



**OFFICE OF THE LEGISLATIVE AUDITOR**  
**STATE OF MINNESOTA**

**EVALUATION REPORT**

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**Health Services in State  
Correctional Facilities**

**FEBRUARY 2014**

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PROGRAM EVALUATION DIVISION  
Centennial Building – Suite 140  
658 Cedar Street – St. Paul, MN 55155  
Telephone: 651-296-4708 • Fax: 651-296-4712  
E-mail: [auditor@state.mn.us](mailto:auditor@state.mn.us) • Web Site: <http://www.auditor.leg.state.mn.us>  
Through Minnesota Relay: 1-800-627-3529 or 7-1-1

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## Evaluation Staff

James Nobles, *Legislative Auditor*

Joel Alter  
Valerie Bombach  
Sarah Delacueva  
David Greenwood-Sanchez  
Jody Hauer  
David Kirchner  
Laura Logsdon  
Carrie Meyerhoff  
Judy Randall  
Catherine Reed  
Jodi Munson Rodriguez  
Laura Schwartz  
KJ Starr  
Jo Vos  
Valerie Were

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## OFFICE OF THE LEGISLATIVE AUDITOR

STATE OF MINNESOTA • James Nobles, Legislative Auditor

February 2014

Members of the Legislative Audit Commission:

The U.S. Constitution requires the provision of adequate health care for offenders in correctional facilities, according to various court rulings. Minnesota has one of the nation's lowest incarceration rates in its state-run prisons. But health services in Minnesota prisons represent a significant state cost, accounting for 20 percent of the state's total prison expenditures. Furthermore, these services affect the health and well-being of many individuals who will one day return to Minnesota communities.

In Spring 2013, the Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate prison-based health services. We found that the Minnesota Department of Corrections (DOC) provides extensive medical, dental, and mental health services to offenders. But there is also considerable room for improvement in the coordination of services to chronically ill inmates, the adequacy of mental health services, and DOC's compliance with generally accepted professional standards for correctional health care. In addition, DOC's medical, dental, and mental health services operate with limited external oversight—for example, they are not subject to licensure, accreditation, or review by an independent ombudsman. Our report offers a variety of recommendations for specific operational improvements, but we also think it is important to implement stronger, ongoing mechanisms for accountability and quality improvement.

Our evaluation was conducted by Joel Alter (project manager), Sarah Delacueva, and KJ Starr. The Department of Corrections and its health services contractor cooperated fully with our evaluation.

Sincerely,

A handwritten signature in black ink that reads "Jim Nobles".

James Nobles  
Legislative Auditor



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- 6.1 Services Provided or Arranged by the Department of Corrections’  
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# Summary

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**Although inmates in state-run correctional facilities have considerable access to health care, services should be more coordinated, consistent, and accountable.**

## Key Facts and Findings:

- The Minnesota Department of Corrections (DOC) provides health services to inmates through a combination of its own employees and contracted services. (p. 3)
- Inmates have considerable access to health care, although several important access issues merit attention. (p. 18)
- DOC has not established a sufficiently coordinated, comprehensive approach for managing the care of individuals with chronic conditions. (p. 37)
- The prison system's residential unit for persons with serious mental illness has increasingly provided crisis and stabilization services rather than therapeutic treatment. (p. 43)
- DOC's compliance with professional standards is mixed, with room for improvement. (pp. 59-60).
- DOC has not developed a comprehensive staffing plan for health services. (p. 91)
- Mechanisms for oversight, accountability, and quality improvement for DOC health services have been limited. (p. 73)
- DOC has not regularly obtained information that would help it ensure that the administrative costs and profits of its health services contractor are reasonable. (p. 99)

- DOC policy requires copayments in a more limited set of circumstances than indicated by Minnesota statutes. (p. 82)

## Key Recommendations:

- DOC should develop a health services staffing plan (p. 93) and strategic plan (p. 94), implement a comprehensive chronic care program (p. 40), identify ways to improve mental health services (pp. 46-57), develop clearer policies for emergencies (p. 34), and ensure that its policies conform more fully with professional standards (p. 95).
- The Legislature should improve oversight by adopting at least one of the following: (1) require DOC to license its correctional facilities, (2) require DOC to seek facility accreditation, or (3) establish a state ombudsman for corrections. (p. 74)
- The Legislature should require the departments of Health and Human Services to periodically determine the compliance with applicable state rules of DOC's specialized units providing intensive nursing or mental health services. (p. 57)
- DOC should collect information on the administrative expenditures and profits of its health services contractor. (p. 100)
- The Legislature should clarify DOC's authority to adopt exemptions to statutory copayment requirements. (p. 83)

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**Courts have held that prisoners have a constitutional right to adequate health care.**

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**The Minnesota Department of Corrections (DOC) spent \$68 million on health services for inmates in fiscal year 2013.**

## Report Summary

The Minnesota Department of Corrections (DOC) operates eight state prisons that house more than 9,000 adults. State law requires the department to provide “professional health care” to these offenders, and court cases have established the right of prisoners to adequate health care under the Eighth Amendment of the U.S. Constitution.

The department’s spending for health services in state facilities totaled \$68 million in fiscal year 2013. The department’s increases in spending in recent years largely reflected health care inflation and increases in the prison population. However, the department’s cost per inmate for health services was higher than that of most states.

Health services units in prisons are staffed by a combination of DOC and contractor employees. DOC employs nurses, mental health therapists, and dental staff, while the contractor provides doctors and psychiatrists.

**Inmates have considerable access to health care, but there is room for improvement.**

Altogether, Minnesota inmates have about 200,000 “encounters” with prison-based health care staff annually. Each facility provides daily on-site access to health care staff, and DOC’s contractor makes arrangements when inmates require off-site appointments or procedures.

While inmates have considerable access to care, DOC’s policies and services need attention in a variety of areas. For example, DOC has not established a sufficiently coordinated, comprehensive approach to managing

the care of inmates with chronic conditions, such as diabetes or asthma. The department has system-wide protocols for managing HIV, hepatitis C, and tuberculosis, but it does not have protocols for other, more common chronic illnesses. DOC facilities vary in the way they track these offenders and the frequency of chronic care visits.

Access to mental health services also varies. Compared with other offenders, inmates with mental illness spend disproportionate amounts of time assigned to units that are segregated from the rest of the prison population, where there is limited access to therapeutic mental health services. In addition, DOC operates a residential unit at the Oak Park Heights prison for offenders with serious mental illnesses, but this unit has faced challenges in providing therapeutic services in recent years. An increasing number of the unit’s residents have had behaviors that limit their ability to participate in treatment, and many require court orders allowing involuntary administration of medications.

**Service timeliness was poorer for women inmates than men.**

An important part of providing health care access is ensuring that services are timely. Consistent with DOC policy, nearly all offenders are screened within a day of their arrival at prison. DOC also requires in-depth exams within offenders’ first 30 days. In fiscal year 2013, 97 percent of initial physical examinations in men’s facilities occurred in the first month, compared with only 18 percent of physical exams for women.

Likewise, nearly all initial mental health examinations of male inmates

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**DOC’s medical and mental health services are not subject to licensing or accreditation reviews.**

occurred within the first 14 days in prison, but women’s initial mental health exams tended to be less timely. Ninety-nine percent of men’s initial dental exams occurred within the first 30 days in prison, while only about half of women’s dental exams complied with a policy requiring these exams within 120 days.

Many inmates—especially women—have prescriptions for psychotropic medications. A psychiatrist should see offenders on such medications at least every 90 days to monitor dosages and possible side effects. The percentage of women’s psychiatric appointments that occurred within 90 days of the previous one was lower than the percentage for men.

**The department does not have a health services staffing plan.**

Professional standards and DOC policies require the development of a health services “staffing plan.” This document would annually evaluate the number and type of positions needed and indicate how care would be provided if some positions are unfilled. The department’s contract with its health services vendor specifies the weekly hours of service required by contractor staff. However, DOC staff provide more hours of health care services than the contractor, and there is no system-wide staffing plan.

Some staffing issues have been a source of concern. For example, only two of the eight prisons have nurses on duty 24 hours a day, 7 days a week. Inadequate consultation with medical personnel during overnight hours may have been a contributing factor in two inmate deaths in recent years, and such issues could be considered in a staffing plan.

**Prison-based health services need additional oversight.**

It is important to ensure that prison health care is skillfully provided by DOC and its health services contractor. Care can affect the quality and duration of individuals’ lives, and lapses in care can expose the state to legal actions. Although DOC contracts for certain health care functions, the department is ultimately responsible for the health services provided to offenders in its facilities.

There is little external review of DOC’s health services. DOC’s correctional facilities are not licensed or accredited. Some DOC health care units provide services of the sort that would typically be licensed by the departments of Health or Human Services, but DOC units are not subject to such regulation. Minnesota no longer has an independent ombudsman to review inmate services and complaints. The state boards of Nursing and Medical Practices hear complaints filed by inmates about individual professionals, but these boards do not have jurisdiction to review certain types of cases.

Internal reviews of health services activities have also been insufficient. A DOC quality improvement committee was inactive for about two years, and past efforts to assess quality did not result in clear plans for improvement. A statutorily mandated DOC Peer Review Committee conducts mortality reviews following inmate deaths but does not examine quality of care in general. The mortality review reports are not public documents, and DOC has not systematically tracked implementation of recommendations from these reviews.

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**Most prisons do not have overnight health care staffing on site.**

DOC's Health Services Unit should improve its own reviews of health services activities, but it also needs outside oversight. For specialized health services programs in DOC, the Legislature should require compliance reviews by the departments of Health and Human Services. In addition, the Legislature should consider (1) requiring DOC to license its facilities, (2) requiring DOC to seek accreditation, or (3) creating a correctional ombudsman. State law requires DOC to license "all correctional facilities" in the state, but DOC has interpreted the law as not requiring licensure of its own facilities.

Oversight of DOC health services would be particularly valuable if done by health care experts, rather than by reviewers with more general backgrounds. Such expertise could come from an ombudsman with a medical review committee or an accrediting organization with specialized understanding of correctional health services.

**Some management and financial issues need DOC or legislative attention.**

DOC policy requires the department's Health Services Unit to develop measurable goals and objectives, with annual assessments of progress. The unit has not provided this type of strategic direction, nor has it systematically measured the performance of its services in achieving broad goals.

