19%	18%	22%
Total	100%	100%	100%	100%

NOTE: Chronic care consists of conditions such as diabetes, hypertension, HIV, tuberculosis, or seizures. Once an inmate is diagnosed with a chronic condition that requires ongoing medical attention, the inmate must visit the physician within a reasonable amount of time to re-evaluate the inmates' condition. Wexford requires a ninety-day evaluation time between chronic care visits and MDOC requires at least an annual evaluation, so PEER chose six months as a reasonable time between chronic care visits.

The MDOC/Wexford medical services contract requires an 85% compliance rate for all medical areas within the contract. However, MDOC did not include chronic care in the medical services contract, so PEER used the same 85% compliance rate that all other medical care areas are held to when determining chronic care six-month visit compliance.

Indeterminate records are records that PEER could not determine as being either compliant or noncompliant. These records existed because of missing chronic care information and missing dates for six-month chronic care visits.

SOURCE: PEER analysis of MDOC inmates' medical records.

Appendix I: Compliance Percentages for Chronic Care 6-Month Physician Referral Notation, by Parent Facility

	Central Mississippi Correctional Facility	South Mississippi Correctional Institution	Mississippi State Penitentiary	Overall Compliance Percentage for All 3 Parent Facilities
Chronic Care 6-Month Physician Referral Notation Compliance	64%	88%	80%	76%
Chronic Care 6-Month Physician Referral Notation Noncompliance	22%	10%	18%	17%
Chronic Care 6-Month Physician Referral Notation Indeterminate	14%	2%	2%	7%
Total	100%	100%	100%	100%

NOTE: Once an inmate has a chronic care visit, the attending physician is required to notate on the chronic care form in the medical records the approximate time within six months that the inmate needs to return for a follow-up visit to re-evaluate the chronic condition.

The MDOC/Wexford medical services contract requires an 85% compliance rate for all medical areas within the contract. However, MDOC did not include chronic care in the medical services contract, so PEER used the same 85% compliance rate that all other medical care areas are held to when determining chronic care six-month physician referral compliance.

Indeterminate records are records that PEER could not determine as being either compliant or noncompliant. These records existed because of missing chronic care information and because some records were mental health records.

SOURCE: PEER analysis of MDOC inmates' medical records.

Appendix J: Compliance Percentages for Chronic Care Medication Treatment Plan, by Parent Facility

	Central Mississippi Correctional Facility	South Mississippi Correctional Institution	Mississippi State Penitentiary	Overall Compliance Percentage for All 3 Parent Facilities
Chronic Care Medication Treatment Plan Compliance	84%	83%	89%	85%
Chronic Care Medication Treatment Plan Noncompliance	2%	15%	11%	9%
Chronic Care Medication Treatment Plan Indeterminate	14%	2%	0%	6%
Total	100%	100%	100%	100%

NOTES: Inmates with chronic care conditions are required by national standards and the medical services contract to have treatment plans. Because chronic conditions require different treatment plans, PEER used the two most common elements to all chronic conditions for determining compliance with treatment plans. These include the follow-up visits and medication.

The MDOC/Wexford medical services contract requires an 85% compliance rate for all medical areas within the contract. However, MDOC did not include chronic care in the medical services contract, so PEER used the same 85% compliance rate that all other medical care areas are held to when determining chronic care medication treatment plan compliance.

Indeterminate records are records that PEER could not determine as being either compliant or noncompliant. These records existed because of missing chronic care information and because some records were mental health records.

SOURCE: PEER analysis of MDOC inmates' medical records.