There are various areas in which DOC health services policies do not adequately reflect professional standards. For instance, DOC does not have a coherent policy addressing emergency medical treatment of offenders. Also, DOC policy allows

longer times for some activities (such as completion of inmates' initial dental exams and preparation of mortality reviews) than suggested by professional standards. DOC should develop more comprehensive policies and review them regularly.

Health services in Minnesota prisons rely on a blend of DOC and contractor staff. These activities have not always been as integrated as they should be, but DOC's recent selection of a new contractor provides an opportunity for a fresh start. DOC collects detailed information on certain health care expenditures of the contractor, but it has not collected information on the contractor's actual overhead expenditures and profits. Such information could help DOC ensure that administrative costs and profit levels are reasonable.

The pharmaceutical prices paid by the health services contractor DOC used through 2013 may have been higher than necessary. On orders for which a comparison could be made, the prices paid in 2012 by DOC's contractor were, in aggregate, somewhat less favorable than those that would have been paid by a State of Minnesota pharmaceutical purchasing alliance.

State law requires inmates to pay \$5 copayments for health services visits. The law does not authorize exemptions from this general policy, but DOC has adopted various exemptions. Most of DOC's exemptions seem reasonable, such as exemptions for provider-initiated visits and mental health visits. However, the Legislature should clarify DOC's authority to adopt exemptions from the general statutory requirement.

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**DOC should ensure that its policies and practices adequately reflect professional standards.**

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# Introduction

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State law requires the Commissioner of Corrections to provide “professional health care” to persons confined in state correctional facilities.<sup>1</sup> As of early 2014, more than 9,000 adult offenders resided in Department of Corrections (DOC) facilities.

In March 2013, the Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate health services provided in DOC correctional facilities. Our evaluation addressed the following:

- **What is the nature and extent of the health services provided to offenders in Minnesota state correctional facilities?**
- **To what extent do these health services comply with professional standards?**
- **Is there adequate oversight of DOC health services? What have external and internal reviews indicated about the adequacy of health services in Minnesota prisons?**
- **Has the Department of Corrections taken sufficient steps to manage health services and related costs?**

As defined by DOC, “health services” include medical, dental, and mental health services, as well as chemical dependency and sex offender treatment. Our evaluation primarily examined the medical, dental, and mental health services in the eight DOC facilities that exclusively serve adult offenders.<sup>2</sup> We evaluated health services provided by DOC staff and through DOC’s contract with a private company. We also examined central office activities that oversee prison-based health services. We briefly describe DOC’s chemical dependency and sex offender treatment services in Chapter 1, but we did not evaluate these services.

We examined DOC’s compliance with selected professional standards. There are two main bodies that have developed standards related to correctional health services: the American Correctional Association and the National Commission on Correctional Health Care.<sup>3</sup> We examined the extent to which DOC policies were consistent with the standards; as time permitted, we also looked at actual

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<sup>1</sup> *Minnesota Statutes* 2013, 241.021, subd. 4. A prisoner can access health care other than that provided by DOC if the prisoner is willing and able to assume all financial responsibility for the requested medical care, transportation, and related security provisions.

<sup>2</sup> These facilities are located in Faribault, Lino Lakes, Moose Lake/Willow River, Oak Park Heights, Rush City, St. Cloud, Shakopee, and Stillwater.

<sup>3</sup> We looked at compliance with many, but not all, of the standards of these organizations. For example, we looked at standards related to health care management, access, and quality issues; however, we did not examine the compliance of individual staff with credentialing requirements.

practices. In addition, we looked at whether DOC facilities and their programs were licensed, certified, or inspected.

We also analyzed a wide range of DOC data related to health care in state prisons. For example, we obtained records of each medical, mental health, or dental “encounter” from January 2008 through June 2013. (An “encounter” is an instance of direct interaction between a health care provider and a patient, typically for the purpose of diagnosing, assessing, or treating the patient.) We analyzed records of pharmaceutical use, off-site medical appointments, and laboratory reports for various time periods. In addition, we looked at lists of mental health caseloads and emergencies, as well as practices for tracking individuals with chronic illnesses.

Further, we reviewed documents since 2008 related to health care incidents and employees. Specifically, we examined DOC internal reviews conducted in cases involving offender deaths; formal inmate grievances related to prison-based health services filed by inmates with DOC; complaints related to prison health services filed with the state’s Board of Medical Practice or Board of Nursing; documents from litigation related to prison-based health services; and DOC and contractor records of disciplinary actions against their health services staff. Some of these records are classified by law as not public, which limits our ability to discuss specific cases in this public report.

During our evaluation, we toured six prisons—seeing where health services were provided, interviewing staff, and meeting with small groups of offenders. Also, we interviewed administrative staff in the DOC central office, and we solicited input via online surveys from DOC-employed medical, dental, and mental health staff, as well as from professionals employed by DOC’s health services vendor.<sup>4</sup>

We also reviewed a variety of financial data. We analyzed DOC expenditure and budget data for fiscal years 2007 through 2013. We examined national surveys by correctional organizations to determine how Minnesota compares with other states in its health care cost per inmate and inmate copayment practices. To determine the reasonableness of the prices paid for Minnesota inmates’ pharmaceuticals, we asked the Minnesota Department of Administration—which makes cooperative purchases of pharmaceuticals for state correctional agencies in many states but not Minnesota—to compare one year of DOC pharmaceutical invoices with its own prices for comparable prescriptions on the same dates.

Some people expressed concern to us about certain clinical decisions made by DOC or its contractor. However, our evaluation team did not have specialized expertise in clinical matters, so we approached these issues with caution. We solicited input about service adequacy from health services practitioners and experts, and we reviewed the findings of investigations prepared by individuals with clinical expertise. However, we do not offer our own judgments about clinical issues in this report.

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<sup>4</sup> To ensure that we received candid responses, we classified the identity of the respondents as private. We received responses from 83 DOC medical staff (38 percent response rate), 47 DOC mental health staff (59 percent response rate), and 12 medical employees of DOC’s health services contractor (46 percent response rate).

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# Background

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**Each of the Minnesota state correctional facilities provides on-site health services.**

This chapter provides a brief overview of correctional health services provided in Minnesota state prisons. We discuss the organization of these services, the array of activities encompassed by the term “health services,” expenditures and staffing, and inmate characteristics pertinent to health services.

## ORGANIZATION

The Minnesota Department of Corrections (DOC) operates ten state correctional facilities—eight for adult offenders and two primarily for juveniles.<sup>1</sup> As of July 2013, DOC had 9,271 adult inmates in facilities it operated.<sup>2</sup> According to state law, the courts commit individuals to DOC for “care, custody, and rehabilitation.”<sup>3</sup>

Each DOC facility provides on-site medical, mental health, and dental services. The department’s Health Services Unit oversees these services and reports to the Deputy Commissioner of the Facility Division. From an organizational perspective, it is noteworthy that:

- **The Department of Corrections provides health services to state inmates through a combination of its own employees and contracted services.**

Exhibit 1.1 summarizes the division of responsibilities between DOC and its contractor for the most common health services positions. In medical and mental health services, there are split responsibilities—DOC employs nurses and therapists, and the contractor employs physicians and psychiatrists. DOC’s contract requires the vendor to arrange for various other services, such as eye care, laboratory services, radiology services, medical transportation, medical supplies, pharmaceuticals, and off-site inpatient and outpatient care.

The department entered into its first system-wide health services contract in 1998, in response to legislative pressure to control prison costs. Prior to 1998, each DOC facility purchased certain health services on its own, such as doctor and hospital services. From 1998 through 2013, the department contracted with a single vendor—Correctional Medical Services, which merged in 2011 with another company to become Corizon Health, Incorporated. The most recent

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<sup>1</sup> The adult facilities are in Faribault, Lino Lakes, Moose Lake/Willow River, Oak Park Heights, Rush City, St. Cloud, Shakopee, and Stillwater. DOC classifies facilities in Red Wing and Togo as juvenile facilities, but these sites also house some adults.

<sup>2</sup> In addition, 501 individuals committed to the custody of DOC were (1) being held in a contracted county jail or (2) on work release or on a community work crew.

<sup>3</sup> *Minnesota Statutes* 2013, 241.01, subd. 3a(a).

**The prisons' nurses, therapists, and dentists are state employees, while the Department of Corrections (DOC) contracts for physicians and psychiatrists.**

### Exhibit 1.1: Employers of Health Services Staff in Minnesota Prisons

Service Category	Department of Corrections Employees	Contractor Employees
<b>Medical services</b>	Nurses and two nurse practitioners	Physicians, nurse practitioners, physician assistants, physical therapists, and optometrists
<b>Mental health services</b>	Therapists	Psychiatrists
<b>Dental services</b>	Dentists and dental assistants	—
<b>Chemical dependency and sex offender treatment</b>	Therapists <sup>a</sup>	—

NOTE: This exhibit shows only the most common types of health services staff.

<sup>a</sup> Sex offender treatment staff at the DOC Moose Lake facility are employees of the Department of Human Services.

SOURCES: Office of the Legislative Auditor, summary of Department of Corrections and contractor staffing data.

contract with this vendor lasted five-and-a-half years.<sup>4</sup> In 2013, the department solicited proposals for its health services contract and selected a new contractor, Centurion Managed Care. This vendor began providing health services in Minnesota prisons in January 2014 and is operating under a contract that expires at the end of June 2016.

Exhibit 1.2 shows the organization of the DOC central office and facility-based health services employees. A central office Health Services Unit—headed by DOC's director of health services—provides system-wide leadership. Each Minnesota prison has a DOC-employed health services administrator who oversees medical activities at the prison and a psychological services director who oversees mental health therapists.