Appendix K: 2007 1st and 2nd Quarter Staffing Levels, by Parent Facility

PEER Report #507

CMCF 1st and 2nd Quarter Staffing Levels						
Position	Required 1st Quarter FTEs	1st Quarter Actual FTEs	1st Quarter Variance	Required 2nd Quarter FTEs	2nd Quarter Actual FTEs	2nd Quarter Variance
Physician	2.00	2.00	0.00	2.00	2.00	0.00
Site Medical Director	1.00	1.00	0.00	1.00	1.00	0.00
Site Manager	1.00	0.44	(0.56)	1.00	1.00	0.00
Medical Records Supervisor	1.00	1.00	0.00	1.00	1.00	0.00
Dentist	2.00	2.00	0.00	2.00	2.00	0.00
Dental Director	1.00	0.00	(1.00)	1.00	0.00	(1.00)
Dental Assistant	3.00	3.00	0.00	3.00	3.00	0.00
Mid-Level (PA/NP)	2.00	1.00	(1.00)	2.00	2.00	0.00
RN (Excluding Director of Nurses)	16.00	9.00	(7.00)	16.00	8.00	(8.00)
Director of Nursing	1.00	0.90	(0.10)	1.00	1.00	0.00
LPN	16.00	18.00	2.00	16.00	20.00	4.00
RN Supervisor	3.00	2.65	(0.35)	3.00	2.00	(1.00)
Central Services Manager	1.00	1.00	0.00	1.00	1.00	0.00
Nursing Assistant	1.00	1.00	0.00	1.00	1.00	0.00
Secretary / Adm. Assistant	2.00	2.00	0.00	2.00	2.00	0.00
Medical Records Clerk /HIT	4.00	4.00	0.00	4.00	4.00	0.00
Radiology Technician	1.50	1.50	0.00	1.50	1.50	0.00
Phlebotomist	3.00	3.00	0.00	3.00	3.00	0.00
Sub Total FTEs	61.50	53.49	(8.01)	61.50	55.50	(6.00)
Comprehensive Mental Health Program						
Psychiatrist	1.50	2.00	0.50	1.50	2.00	0.50
Master Mental Health Professional	2.00	1.00	(1.00)	2.00	2.00	0.00
Sub Total FTEs	3.50	3.00	(0.50)	3.50	4.00	0.50
Pharmaceutical Services						
Pharmacy Technicians	2.00	2.00	0.00	2.00	2.00	0.00
Sub Total FTEs	2.00	2.00	0.00	2.00	2.00	0.00
Total FTEs	67.00	58.49	(8.51)	67.00	61.50	(5.50)
SOURCE: MDOC Quarterly Reports for January-June 2007						
*Staffing totals are approximate, rounded totals						
**FTE=Full-time equivalent staff						

SMCI 1st and 2nd Quarter Staffing Levels						
Position	Required 1st Quarter FTEs	1st Quarter Actual FTEs	1st Quarter Variance	Required 2nd Quarter FTEs	2nd Quarter Actual FTEs	2nd Quarter Variance
Physician	0.50	1.00	0.50	0.50	0.70	0.2
Site Medical Director	1.00	1.00	0.00	1.00	1.00	0.0
Medical Records Supervisor	1.00	1.00	0.00	1.00	1.00	0.0
Dentist	1.00	1.00	0.00	1.00	1.00	0.0
Dental Assistant	2.00	1.57	(0.43)	2.00	2.00	0.0
Mid-Level (PA/NP)	2.00	1.00	(1.00)	2.00	1.01	(1.0)
RN (excluding Director of Nursing)	8.00	9.00	1.00	8.00	7.63	(0.4)
Director of Nursing/Site Manager	1.00	1.00	0.00	1.00	1.00	0.0
LPN	8.00	8.00	0.00	8.00	8.33	0.3
Nursing Assistant	4.00	4.00	0.00	4.00	3.82	(0.2)
RN Charge	1.00	1.00	0.00	1.00	1.00	0.0
Secretary/Administrative Assistant	1.00	1.00	0.00	1.00	1.00	0.0
Medical Records Clerk/HIT	2.00	2.00	0.00	2.00	2.00	0.0
Radiology Technician	1.00	1.00	0.00	1.00	1.00	0.0
Medical Supply Assistant	1.00	1.00	0.00	1.00	1.00	0.0
Phlebotomist	1.00	1.00	0.00	1.00	1.00	0.0
Sub Total	35.50	35.57	0.07	35.50	34.49	(1.0)
Comprehensive Mental Health Program						
Psychiatrist	0.50	0.13	(0.37)	0.50	0.3	(0.2)
Master Mental Health Professional	2.00	0.75	(1.25)	2.00	0.9	(1.1)
Sub Total	2.50	0.88	(1.62)	2.50	1.2	(1.3)
Pharmaceutical Services						
Pharmacy Technicians	1.00	1.00	0.00	1.00	1.0	0.0
Sub Total	1.00	1.00	0.00	1.0	1.0	0.0
TOTAL	39.00	37.45	(1.55)	39.00	36.71	(2.29)
SOURCE: MDOC Quarterly Reports for January-June 2007						
*Staffing totals are approximate, rounded totals						
**FTE=Full-time equivalent staff						