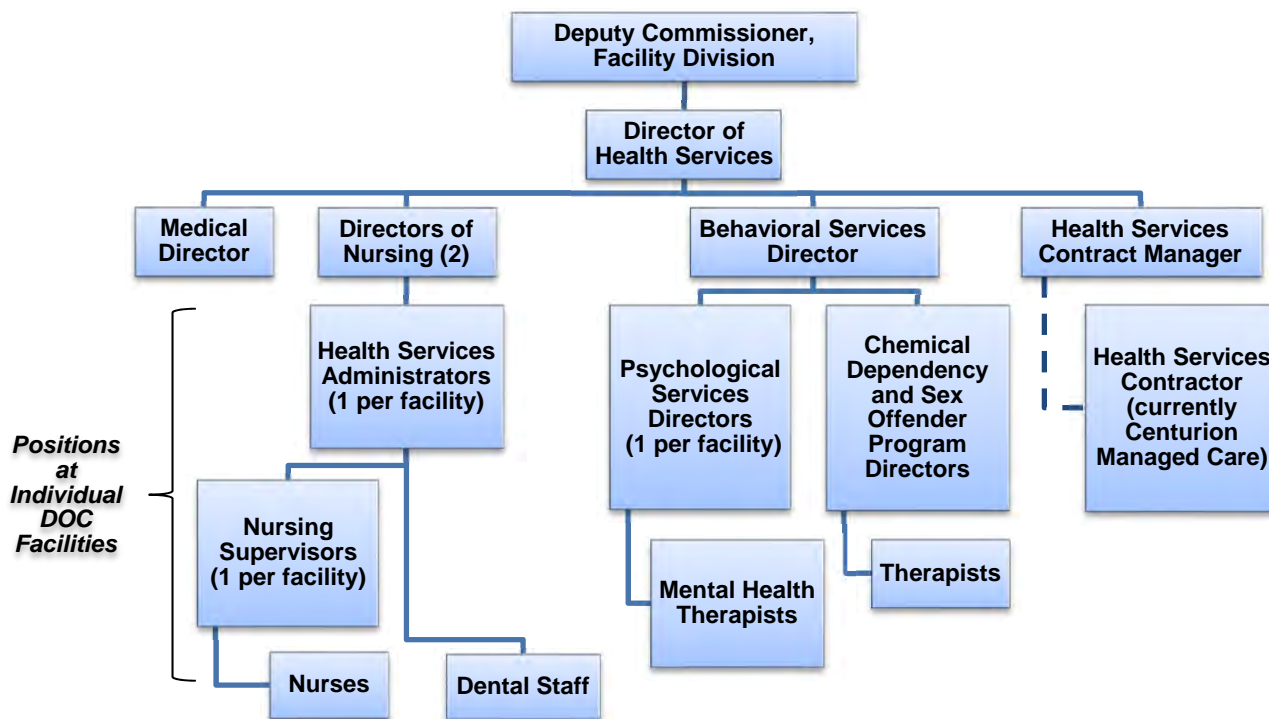
## SERVICES

Each prison has a health services unit that makes arrangements for offender visits with medical, dental, or mental health staff. Chapter 2 provides additional information on routine health care visits, many of which are initiated by offender requests during each prison's "sick-call" process. Nurses determine what follow-up is required for each request, and they schedule offender appointments with physicians, as needed. Specialized units in two prisons provide more intensive medical services on-site for offenders who need a higher level of care. The 100-bed Linden Unit at the Faribault prison provides round-the-clock nursing services—for example, for offenders with dementia or requiring wound care. The 54-bed Transitional Care Unit at the Oak Park Heights prison also provides intensive nursing care—for example, before and after offenders undergo surgery.

<sup>4</sup> This contract was amended several times. The final amendment extended the original five-year contract by six months to provide DOC with additional time to assess the impact of federal health care legislation before soliciting proposals and entering into a new health services contract.



**Exhibit 1.2: Organization of Department of Corrections Health Services**



NOTES: This chart presents a simplified overview of key health services components; it does not show every central office and facility health services position. DOC’s health services contractor through December 2013 was Corizon Health, Inc.

SOURCE: Office of the Legislative Auditor, summary of information from the Minnesota Department of Corrections.

The Oak Park Heights facility also provides on-site dialysis. If an offender requires health care services outside the prison—for example, a surgical procedure or a consultation with a specialist—DOC’s health services contractor makes these arrangements.

DOC facilities also provide an array of mental health services. At one end of the spectrum, each prison offers self-help groups on various topics; these are facilitated by volunteers. For offenders who need assistance from professional staff, DOC mental health staff conduct group and individual therapy sessions, assess offenders’ needs, and intervene in crisis situations. Offenders whose mental illnesses or cognitive limitations inhibit their ability to safely live with the rest of the prison population may reside in living areas that offer special access to supportive services. For male offenders whose acute mental illnesses require residential care, the department operates a 47-bed Mental Health Unit at the maximum security Oak Park Heights facility. We discuss mental health services in more detail in Chapter 3.

We examined the number and type of “encounters” inmates have had with health services staff, based on DOC records. Encounters are typically face-to-face

meetings between offenders and health care providers. In an average year, the DOC Health Services Unit records more than 200,000 encounters of various types across its facilities. We found that:

- **DOC relies heavily on its own nurses and mental health therapists to meet inmates' needs.**

Exhibit 1.3 shows types of health services encounters in fiscal year 2013. In that year, one-third of all encounters were mental health therapist visits, and another one-third were visits with nurses. The exhibit shows that “injection and immunization” encounters were the most prevalent type of nursing visit, and there were particularly high numbers of such encounters at facilities that perform initial offender intake exams. After nursing and mental health encounters, the next largest group of encounters in 2013 were those classified by DOC as “medical” encounters (16 percent); typically these were visits with contract physicians.

**Most health services visits by inmates in 2013 were with nurses or mental health therapists.**

### Exhibit 1.3: Inmate Encounters with Health Services Staff, Fiscal Year 2013

	<u>Number of Encounters</u>	<u>Percentage of All Encounters</u>
Nursing		
Injection and immunization	29,012	14.4%
Sick call	14,660	7.3
Intake	14,092	7.0
Chronic care	7,537	3.7
Emergency or urgent	<u>1,740</u>	<u>0.9</u>
Nursing subtotal	67,041	33.3%
Mental health	67,456	33.5%
Medical (physicians)	31,506	15.6
Laboratory and x-ray	18,775	9.3
Dental	13,325	6.6
Optometry	<u>3,248</u>	<u>1.6</u>
TOTAL	201,351	100.0%

NOTES: “Encounters” are usually face-to-face meetings between a patient and a health care provider. “Mental Health” includes encounters with mental health therapists but not psychiatrists. Encounters with psychiatrists are not consistently recorded in DOC’s encounter database.

SOURCE: Office of the Legislative Auditor, analysis of Department of Corrections data.

The number of encounters in most categories remained fairly stable from year to year, but there has been a decline in dental services encounters. Offenders had nearly 17,000 dental encounters in fiscal year 2009, but they averaged fewer than 13,500 encounters in subsequent years. Later, we note that there have been reductions in dental spending and staffing.

Exhibit 1.4 provides information on DOC’s chemical dependency and sex offender treatment programs. We did not evaluate these programs, but they perform a critical function within state prisons and consume a significant share of DOC’s total health services resources (see the next section).

## Exhibit 1.4: Chemical Dependency (CD) and Sex Offender Programs in Minnesota Prisons, 2013

Facility/Program Name	Available Beds	Target Population	Typical Program Length	Additional Information
<b>Chemical Dependency Programs</b>				
Faribault/New Dimensions	176	Adult males	7-8 mo.	
Lino Lakes/TRIAD	256	Adult males	7-8 mo.	Includes 32 beds for persons with a dual diagnoses of mental illness and CD. Includes 22 beds for supervised release violators and previous treatment completers (90-120 day program).
Lino Lakes/Track 2	50	Adult males	7-8 mo.	Participants are chemically-dependent sex offenders, and most complete CD treatment before entering sex offender treatment.
Moose Lake/Paradigm	60	Adult males	7-8 mo.	Includes 12 beds for sex offenders who are chemically dependent.
St. Cloud/Reshape	24	Adult males	7-8 mo.	Participants are chemically-dependent sex offenders, and most complete CD treatment before entering sex offender treatment.
Shakopee/Changing Paths	40	Adult females	7-8 mo.	
Stillwater/Atlantis	36	Adult males	7-8 mo.	
Togo/Portages	8	Juvenile males	6 wks.	
Togo/Compass	40	Adult females	6 mo.	
Willow River/Positive Changes	180	Adult males	6 mo.	
<b>SUBTOTAL, CD Programs</b>	<b>870</b>			
<b>Sex Offender Programs</b>				
Lino Lakes/Sex Offender Treatment Program	208	Adult males with high-to-moderate risk of sexual reoffending	20-30 mo.	In addition to sex offender treatment, this program provides CD treatment (50 beds), groups for lower functioning offenders, and a "Transitions" program for offenders in their last six months prior to release.
Rush City/Sex Offender Treatment Program	71	Adult males with high-to-moderate risk of sexual reoffending	20-25 mo.	Facility has a higher custody level ("close custody") than other DOC facilities with sex offender treatment programs. Facility is piloting a shorter program (12-18 months).
Moose Lake-Willow River/Minnesota Sex Offender Treatment Program	50	Adult males seen as a higher risk of being civilly committed to the Minnesota Sex Offender Program	36 mo.	Program is staffed by the Department of Human Services Minnesota Sex Offender Program.
Shakopee/Sex Offender Treatment Program	8	Adult female sex offenders	24 mo.	Unlike DOC's other sex offender programs (which have 30 hours of programming a week and participants who live together), this program has fewer hours of services (9 hours of groups per week plus 2 individual therapy sessions per month) and participants do not live together as a group.
Red Wing/Sex Offender Treatment Program	20	Juvenile male sex offenders	9-24 mo.	Mainly serves offenders who previously participated unsuccessfully in community-based residential programs for sex offenders.
<b>SUBTOTAL, Sex Offender Programs</b>	<b>357</b>			

SOURCE: Office of the Legislative Auditor, based on data provided by the Minnesota Department of Corrections in July 2013.

The department has more than 800 chemical dependency treatment beds in its adult and juvenile correctional facilities. To determine which inmates will be assigned to prison-based chemical dependency treatment programs, DOC uses an actuarial assessment instrument to identify individuals who represent the highest risks of reoffending and have the highest needs for treatment.

In addition, the department has about 350 treatment beds for sex offenders. Sex offenders entering Minnesota prisons are assessed using standardized tools to determine their risk of reoffending, and the highest-risk offenders receive the highest priority for treatment. Some other offenders may also be admitted to treatment—for example, if they have at least five victims, have a stated intent to reoffend, or are deemed dangerous for having injured or killed a victim, used a weapon in an assault, or sexually penetrated a victim under age 13. Later in this chapter, we discuss the extent to which inmates have been given “directives” by DOC staff to participate in chemical dependency or sex offender programs.

## SPENDING AND STAFFING

The provision of health services is just one of the expenses of operating a state prison system, but it is a significant one. We found that:

- **In fiscal year 2013, the Department of Corrections spent nearly \$68 million in state funds for inmate health services, which was about 20 percent of the DOC facilities’ total operating costs.**

Exhibit 1.5 shows that the largest components of DOC’s health services spending in fiscal year 2013 were contracted medical services (\$28.0 million), including the costs of physicians, psychiatrists, and prescription medications, among other things, and DOC-provided medical services (\$17.6 million), largely composed of nursing costs. In Chapter 5, we discuss the impact of inflation and growth of the inmate population on spending increases, and we discuss how the department’s spending has compared with its health services budget.