MSP 1st and 2nd Quarter Staffing Levels						
Position	Required 1st Quarter FTEs	1st Quarter Actual FTEs	1st Quarter Variance	Required 2nd Quarter FTEs	2nd Quarter Actual FTEs	2nd Quarter Variance
Physician	4.00	3.44	(0.56)	4.00	3.00	(1.00)
Site Medical Director	1.00	1.00	0.00	1.00	1.00	0.00
Medical Records Supervisor	1.00	1.00	0.00	1.00	1.00	0.00
Dentist	3.50	2.00	(1.50)	3.50	3.50	0.00
Dental Assistant	4.00	3.75	(0.25)	4.00	4.00	0.00
Mid-Level (PA/NP)	1.00	0.00	(1.00)	1.00	1.00	0.00
RN (excluding Director of Nursing)	16.00	8.50	(7.50)	16.00	11.60	(4.40)
Director of Nursing/Site Manager	1.00	1.00	0.00	1.00	1.00	0.00
Assistant Director of Nursing	1.00	1.00	0.00	1.00	1.00	0.00
LPN (To assist RN, Hospice, Medication Administration)	27.00	15.60	(11.40)	27.00	21.50	(5.50)
RN Charge	2.00	2.00	0.00	2.00	2.00	0.00
RN Supervisor	2.00	2.00	0.00	2.00	2.00	0.00
Central Services Manager	1.00	1.00	0.00	1.00	1.00	0.00
Nursing Assistant	5.00	5.00	0.00	5.00	5.00	0.00
Secretary/Administrative Assistant	3.00	4.00	1.00	3.00	4.00	1.00
Medical Records Clerk/HIT	4.00	4.00	0.00	4.00	4.00	0.00
EMT/Paramedic	4.80	3.80	(1.00)	4.80	3.80	(1.00)
Radiology Technician	2.00	2.00	0.00	2.00	2.00	0.00
Physical Therapist	0.50	0.50	0.00	0.50	0.50	0.00
Physical Therapy Assistant	0.50	0.50	0.00	0.50	0.50	0.00
Medical Supply Assistant	1.00	1.00	0.00	1.00	1.00	0.00
Laboratory Technician	2.00	2.00	0.00	2.00	2.00	0.00
Phlebotomist	1.00	1.00	0.00	1.00	1.00	0.00
Sub Total	88.30	66.09	(22.21)	88.30	77.40	(10.90)
Comprehensive Mental Health Program						
Psychiatrist	1.00	0.00	(1.00)	1.00	0.00	(1.00)
Chief Psychiatrist	1.00	1.00	0.00	1.00	1.00	0.00
Mental Health Director	1.00	0.00	(1.00)	1.00	0.00	(1.00)
Master Mental Health Professional	3.00	1.00	(2.00)	3.00	4.00	1.00
Sub Total	6.00	2.00	(4.00)	6.00	5.00	(1.00)
Pharmaceutical Services						
Pharmacist	1.00	1.00	0.00	1.00	1.00	0.00
Pharmacy Technicians	2.00	2.00	0.00	2.00	2.00	0.00
Sub Total	3.00	3.00	0.00	3.00	3.00	0.00
Total FTEs	97.30	71.09	(26.21)	97.30	85.40	(11.90)
SOURCE: MDOC Quarterly Reports for January-June 2007						
*Staffing totals are approximate, rounded totals						
**FTE=Full-time equivalent staff						