Minnesota’s correctional health services have been paid for mainly with appropriations from the General Fund, supplemented by small amounts of revenue from other sources, such as copayments and grant awards.<sup>5</sup> Through fiscal year 2013, none of Minnesota’s inmate health care costs were covered by the federal health care program for low-income individuals (Medicaid) or Minnesota’s program for this population (Medical Assistance).<sup>6</sup> Until recently, state law prohibited inmate health care coverage by Medical Assistance, and Minnesota was not authorized to cover inmate inpatient hospital stays with Medicaid. Effective January 1, 2014, state law authorizes Minnesota’s Medical Assistance program to pay for inpatient hospital services provided outside DOC, and Minnesota can receive a federal Medicaid match for these services.<sup>7</sup> The

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**State appropriations from the General Fund have covered the cost of nearly all prison-based health services activities in Minnesota.**

<sup>5</sup> In 2010, the Minnesota Legislature reduced DOC’s General Fund budget and temporarily replaced the funds with stimulus money provided under the American Recovery and Reinvestment Act. Almost \$24 million of the stimulus money went toward health services expenditures.

<sup>6</sup> *Minnesota Statutes* 2012, 256B.055, subd. 14.

<sup>7</sup> *Laws of Minnesota* 2013, chapter 108, art. 6, sec. 6.

### Exhibit 1.5: Department of Corrections' Health Services Expenditures and Staffing, Fiscal Years 2007-2013

Expenditure Categories	Expenditures (in Millions) by Fiscal Year						
	2007	2008	2009	2010	2011	2012	2013
Central administration	\$ 2.1	\$ 2.1	\$ 1.9	\$ 2.0	\$ 2.2	\$ 2.8	\$ 2.7
Health services contract	20.4	22.4	24.1	25.2	26.8	28.0	28.0
DOC-provided services							
Medical	12.5	13.7	15.5	16.3	16.9	17.0	17.6
Mental health	5.3	5.1	5.4	5.9	6.1	6.2	6.7
Dental	2.3	2.3	2.3	1.7	1.8	1.7	1.8
Chemical dependency	4.4	5.1	6.2	6.3	6.2	6.1	7.1
Sex offender	2.1	2.5	2.7	3.3	3.3	3.1	3.4
Other	0.5	0.5	0.7	0.7	0.7	0.6	0.6
DOC services subtotal	\$27.2	\$29.3	\$32.7	\$34.2	\$35.0	\$34.7	\$37.1
TOTAL	\$49.6	\$53.7	\$58.7	\$61.4	\$63.9	\$65.5	\$67.8

Staffing Categories	Staffing (in Full-Time-Equivalent Staff) by Fiscal Year						
	2007	2008	2009	2010	2011	2012	2013
Central administration	13.9	18.4	18.8	18.1	19.9	18.6	18.6
DOC-provided services							
Medical	155.3	166.7	176.5	186.9	191.1	182.1	185.7
Mental health	69.3	63.9	64.5	70.6	73.9	73.6	77.5
Dental	22.6	22.1	20.8	14.1	14.7	14.2	14.7
Chemical dependency	65.7	72.6	84.3	89.2	84.5	84.8	97.7
Sex offender	31.0	33.6	34.8	43.2	41.4	39.2	40.9
Other	4.5	4.7	6.4	7.0	6.1	4.8	4.8
DOC services subtotal	348.3	363.5	387.3	410.9	411.8	398.8	421.3
TOTAL	362.3	381.9	406.1	429.0	431.6	417.3	439.9

NOTES: "Other" includes central office costs and staffing for Mental Health Unit commitments, certain mental health medications, mental health discharge planning, and contract beds. This exhibit reflects only expenditures from the General Fund; expenditures funded by other sources—such as grants or offender copayments—are minor. An exception was in fiscal year 2010, when federal American Recovery and Reinvestment Act funds covered most of the cost of DOC's health services contract. Columns do not always sum to the total shown, due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Minnesota Department of Corrections data.

state may not receive aid through these programs to pay for services taking place within DOC facilities.

Exhibit 1.5 also shows changes in the department's full-time-equivalent staffing in health services. We found:

- **In recent years, the number of full-time-equivalent DOC employees increased throughout health services, with the exception of dental services.**

Overall, the number of full-time-equivalent health services staff increased from 362 in fiscal year 2007 to 440 in fiscal year 2013—a 21 percent increase.<sup>8</sup> Between fiscal years 2007 and 2013, dental was the only service area that did not see staff increases. During this period, the number of full-time-equivalent dental staff declined from about 23 to 15.

## INMATE CHARACTERISTICS

The body of research on inmate health is somewhat limited by the fact that inmates are excluded from some of the major surveys that track health trends in the United States. However, recent studies related to inmate health have found:

- **Inmates tend to be less healthy than persons in the general population of a similar age.**

**Researchers have found higher rates of chronic illnesses in inmates than in the general population.**

Inmates are disproportionately burdened by infectious diseases, substance abuse, and psychiatric illness relative to the general, noninstitutionalized population.<sup>9</sup> One particularly rigorous study found that inmates had significantly higher odds of having chronic conditions such as hypertension, diabetes, myocardial infarction, asthma, arthritis, and cervical cancer (in women) than adults in the general population.<sup>10</sup> Inmates also have higher rates of certain infectious diseases such as HIV/AIDS, tuberculosis, and hepatitis C.

Inmate health partly reflects lifestyles and choices made before entering prison. Inmates may be less healthy than the general population as a result of lack of previous health care, poor diet and exercise choices, or exposure to violence or traumatic events. With respect to prior health care, inmates typically have received less regular primary care, depending instead on emergency rooms or urgent care to meet their health needs. For example, in 2000, the Florida Department of Corrections found that almost two-thirds of inmates had their first significant health care experience (such as a surgery or even a filled prescription) while in prison.<sup>11</sup> Many inmates have had low incomes, which is related to lack of nutritious food options and living in unsafe neighborhoods. Further, low-income individuals tend to be uninsured or underinsured, meaning they may have to forgo medications that would help them control chronic conditions such as diabetes or high blood pressure.

<sup>8</sup> These figures do not include the providers—mainly physicians and psychiatrists—employed by DOC's health services contractor. From July 1, 2008, to December 31, 2013, the total weekly provider hours required by the contract grew from 694 to 767, an 11 percent increase.

<sup>9</sup> Ingrid Binswanger, "Prevalence of Chronic Medical Conditions Among Jail and Prison Inmates in the USA Compared with the General Population," *CorrDocs* (quarterly newsletter of the Society of Correctional Physicians) 13, no. 1 (March 2010).

<sup>10</sup> I.A. Binswanger, P.M. Krueger, and J.F. Steiner, "Prevalence of Chronic Medical Conditions Among Jail and Prison Inmates in the USA Compared with the General Population," *Journal of Epidemiology & Community Health* 63, no. 11 (Nov 2009).

<sup>11</sup> Carrie Abner, "Graying Prisons: States Face Challenges of an Aging Inmate Population," *State News* (Council of State Governments) 49, no. 10 (November/December 2006): 9.

In addition to preexisting health issues, the prison setting can have adverse physical and mental impacts on inmates. Communicable diseases, such as tuberculosis, HIV/AIDS, and hepatitis C may spread more readily in prisons than in the general population due to overcrowded conditions, poor ventilation, and inmates' risky behaviors (such as shared needles used for drug use or tattooing and high-risk sexual behaviors).<sup>12</sup> Inmates may also suffer physically in cases where prisons offer poor nutrition and limited physical activity. Prison may exacerbate or give rise to new mental health issues due to the risk of violence and intimidation or decreased self-esteem, social connections, and autonomy.<sup>13</sup>

## Aging

In general, as people age physically, their bodies begin to deteriorate and their medical needs increase. As a result of the stressors they experience both before and during prison, prison inmates tend to age faster than the general population and may appear to be physically and medically older than their actual age.<sup>14</sup> Beyond premature aging of inmates, prison populations have also been aging in the literal sense. We found:

- **Older inmates—presumably with more susceptibility to health problems—now comprise a larger share of Minnesota's inmate population than they did in past years.**

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**Nearly 14 percent of offenders in Minnesota prisons were over age 50 in 2013.**

The percentage of Minnesota inmates over age 50 grew from 5.6 percent in 1998 to 13.5 percent in 2013. Nationally, the prison population age 55 and older grew by 282 percent between 1995 and 2010, while the total prison population grew by 42 percent.<sup>15</sup> This increase in elderly inmates is partially attributable to the general aging of U.S. society. In addition, criminal justice policies in recent decades have resulted in longer sentences, increasing the number of inmates who remained in prison long enough to grow old.

## Disabilities and Chronic Conditions

We looked at a snapshot of inmate characteristics, known as “health profiles,” for those inmates in DOC facilities as of mid-2013.<sup>16</sup> These data indicated that 3 percent of the prison population had a physical disability, including impairments of mobility, hearing, speech, or vision. There were no ventilator-dependent inmates, and only a handful of paraplegic and quadriplegic inmates.

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<sup>12</sup> Zulficar Gregory Restum, “Public Health Implications of Substandard Correctional Care,” *American Journal of Public Health* 95, no. 10 (October 2005): 1691.

<sup>13</sup> Rebecca Reviere, “Aging Behind Bars: Health Care for Older Female Inmates,” *Journal of Women and Aging* 16, no. 1/2 (January 2004): 59.

<sup>14</sup> Abner, “Graying Prisons: States Face Challenges of an Aging Inmate Population”: 9.

<sup>15</sup> Human Rights Watch, *Old Behind Bars: The Aging Prison Population in the United States*, 2012.

<sup>16</sup> DOC staff cautioned us that health profiles might not always be updated after offenders enter prison—for example, to reflect new conditions or diagnoses.

In addition, we used DOC records related to offender health encounters to analyze offenders with chronic conditions and found that:

- **As of mid-2013, about one-third of the prison population had been diagnosed with a chronic condition, most commonly hypertension.**

More than 3,000 of the inmates incarcerated in state facilities as of July 1, 2013, had been diagnosed with asthma, diabetes, epilepsy, heart conditions, hepatitis C, HIV/AIDS, or hypertension.<sup>17</sup> About 23 percent of all offenders had just one of these chronic conditions, while an additional 10 percent of offenders were diagnosed with more than one condition, such as co-occurring diabetes and hypertension. Exhibit 1.6 shows the numbers and percentages of inmates with each of several chronic conditions.

**Hypertension was the most common chronic illness among Minnesota inmates.**

### Exhibit 1.6: Prisoners with Chronic Health Conditions, 2013

	Number of Offenders with Condition	Percentage of All Offenders
Hypertension	1,799	19.4%
Asthma	761	8.2
Diabetes	667	7.2
Hepatitis C <sup>a</sup>	550	5.9
Epilepsy	235	2.5
Heart condition	226	2.4
HIV/AIDS	50	0.5
Any chronic condition or combination of conditions	3,054	32.9

NOTES: The exhibit includes adult offenders in DOC prison facilities as of July 1, 2013. An offender is counted if he or she was diagnosed with one of the listed conditions by a DOC-contracted physician between January 1, 2008, and July 1, 2013. An offender who was diagnosed with more than one listed condition is counted toward all applicable conditions; thus, the last row does not equal the sum of the preceding rows.

<sup>a</sup> Many prisoners are not tested for hepatitis C. Offenders may request testing once per incarceration.

SOURCE: Office of the Legislative Auditor, analysis of Department of Corrections data.

## Mental Health

Many offenders are regular users of DOC's behavioral health services. We found:

- **About 28 percent of offenders incarcerated as of mid-2013 were receiving mental health services.**

<sup>17</sup> Our analysis included only diagnoses made by DOC-contracted physicians between 2008 and 2013. If an offender was diagnosed with a chronic condition by a community provider, but never received treatment for that condition from a DOC-contracted physician, he or she was not included in our analysis.



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**Twelve percent of Minnesota prison inmates have been diagnosed with a serious and persistent mental illness, and many others receive mental health services.**

As of mid-2013, 2,633 offenders were classified by DOC facilities as being on the mental health caseload in the facilities in which they were incarcerated.<sup>18</sup> The mental health caseload includes offenders receiving various levels of mental health services, from intermittent individual or group therapy to long-term residential placements in supportive living services or the Mental Health Unit.

Of the offenders on the mental health caseload, 32 percent had, at some point during their prison stay, been diagnosed with a “serious and persistent mental illness” as defined in state law.<sup>19</sup> Twelve percent of the entire offender population had been diagnosed with a serious and persistent mental illness while at a DOC facility, with the most common qualifying diagnosis being major depression (6 percent of all offenders as of mid-2013).

## Treatment Programs

DOC’s behavioral health staff also provide programming for those offenders who have been directed to complete chemical dependency or sex offender treatment programs. We found that, during their current incarceration,

- **Sixty-five percent of the prison population (as of July 2013) had been directed to complete chemical dependency treatment, and 18 percent had been directed to complete sex offender treatment.**

Directives are most often issued by DOC “program review teams,” which are assigned by a warden and consist of at least two case managers and/or program directors.<sup>20</sup> As of mid-2013, nearly three-quarters (72 percent) of the prison population had been directed to complete chemical dependency treatment, sex offender treatment, or both. We did not evaluate chemical dependency or sex offender treatment programs as part of this evaluation.

## Pharmaceutical Use

Based on a review of monthly reports from the first half of 2013, we found that:

- **An average of 63 percent of the prison population had an active pharmacy order of any sort in a given month, and an average of 31 percent of the prison population had an active order for a psychotropic medication (for a mental illness).**

These percentages do not include nonprescription, over-the-counter medications. If offenders wish to use nonprescription, over-the-counter medications, they must

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<sup>18</sup> Based on the way the Lino Lakes facility reported its data, this number excludes offenders at that facility who were on the mental health caseload but not taking psychotropic medications.

<sup>19</sup> *Minnesota Statutes* 2013, 245.462, subd. 20(c)(4)(i), states that a person has serious and persistent mental illness if he or she is an adult and “has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective disorder, or borderline personality disorder.”

<sup>20</sup> DOC Policy 203.019 (Program Review Team).

purchase them from the items stocked at the prison canteen.<sup>21</sup> We did not analyze the purchase or use of over-the-counter medications.

## Mortality

We also examined the incidence of deaths among offenders in Minnesota prisons. We found that:

- **Compared with other states, Minnesota has had a low prison mortality rate but an above-average prison suicide rate.**

**Over a recent ten-year period, Minnesota had the nation's lowest prison mortality rate.**

Recently, the U.S. Bureau of Justice Statistics analyzed mortality rates in state prisons between 2001 and 2010.<sup>22</sup> Minnesota's overall mortality rate over this ten-year period—155 deaths per 100,000 prisoners—was the lowest of the 49 states for which there were sufficient data to compare.<sup>23</sup> Nationwide over this period, there were 252 deaths per 100,000 state prisoners.

One area in which Minnesota's prison mortality rate was above the national average was suicides. Over a ten-year period, Minnesota had 20 suicides per 100,000 state prisoners, compared with 16 nationally.<sup>24</sup> On average, there have been about two inmate suicides per year in Minnesota's prison system.

Comparisons of states' prison mortality and suicide rates should be viewed with caution. The Bureau of Justice Statistics said: "Mortality rates between states are not directly comparable because rates are not adjusted for differences in age, sex, race, geographic location, and any other characteristics."<sup>25</sup> For example, a recent analysis showed that Minnesota's proportion of prisoners over age 55 was smaller than all but two of 24 reporting states in that study, so this could be a factor in Minnesota's low mortality rate.<sup>26</sup> It is unclear whether the adequacy of health services provided in state prisons played a role in states' rankings on mortality rates or suicide rates.

<sup>21</sup> Practitioners may occasionally prescribe over-the-counter medications for demonstrated health maintenance needs (such as daily aspirin for a heart problem).

<sup>22</sup> Margaret E. Noonan, *Mortality in Local Jails and State Prisons, 2000-2010, Statistical Tables* (Washington, DC: U.S. Bureau of Justice Statistics, December 2012).

<sup>23</sup> *Ibid.*, 22.

<sup>24</sup> *Ibid.*

<sup>25</sup> *Ibid.*, 3. The analysis excluded deaths by execution. However, states with capital punishment or that make greater use of life sentences without parole might be more likely than other states to have inmates serving very long sentences—and who may eventually die in prison. This is one example of how an external factor—state sentencing policy—may affect prison mortality rates.

<sup>26</sup> Human Rights Watch, *Old Behind Bars*, 101.

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# Adequacy of General Services

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As we describe below, prisoners have a constitutional right to adequate health care. Minnesota law provides little guidance about what constitutes adequate care, requiring only that the Commissioner of Corrections provide “professional health care” to inmates.<sup>1</sup> The contours of adequate health care have been formed largely by court decisions, professional standards, and policies developed by the Minnesota Department of Corrections (DOC).

In this chapter, we discuss standards that have been used to evaluate the adequacy of correctional health care. We then evaluate the adequacy of DOC’s services for the general prison population, largely measured against standards established in the corrections field and DOC’s own policies.

## STANDARDS FOR CORRECTIONAL HEALTH CARE

### Legal Requirements

Various court decisions have established that prisoners have a right to adequate medical, dental, and mental health care under the Eighth Amendment to the U.S. Constitution.<sup>2</sup> The state has a duty to provide adequate health care to prisoners even when health care services are contracted out to a private vendor.<sup>3</sup> To prevail on an Eighth Amendment claim that health care services are inadequate, prisoners must show that there was deliberate indifference to their serious medical needs.<sup>4</sup> A serious medical need is one that (1) has been diagnosed by a doctor as requiring treatment or (2) is obvious to a layperson.<sup>5</sup> Prison officials must have known of and disregarded an excessive risk to inmate health to demonstrate deliberate indifference.<sup>6</sup>

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<sup>1</sup> *Minnesota Statutes* 2013, 241.021, subd. 4.

<sup>2</sup> In 1976, the U.S. Supreme Court established that denial of adequate medical care to prisoners could constitute cruel and unusual punishment in violation of the Eighth Amendment. *Estelle v. Gamble*, 429 U.S. 97 (1976). Prisoners’ right to medical care includes a right to mental health care—see *Brown v. Plata*, 131 S. Ct. 1910 (2011). Adequate dental care is also included in the right to medical care—see *Moore v. Jackson*, 123 F.3d 1082 (8th Cir. 1997).

<sup>3</sup> *West v. Atkins*, 487 U.S. 42, 56-57 (1988).

<sup>4</sup> *Estelle*, 429 U.S. at 106.

<sup>5</sup> *Schaub v. Vonwald*, 638 F.3d 905, 914 (8th Cir. 2011) citing *Camberos v. Branstad*, 73 F.3d 174, 176 (8th Cir. 1995).

<sup>6</sup> *Farmer v. Brennan*, 511 U.S. 825, 837 (1994).

**Court decisions have established that prisoners have a constitutional right to adequate health care.**

In various states, class action lawsuits have resulted in court findings of Eighth Amendment violations and sometimes court supervision of prison health care systems.<sup>7</sup> These cases have outlined the essential components of an adequate health care system. Exhibit 2.1 shows some of the rights which have been established in cases where courts have found systemic deficiencies in prisoner health care. Minnesota prisoners initiated at least two major class action suits related to health care that continued past preliminary stages of litigation. One, *Hines v. Anderson*, resulted in a consent decree that set medical care standards in Minnesota's maximum security prison from 1977 to 2008.<sup>8</sup>

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### **Exhibit 2.1: Examples of Rights Prisoners Have to Health Care Services**

- Screening at intake for medical and mental health issues
- Evaluation, treatment, and medication administration by qualified staff in sufficient numbers
- Medical records which are complete, usable, and accessible
- Adequate facilities to treat prisoners
- Access to necessary health care services in a reasonable amount of time
- Adequate medical equipment or supplies
- Adequate treatment and management of chronic conditions
- Existence of a quality improvement system

SOURCE: Office of the Legislative Auditor, analysis of case law.