Appendix L: Number of Licensed, Registered, or Certified Medical Staff Employed by Wexford at the Three Parent Facilities Combined, As of October 29, 2007

Licensure Status By Position				
	Positions Assigned	Number Properly Licensed, Certified, or Registered	Number without Appropriate Credentials	Percentage with Appropriate Credentials
Position Titles				
Physicians	10	10	0	100.00%
Physician Assistants	1	1	0	100.00%
Psychiatrists	7	7	0	100.00%
Nurse Practitioners	7	7	0	100.00%
LPNs	135	135	0	100.00%
RNs	109	109	0	100.00%
Radiology Technicians	7	4	3	57.14%*
X-ray Technicians	1	1	0	100.00%
EMTs	6	6	0	100.00%
Pharmacists	4	4	0	100.00%
Pharmacy Technicians	5	4	1	80.00%
Dentists	9	9	0	100.00%
Dental Hygienists	1	1	0	100.00%
Dental Assistants	9	8	1	88.89%
Physical Therapists	2	2	0	100.00%
Physical Therapy Assistants	1	1	0	100.00%
Total	314	309	5	98.41%
*Percentage includes one radiology technician position at CMCF that could not be verified due to incomplete information provided by the facility.				
SOURCE: PEER analysis of MDOC and Wexford Health Sources employee register.				

Agency Response



STATE OF MISSISSIPPI

DEPARTMENT OF CORRECTIONS

CHRISTOPHER B. EPPS
COMMISSIONER

November 29, 2007

Max K. Arinder, Ph.D.
Executive Director, PEER
Post Office Box 1204
Jackson, MS 39215-1204



RE: PEER REPORT RESPONSE

Dear Dr. Arinder:

Please find attached the Mississippi Department of Corrections (MDOC) response to the Executive Summary entitled: "Medical Care for State Inmates: The MDOC Contract Management and its Provision of Specialty Medical Care".

As you know, PEER Committee rule 3.40 does not allow an agency to take the draft reports from the PEER office; which put us at a serious disadvantage in responding. Therefore, I respectfully request that I and four (4) of my Executive Staff members be allowed to testify before PEER under rule 1.53.

In conclusion, should you have any questions, please feel free to contact me at 601.359.5621.

Sincerely,

A handwritten signature in cursive script that reads "Christopher B. Epps".

Christopher B. Epps
Corrections Commissioner
State of Mississippi

CBE/aa

Pc: File

Attachments

Summary of Attachments to Commissioner's Response

As referenced in Commissioner Epps's response to this PEER Committee report, MDOC provided PEER with six exhibits as attachments to his response.

Exhibit A (48 total pages): Exhibit A is a copy of the agreement between the Mississippi Department of Corrections and Wexford Health Sources, Inc., for onsite inmate health services at Central Mississippi Correctional Facility, South Mississippi Correctional Institution, and Mississippi State Penitentiary. This agreement also includes limited responsibilities for Wexford at the eleven county regional facilities, seventeen community work centers, and for minimum security inmates residing at the three male restitution centers and the Governor's Mansion.

Exhibit B (23 pages): Exhibit B is Wexford Health Sources' plan to implement electronic medical records for the Mississippi Department of Corrections. This plan includes an assessment of all options available to the Department of Corrections and the costs associated with implementing each option into an electronic medical record system for the state correctional system.

Exhibit C (8 pages): Exhibit C is a copy of Commissioner Epps's letters on April 25, 2007, and May 15, 2007, in which the commissioner informs Wexford Health Sources of its failure to comply with the staffing requirements established in Section 7.5 of the Wexford contract. This exhibit also includes a description of recruiting incentives used to attract and retain staff at Mississippi State Penitentiary.

Exhibit D (10 pages): Exhibit D is a copy of Wexford Health Sources' FY 2007 Annual Report for the Mississippi Department of Corrections.

Exhibit E (2 pages): Exhibit E is a copy of the Mississippi Department of Corrections' agency policy 25-04-H entitled Confidentiality of Medical Records and Health Information. In this policy, the department discusses its responsibility to ensure that all inmate medical records remain confidential.