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While courts have found Eighth Amendment violations and established the outlines of prisoners' rights to health care, it is difficult to show Eighth Amendment violations. Treatment must be "so inappropriate as to evidence intentional maltreatment or a refusal to provide essential care."<sup>9</sup> The Eighth Amendment does not confer a right to a particular course of treatment.<sup>10</sup> A difference of opinion among medical practitioners is not sufficient to demonstrate an Eighth Amendment violation.<sup>11</sup> Medical negligence (and perhaps even gross

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<sup>7</sup> For example, see: *Hadix v. Caruso*, 465 F.Supp.2d 776 (W.D. Mich. 2006); *Brown v. Plata*, 139 S. Ct. 1910 (2011); *Hoptowit v. Ray*, 682 F.2d 1237 (9th Cir. 1982); *Newman v. Alabama*, 503 F.2d 1320 (5th Cir. 1974); *Ruiz v. Estelle*, 503 F.Supp. 1265 (S.D. Tex. 1980); *Madrid v. Gomez*, 889 F.Supp. 1146 (N.D. Cal. 1995); and *Costello v. Wainwright*, 525 F.2d 1239 (5th Cir. 1976).

<sup>8</sup> *Hines v. Anderson*, 439 F. Supp. 12 (D. Minn. 1977), applied to Minnesota's primary maximum security prison for men. In 1977, that prison was the Stillwater facility. From 1999 until the termination of the decree in 2008, the decree applied exclusively to the current maximum security facility (Oak Park Heights). The second case, *DeGidio v. Pung*, 704 F. Supp. 922 (D. Minn. 1989), alleged violations of the *Hines* consent decree and sought additional injunctive relief in the wake of a tuberculosis outbreak at Stillwater prison.

<sup>9</sup> *Dulany v. Carnahan*, 132 F.3d 1234, 1242 (8th Cir. 1997) citing *Smith v. Jenkins*, 919 F.2d 90, 93 (8th Cir. 1990).

<sup>10</sup> *Ibid.* at 1239.

<sup>11</sup> *Ibid.* at 1242.

negligence) does not constitute an Eighth Amendment violation.<sup>12</sup> Also, since the federal Prison Litigation Reform Act was passed in 1995, there have been significant procedural bars to prisoners filing lawsuits in federal court.<sup>13</sup>

In addition to claims regarding constitutional violations, prisoners may file medical malpractice, professional negligence, or other civil actions against prison officials or health care providers. To prevail in such a case, the standard is lower than the threshold for cases alleging violations of constitutional rights. Prisoners must show that the care they received fell below the community standard of care and that the departure from that standard of care resulted in harm.<sup>14</sup> Minnesota law establishes strict statutory requirements for filing medical malpractice cases.<sup>15</sup>

Various immunities in state statutes and federal and state case law may protect government officials and employees from liability on claims made against them. Where an employee is liable, the state indemnifies the employee when the employee was acting within the scope of his or her employment.<sup>16</sup>

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**Professional standards provide benchmarks for health care services in correctional facilities.**

## Professional Standards

Court decisions are not the only measure of what constitutes adequate care. Litigation is expensive and time-consuming, and many lawsuits are settled by the affected parties or dismissed prior to a judgment of the court.

However, past court decisions have influenced the development of professional standards in the corrections field. These standards establish generally accepted “best practices” for policies, procedures, and systems. Such standards may be used to accredit individual correctional facilities in states wishing to pursue accreditation. In Minnesota, the Department of Corrections has not sought

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<sup>12</sup> Mere negligence does not amount to an Eighth Amendment violation. *Farmer*, 511 U.S. at 834-835 (1994). Even gross negligence may not amount to an Eighth Amendment violation. *Popoalii v. Correctional Medical Services*, 512 F.3d 488, 500 (8th Cir. 2008).

<sup>13</sup> *Prison Litigation Reform Act*, Public Law 104-134, April 26, 1996. In particular, the act: (1) requires prisoners to exhaust administrative remedies within the prison prior to filing suit; (2) bars prisoners from suing for mental or emotional injuries without showing a physical injury; (3) requires prisoners to pay court filing fees rather than have them waived due to indigence; and (4) bars suits if, on at least three prior occasions, the prisoner’s suits were dismissed for being frivolous or malicious, or failing to state a claim upon which relief can be granted. An exception from this bar exists in cases of imminent danger or serious physical injury.

<sup>14</sup> For a general outline of medical negligence, see *Plutshack v. University of Minnesota Hospitals*, 316 N.W.2d 1, 5 (1982). The community standard of care is the customary practice of physicians or other care providers in a given community. *Ibid.* at 5 citing *Swanson v. Chatterton*, 160 N.W.2d 662, 666 (1968).

<sup>15</sup> *Minnesota Statutes* 2013, 145.682.

<sup>16</sup> In general, the state and its employee will not be liable for torts arising out of policy-level decisions made by employees. *Minnesota Statutes* 2013, 3.736, subds. 1 and 3(b). In addition, common law immunities protect state employees from torts arising from their exercise of professional judgment or discretion—see *Armstrong v. State*, No. A06-1488 at 5 (Minn. App. 2007). Employees may have immunity from constitutional claims when the constitutional right which was violated was not clearly established—see *Fisher v. State*, No. A06-76 (Minn. App. 2007).

facility accreditation for many years, but DOC has adopted policies for its facility operations based partly on the corrections profession's standards. For day-to-day determinations of what constitutes adequate health care services, professional standards provide important guidance. The two main bodies that have established professional standards related to correctional health care are the National Commission on Correctional Health Care and the American Correctional Association.

## ACCESS TO CARE

An effective correctional health care system must provide reasonable access to health care services. The National Commission on Correctional Health Care's standards state that inmate access to care for serious medical, dental, and mental health needs "is the principle on which all [the commission's] standards are based."<sup>17</sup> We found that:

- **Minnesota inmates have considerable access to care to meet their serious medical, mental health, and dental needs, although some important access issues merit attention.**

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**Nurses work on-site in DOC prisons seven days a week, but six prisons do not have overnight nursing coverage.**

Each DOC facility has nursing staff on duty seven days a week, although six of DOC's eight adult correctional facilities do not have nursing coverage 24 hours a day. (We discuss the issue of 24-hour nursing coverage later in this chapter.) DOC's contract with its health services contractor establishes the amount of time that the contractor's medical and psychiatric staff are expected to be on duty at each facility. For primary care physicians, the amount of time ranges from 20 to 80 hours per week, depending on the facility. DOC facilities have "sick call" for inmates four or five days a week. ("Sick call" provides offenders with a chance to report nonemergency illnesses or injuries to nurses, who determine whether further appointments or services are needed.) Although DOC assesses a \$5 copayment for certain services (discussed in Chapter 5), DOC policy specifies that offenders with insufficient funds will not be denied care. We saw no evidence that inmates have been deterred from seeking care for serious health needs—for example, by holding sick call at unreasonable times of the day. Department policies establish a framework of expectations for timely screenings, assessments, and care.

We conducted surveys of medical staff in DOC prisons to solicit comments or suggestions on various aspects of care.<sup>18</sup> Most of the survey respondents said inmates have excellent access to care, compared with that of the general population. The following comments from three nurses reflect the general sentiment we heard from respondents:

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<sup>17</sup> National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), 3.

<sup>18</sup> We conducted surveys of DOC-employed nursing, mental health, and dental staff and contractor-employed medical and psychiatric staff. We asked respondents to provide narrative answers to questions about health care access, quality, and cost. We recognized that health care providers' responses may reflect some biases, but we also thought it was important to hear from individuals who observe the delivery of services each day.

I truly believe [offenders] get a high quality of health care, in most cases better than the general population. I believe that offenders have adequate, if not better, access to specialists, medications, lab and diagnostic tests.

I believe that offenders in the DOC have better access to health care than elderly residents that reside in nursing homes.

I see many offenders in sick call and they generally see the doctor within one to two days if an appointment is indicated. I know from my experience that getting an appointment with my medical doctor would take much longer.

We met with a total of 20 inmates during visits to three DOC facilities, and their opinions about health care services were mixed.<sup>19</sup> Some had generally positive comments about access to services and health services staff. One inmate described health services as his “lifeline,” and another said the medical services he has received in prison have added years to his life. Others expressed concerns about their access to medications or services that would address their medical, dental, or mental health problems. For example, some said that potentially helpful medications or treatments have been denied, or that staff lack knowledge to adequately manage particular health conditions.

The remainder of this chapter (and Chapter 3 as well) discusses issues that specifically address various aspects of inmate access to care—such as the adequacy of sick call, the timeliness of routine screenings and appointments, and the adequacy of after-hours emergency care.

## ROUTINE HEALTH CARE

### Sick Call

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**Offenders sign up for “sick call” when they want to see medical staff.**

Each DOC facility has clinical space for routine health care visits. One way that offenders see health care staff is through the “sick-call” process. Offenders submit requests for medical or dental services, and these requests are reviewed by nurses at each prison. Typically, sick call occurs when offenders meet individually with a nurse during a prescribed time period on weekdays. The nurse may review the offender’s medical records, take the offender’s vital signs, and perform assessments related to the offender’s concerns. The nurse may educate the offender on how to manage a health concern or schedule a follow-up visit with appropriate health services staff.

Aside from sick-call visits with nurses, offenders have other opportunities to see health care staff. For example, health care staff sometimes initiate immunizations of offenders or follow-up appointments. Health care staff may go

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<sup>19</sup> The small sample of inmates we interviewed was not large enough to be representative of the whole inmate population. We gave health services staff at facilities general guidelines about the types of inmates we would like to interview, but—for logistical reasons—we allowed facility staff to select the inmates we met with. Health services staff were not present during these interviews.

to prison living units to see inmates who cannot attend sick call due to their illnesses or facility security provisions, or who are living apart from the general prison population in “segregation units.”

Regarding the sick-call process, we observed that:

- **Some sick-call practices of Minnesota prisons do not meet professional or state standards.**

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**Two DOC facilities offer sick call four days a week, which is less than the five-day requirement in state policy and professional standards.**

First, some DOC facilities do not have sick call sufficiently often. Professional standards require the availability of sick-call services at least five days a week.<sup>20</sup> Similarly, DOC’s policy called “Offender Sick Call” requires the availability of clinical services at least five days a week.<sup>21</sup> However, two of DOC’s eight state correctional facilities for adults (Shakopee and Moose Lake) have written policies specifying that sick call will be held only four days a week. DOC officials told us that inmates in these facilities can be seen by health services staff outside of the formal sick-call process, and they said this complies with DOC standards. Thus, there is some question about exactly what constitutes sick call. However, it is worth noting that DOC rules require jails with more than 200 inmates to hold sick call at least five days a week in addition to making “continuous responses” to health care requests they receive.<sup>22</sup> In our view, the policies of two DOC prisons are not consistent with the DOC requirement of five-day-a-week sick call that is applied to local facilities.

Second, DOC’s system-wide policies do not specifically address the role of security staff in transmitting offender requests to be seen by health care staff. Prisoners may sign up for sick call in various ways, such as sign-up sheets posted in living units or by inserting requests into a secure box. Sometimes sick-call requests are transmitted by offenders to security staff, who are then expected to relay these requests to health care staff. Professional standards caution that security staff should not be in a position to deny care to offenders.<sup>23</sup> Some health care staff expressed concern to us that security guards in Minnesota prisons may act as intermediaries in the process by which offenders make sick-call requests.

Third, DOC’s responsiveness to inmate sick-call requests is difficult to systematically assess, given varying practices among facilities for recording these

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<sup>20</sup> The National Commission on Correctional Health Care says inmate requests for nonemergency services must be reviewed within 24 hours of offender requests, and the inmate must then be seen (if appropriate) by a health care professional within the next 24 hours (or 72 hours on weekends)—see NCCCHC, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-E-07 (Nonemergency Health Care Requests and Services).

<sup>21</sup> DOC Division Directive 500.250 (Offender Sick Call).

<sup>22</sup> *Minnesota Rules*, 2911.5800, subp. 9, posted October 8, 2007.

<sup>23</sup> According to American Correctional Association, *Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions* (Alexandria, VA, January 2002), Standard 1-HC-1A-01 (Access to Care), “No member of the correctional staff should approve or disapprove offender’s requests for health care services.” National Commission for Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standards P-A-03 (Medical Autonomy) and P-E-07 (Nonemergency Health Care Requests and Services) say clinical decisions should be made without interference from nonclinical personnel, and the list of acceptable sick call request approaches does not include making requests to security staff.



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**Some DOC prisons do not retain documentation of inmate requests for health services.**

requests. DOC policy says staff will respond to certain types of requests (called “kites”) within five working days, whenever possible.<sup>24</sup> However, DOC policy also authorizes individual facilities to determine whether they will retain documentation of these requests as part of medical records.<sup>25</sup> We were told that some of these requests are retained, and some are not; consequently, we did not attempt to examine DOC follow-up to a sample of requests. DOC’s policy seems contrary to guidance offered by the National Commission on Correctional Health Care:

[Our standards require] that inmates’ routine health care needs are met and specifies that inmates are to have the ability to request services directly from health staff daily; that sick-call slips are picked up at least every 24 hours; that inmates are seen within 24 hours of triage if the request does not provide enough information to make an informed assessment; and that clinical need dictates the timing of a midlevel, physician or specialist provider appointment. Without documentation of these steps, it is not possible to evaluate the responsiveness of your sick-call system, and if you are seeking accreditation, to determine if you are in compliance.<sup>26</sup>

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## RECOMMENDATIONS

*The Department of Corrections should:*

- *Establish a fifth day of sick call per week at the Shakopee and Moose Lake prisons;*
- *Adopt policies that limit the instances in which non-health care staff may transmit inmate requests to see health care staff; and*
- *Adopt a policy that requires DOC facilities to maintain documentation of sick-call requests for at least 90 days.*

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It is unclear whether the issues we discussed above have caused significant problems. For example, staff assured us that offenders who need immediate attention can be seen by health care staff outside the sick-call process, and we do not have evidence that security staff have failed to pass along inmate requests to health services staff. Still, these recommendations are consistent with professional standards, would help ensure access to services, and would facilitate review of staff responsiveness to sick-call requests.

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<sup>24</sup> DOC Division Directive 303.101 (Kites/Communication). According to this policy, “kites are the communication process that offenders must utilize for general requests, questions, and informal resolution to concerns.”

<sup>25</sup> DOC Division Directive 500.045 (Health Record Documentation).

<sup>26</sup> National Commission on Correctional Health Care, *Documentation*, <http://www.ncchc.org/documentation>, accessed October 8, 2013.

## Timeliness

Timely health screenings, evaluations, and appointments are important parts of offender access to health care because they allow health services staff to identify and address offenders' needs as soon as possible. In this section, we discuss the timeliness of different types of health assessments administered to all inmates, which can be divided into screenings and more detailed examinations. We also discuss the timeliness of health services appointments to address specific issues.

### Screening

DOC policy says that a medical, dental, mental health, and sexual assault risk screening must occur within 24 hours of an offender's arrival at the intake facility.<sup>27</sup> This screening is more superficial than the detailed physical assessments that occur later, but it identifies offenders with urgent medical needs that must be addressed immediately, as well as offenders with significant medical needs who may require a more thorough examination on an expedited schedule. In addition to identifying pressing medical issues, the nurses conducting the initial health screening also discuss the offender's medications and food allergies and administer a tuberculosis test. We found:

- **Nearly all offenders receive a timely initial health screening when they first enter prison.**

The vast majority of initial health screenings took place at the facilities designated by DOC as intake facilities: St. Cloud for newly sentenced male offenders, Lino Lakes for male offenders returning to prison for violating supervised release, and Shakopee for female offenders. We found that in fiscal year 2013, all three facilities conducted most initial health screenings within the 24-hour window established in DOC policy. Overall, 96 percent of screenings occurred on the day of arrival, and 97 percent by the next day. The St. Cloud and Lino Lakes facilities maintained this high level of compliance across the five-year period we examined; Shakopee lagged behind the other intake facilities at the beginning of the period, but improved dramatically by 2013.<sup>28</sup>

### Detailed Initial Examinations

After the initial screening process, offenders return to health services for more thorough physical, mental health, and dental examinations.<sup>29</sup> Most initial examinations take place at the intake facilities of St. Cloud, Lino Lakes, and Shakopee. We found:

<sup>27</sup> DOC Division Directive 500.050 (Health Screenings and Full Health Appraisals) and DOC Division Directive 500.055 (Dental Services).

<sup>28</sup> In 2010, Shakopee conducted only 67 percent of intake screenings on the day of arrival or day after—down from 87 percent in 2009. In 2011, Shakopee's on-time initial screening rate began to climb, eventually reaching 99 percent in 2013.

<sup>29</sup> These in-depth examinations generally do not occur after inmates transfer from one DOC facility to another.

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**Minnesota prisons promptly screen new inmates for health issues.**

- **Most initial physical, mental health, and dental examinations for male offenders occurred within the time frames specified by DOC policy; examinations for female offenders were much less timely.**

The two main bodies that accredit correctional facilities have different standards regarding how soon a physical examination should occur following intake. DOC's written policy reflects the American Correctional Association standard, which says that a complete physical should occur within 14 or 30 days of admission, depending on whether significant health problems are identified at admission.<sup>30</sup> The more rigorous National Commission on Correctional Health Care standard says physical examinations should always occur within seven days of admission.<sup>31</sup>

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**DOC's in-depth examinations of new female prisoners were less timely than the examinations of new male prisoners.**

In fiscal year 2013, 96 percent of the initial physical examinations in men's facilities took place within 30 days of admission to the facility, complying with the DOC policy.<sup>32</sup> However, facilities housing male offenders met the more rigorous seven-day standard only 59 percent of the time. Shakopee, which houses the vast majority of female offenders, usually failed to comply with DOC's policy and professional standards. In fiscal year 2013, only 8 percent of Shakopee's initial physical examinations took place within 30 days of admission.

According to DOC policy and both sets of professional standards, all offenders should receive a complete mental health examination within 14 days of admission.<sup>33</sup> On the whole, initial mental health assessments have occurred in a timely fashion for both men and women. Over the period we examined, St. Cloud, the male intake facility, consistently conducted at least 99 percent of initial mental health assessments within 14 days of the offender's admission to the department. Shakopee's compliance rates for initial mental health assessments of female offenders were somewhat lower; over time, the facility's annual percentage of on-time assessments ranged from 86 to 96 percent.

With respect to dental examinations, DOC policy says that initial examinations by a dentist should occur within 120 days of intake.<sup>34</sup> This policy is much more lenient than the National Commission on Correctional Health Care standard,

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<sup>30</sup> American Correctional Association, *2012 Standards Supplement* (Alexandria, VA, June 2012), Standard 1-HC-1A-22 (Health Appraisal).

<sup>31</sup> National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-E-04 (Initial Health Assessment).

<sup>32</sup> The records we reviewed did not indicate which offenders were flagged as having significant health problems upon admission, so we could not determine compliance with the 14-day standard for this population.

<sup>33</sup> DOC Division Directive 500.303 (Mental Health Assessment); National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-E-05 (Mental Health Screening and Evaluation); and American Correctional Association, *2012 Standards Supplement* (Alexandria, VA, June 2012), Standard 1-HC-1A-29 (Mental Health Evaluations).

<sup>34</sup> DOC Division Directive 500.055 (Dental Services) requires that offenders receive an initial dental exam unless they received such an exam during a prior incarceration within the past three years.

**Inmates may request physical examinations every year or two, depending on their age.**

which calls for initial dental exams during an offender's first 30 days.<sup>35</sup> At DOC's main intake facility for men, 99 percent of initial dental exams in fiscal year 2013 occurred within 30 days and virtually all of them occurred within 120 days. At the women's prison, only 40 percent of the initial dental examinations were completed within the 120-day window established in DOC policy.

### Periodic Physical Examinations

Beyond the initial physical examination that accompanies admission to DOC, offenders have the right to request periodic physical examinations. DOC policy allows annual physical examinations for offenders under age 19 or over age 50, and biennial exams for those between ages 19 and 50.<sup>36</sup> We examined records of these periodic physicals and found that:

- **Relatively small proportions of the offenders in Minnesota correctional facilities received periodic physical exams between 2008 and 2013.**

Of all offenders imprisoned during this period, 11 percent had a periodic physical exam. Because some of these offenders were in prison for short periods of time, we focused on offenders who were continuously incarcerated in DOC facilities for extended periods between 2008 and 2013. We found that, of offenders imprisoned continuously for four or more years, 20 percent had at least one periodic exam between 2008 and 2013. Of offenders imprisoned for two to four years, 13 percent had at least one periodic exam. The limited number of periodic exams may reflect an absence of requests for such exams from offenders, lack of offender awareness of DOC policies regarding periodic exams, or other factors.<sup>37</sup>

Despite the fact that offenders can request periodic physicals every year or two years (depending on their age), very few offenders received more than one periodic physical examination during the period we examined. Specifically, 90 percent of the offenders who had any periodic physicals had only one. However, for the small group of offenders who had more than one periodic physical, we noted that the exams tended to occur more frequently than authorized by DOC policy. We focused on offenders who were continuously incarcerated for at least four years and had at least two physicals: 69 offenders between ages 19 and 50 years, and 37 offenders older than 50. For offenders between ages 19 and 50, who should receive periodic physicals no more than every two years, 76 percent of subsequent physicals occurred less than two years after the previous one. For offenders older than 50, who should receive periodic physicals no more than once a year, 40 percent of subsequent physicals occurred less than one year after the previous one.