Exhibit F (1 page): Exhibit F is a copy of the Mississippi Department of Corrections' schedule restating PEER's calculation of FY 2007 medical costs.

Copies of these exhibits will be maintained on file at the PEER office for review upon request.

The Mississippi Legislature

Joint Committee on Performance Evaluation and Expenditure Review

PEER Committee

SENATORS
MERLE FLOWERS
Vice Chair
GARY JACKSON
Secretary
SAMPSON JACKSON
DEAN KIRBY
EZELL LEE
LYNN POSEY
RICHARD WHITE



REPRESENTATIVES
HARVEY MOSS
Chair
WILLIE BAILEY
ALYCE CLARKE
DIRK DEDEAUX
JOEY HUDSON
WALTER ROBINSON
RAY ROGERS

Post Office Box 1204
Jackson, Mississippi 39215-1204

Max K. Arinder, Ph. D.
Executive Director

www.peer.state.ms.us

OFFICES:
Woolfolk Building, Suite 301-A
501 North West Street
Jackson, Mississippi 39201

TELEPHONE:
(601) 359-1226

FAX:
(601) 359-1420

December 6, 2007

Mr. Christopher B. Epps
Commissioner, Department of Corrections
723 North President Street
Jackson, MS 39201

HAND DELIVERED

Dear Commissioner Epps:

I am writing in reference to your letter of December 4, 2007, requesting that you be allowed to provide testimony before the Committee in lieu of a written response to the draft report on the MDOC medical services contract. After careful consideration, and in consultation with other Committee members, I am denying your request for the proposed oral testimony for a number of reasons, not the least of which is that it may be seen as a precedent for avoiding PEER's well-established procedure for conducting an exit conference and obtaining an agency response. It is my understanding that, upon inquiry, you voiced no concerns regarding the facts presented in the report during the initial exit meeting, but made no comment on matters of perspective or agency interpretation. An agency response is not required, but if you wish to reconsider your position and write a response to the draft report clarifying the Department's position on matters addressed in the report you may certainly do so.

To make it possible for you to respond I am authorizing PEER staff to reopen the response period by making the draft report available to you in the PEER office from receipt of this letter until 5:00 PM on Sunday, December 9, 2007. Your written response must be in the PEER office by 12:00 noon on Monday, December 10, 2007, for placement in the agenda books. Please let the PEER staff know whether you wish to avail yourself of this extended response opportunity by 5:00 PM on Thursday, December 6, 2007, so staff can be available to open the office over the weekend.

The PEER Committee meeting scheduled for December 11-12, 2007, will be the last of the year and this Committee will attempt to close all pending business on those dates. As you know, the Committee that convenes in January will be a newly appointed Committee and the current Committee wishes to leave it with as clean an agenda as possible. Thank you in advance for your consideration of this matter and please contact the PEER office as described above if you will need access to the report over the weekend to assist you in drafting an agency response. If you would like, please call Max Arinder at (601) 359-1226 to discuss the matter further.

Sincerely,

A handwritten signature in cursive script that reads "Harvey Moss".

Rep. Harvey Moss, Chairman
Mississippi Joint Legislative PEER Committee

PEER Committee Staff

Max Arinder, Executive Director
James Barber, Deputy Director
Ted Booth, General Counsel

Evaluation

David Pray, Division Manager
Linda Triplett, Division Manager
Larry Whiting, Division Manager
Chad Allen
Antwyn Brown
Kim Cummins
Brian Dickerson
Lonnie Edgar
Barbara Hamilton
Matthew Holmes
Karen Land
Kevin Mayes
Sarah Resavy
Brad Rowland
Jennifer Sebren

Editing and Records

Ava Welborn, Chief Editor/Archivist and Executive Assistant
Tracy Bobo

Administration

Mary McNeill, Accounting and Office Manager
Sandra Haller
Rosana Slawson
Gale Taylor

Data Processing

Larry Landrum, Systems Analyst

Corrections Audit

Louwill Davis, Corrections Auditor