<sup>35</sup> National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-E-06 (Oral Care); and American Correctional Association, *2012 Standards Supplement* (Alexandria, VA, June 2012), Standard 1-HC-1A-17 (Dental Care).

<sup>36</sup> DOC Division Directive 500.050 (Health Screenings and Full Health Appraisals).

<sup>37</sup> The data we analyzed did not include information about *requests for* periodic physicals. Therefore, we are unable to comment on whether physicians examined all requesting offenders or the timeliness of DOC's response to exam requests.

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**When inmates need to see a provider outside of prison, these appointments are scheduled by DOC's health services contractor.**

## Off-Site Appointments

In Minnesota correctional facilities, the entire off-site scheduling process is handled by DOC's health services contractor. Off-site appointment requests are made by contracted physicians who are familiar with the offenders' conditions. The requests are reviewed by the contractor's utilization management staff and, if the request is approved, scheduled by the contractor's appointment schedulers.<sup>38</sup>

We examined the length of time from the practitioner's request for an appointment to the contractor's approval decision, the length of time taken to schedule the appointment (place it on the calendar), and the length of time from the request to when the appointment actually occurred.<sup>39</sup> For most parts of the process, DOC's policies and contract establish standards for timeliness, with differences that depend on whether the appointment is deemed urgent by the requesting practitioner. The contract authorizes sanctions if the contractor fails to comply with specified deadlines.<sup>40</sup> We found that:

- **Many urgent requests for off-site care did not appear to be handled within the time frames specified in DOC's health services contract, but documentation was incomplete.**

Exhibit 2.2 shows the contractually specified time frames, as well as the percentage of requests for which the stated deadlines were met, according to DOC's records. Our analysis of DOC's tracking log showed that some non-urgent requests and many of the urgent requests did not meet DOC contract requirements.

However, DOC's contract specifies that "lapses caused by patient non-cooperation or security concerns" would not be subject to sanctions, as determined by DOC "in consultation with the Contractor's Regional Manager and the DOC medical director."<sup>41</sup> DOC's tracking log for off-site appointments did not indicate cases in which exceptions to the timeliness requirements had been authorized, and records documenting such authorizations in individual cases were spotty. We reviewed DOC and contractor records for a random sample of 40 cases in which it appeared that the contract's timeliness standards were not met. In some instances, extensions of the timelines were authorized by the

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<sup>38</sup> We determined that about 80 percent of practitioner requests for off-site appointments were approved during the period we looked at. Although we heard some concerns that procedures were either inappropriately authorized or denied, we did not evaluate the appropriateness of clinical judgments.

<sup>39</sup> We obtained DOC's tracking log for off-site appointments requested from 2010 to 2013. However, most of the appointments from 2010 to 2012 did not have valid entries for the date of the practitioner's request. Thus, we focused our analysis of scheduling timeliness on appointments requested between September 2012 and September 2013.

<sup>40</sup> Sanctions related to off-site appointments are discussed further in the Contract Management section of Chapter 6.

<sup>41</sup> State of Minnesota Professional and Technical Services Contract between DOC and Correctional Medical Services, Inc., Amendment 3 to Contract Number B15244, Revision 7, effective May 2011.

**Exhibit 2.2: Off-Site Appointment Timeliness, September 2012 to September 2013**

Activity	Urgent Requests		Non-Urgent Requests	
	Contract Requirement	Percentage of Requests in Compliance <sup>a</sup>	Contract Requirement	Percentage of Requests in Compliance <sup>a</sup>
Approval/denial of requests	The contractor's utilization management coordinator must act on the request within 24 hours <sup>b</sup>	65%	The contractor's utilization management coordinator must act on the request within 7 calendar days	89%
Appointment scheduling	Not specified	NA	Appointments must be scheduled and shown on tracking log within 28 business days of utilization management review	90
Appointment occurs	Appointments must occur within 2 business days of request	60	Appointment must occur within time frame indicated by the requesting practitioner OR within 60 days of utilization management review	84

NOTES: The tracking log we reviewed consisted of requests for off-site appointments taking place between January 1, 2010, and September 27, 2013. However, DOC archives records more than one year old in a manner that overwrites the original request date. Since we required the original request date for most of our calculations, we limited our analysis to one year of data: September 24, 2012, through September 27, 2013.

<sup>a</sup> The compliance percentages above summarize only what was reflected on the off-site tracking log. We reviewed additional documentation for a small sample of "late" appointments and found that some appeared to have reasonable explanations or documentation that the later appointment had been authorized by the requesting practitioner.

<sup>b</sup> The contractor's response time is the only standard presented here that is not covered in the contract. The 24-hour time frame is instead established in DOC Division Directive 500.127 (Utilization Review Process and Scheduling of Approved Appointments).

SOURCE: Office of the Legislative Auditor, analysis of Department of Corrections health services contract, policies, and off-site tracking log.

requesting practitioner; in other cases, there was not sufficient documentation of why the appointment occurred outside the parameters established in the contract. We did not determine whether any of these delays caused inadequacies in patient care. DOC's contract manager told us that, in his view, the contractor's scheduling of off-site appointments complied with contract requirements.

**DOC should improve its recordkeeping regarding the timeliness of inmates' health care appointments at off-site locations.**

**RECOMMENDATION**

*The Department of Corrections' tracking log for off-site appointments should indicate when and why DOC has authorized exceptions to contractual requirements.*

According to the tracking log, more than one-third of urgent requests for off-site appointments were not in compliance with DOC requirements. Although many of these delays may be for acceptable reasons, DOC does not record such reasons in its tracking log. In addition, DOC's health services contractor told us that some appointments were erroneously recorded in the tracking log as "urgent."

Different parties have expressed concern about the scheduling of off-site appointments. For example, 20 percent of offender complaints to the Board of Medical Practices between 2008 and 2013 were related to off-site scheduling. DOC nurses also expressed concerns about the timeliness of off-site scheduling in survey responses. At a minimum, we think DOC should improve its documentation of instances in which “late” off-site appointments have been authorized as having met the allowed exceptions in the contract. DOC should also monitor this log once it contains this additional data, and take action if it finds that off-site requests are being inappropriately delayed.

### **Mental Health Appointments**

Mental health services in DOC are provided by a combination of contractor-employed psychiatrists and DOC-employed therapists. DOC’s contract specifies the expected hours of psychiatric service the contractor will provide at each DOC facility, ranging from 8 hours per week at Moose Lake/Willow River to 42 hours per week at St. Cloud. Psychiatrists mainly see patients for purposes of medication management. In addition, each DOC facility has mental health therapists, who primarily provide individual and group counseling.

#### *Psychiatrist Appointments*

Professional standards and DOC policy do not establish specific requirements for how often individuals with significant mental health problems should be seen by a psychiatrist. However, DOC officials told us that individuals who have prescriptions for psychotropic medications should be seen by a psychiatrist at least every 90 days. We found that:

- **Psychiatric appointments—in contrast to medical, dental, and non-psychiatric mental health appointments—are not tracked in the Department of Corrections’ main information system.**

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**DOC has not centrally tracked the frequency of inmates’ psychiatric visits, and some of these visits have not occurred in a timely manner.**

DOC started recording medical appointments in its main information system more than a decade ago. Department officials told us that psychiatric appointments were not entered into this system because DOC wanted to focus scarce psychiatric time on service delivery rather than record keeping. Individual facilities keep records of psychiatric visits, but there is no centralized way for DOC to monitor the frequency of psychiatric encounters with offenders. Furthermore, the DOC central office does not have information on trends in psychiatric encounters or backlogs, which could inform decisions about the adequacy of psychiatric staffing.

To assess compliance with DOC’s expectation that psychiatric patients be seen every 90 days, we obtained information from each facility regarding psychiatric caseloads as of June 2013 and the dates of these offenders’ most recent psychiatric appointments. We also talked with mental health directors in each facility and reviewed notes from meetings of facility mental health directors. We found that:

- **Some offenders on the psychiatric caseload—particularly among women—have not been seen for psychiatric follow-up visits at least every 90 days.**

The Shakopee women’s prison had particular difficulty conducting timely psychiatric appointments. As of June 2013, 28 percent of offenders on that prison’s psychiatric caseload had not seen a psychiatrist within the previous three months. The facility’s mental health director told us in November 2013 that the facility was still behind schedule for psychiatric appointments. Other facilities had lower percentages of offenders waiting more than 90 days between psychiatric appointments.<sup>42</sup>

While we did not have data on the St. Cloud facility’s psychiatric backlog, that facility has been stretched thin in recent years. Psychiatrists at St. Cloud (1) assess male offenders with psychotropic prescriptions at the time of intake to the prison system to determine whether those medications should be adjusted or discontinued and (2) periodically meet with offenders on psychotropic medications who are housed permanently at St. Cloud. According to meeting notes, the St. Cloud psychiatrists have had difficulties in recent years providing timely initial appointments to newly admitted offenders.<sup>43</sup>

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## RECOMMENDATION

***The Department of Corrections should centrally track the dates of psychiatric appointments and monitor their frequency.***

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A central data system would allow better monitoring of appointment timeliness. It is important for patients on psychotropic medications to be monitored regularly, due to the potential side effects of these medications and the need to ensure that dosages are appropriate. In addition, monitoring the frequency of psychiatric appointments may help DOC manage psychiatric staffing levels at individual facilities.

### *Mental Health Therapist Appointments*

DOC-employed mental health therapists have extensive contact with inmates in DOC prisons. Chapter 1 noted that therapists had about 67,000 “encounters” with offenders in fiscal year 2013, most of which were for mental health assessments, treatments, or interventions.

Professional standards suggest that prisoners receiving “basic mental health services” (such as therapy) should be seen as needed, but not less frequently than

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<sup>42</sup> We did not include the St. Cloud facility in this analysis because that facility did not provide us with information on each offender’s most recent psychiatric appointment.

<sup>43</sup> DOC does not maintain historical data on timeliness of psychiatric appointments, so we reviewed mental health director meeting notes to better understand staffing challenges.



**Typically, inmates with mental health issues meet regularly with DOC therapists.**

every 90 days.<sup>44</sup> DOC does not have an official policy to this effect, but the department’s mental health officials told us that the 90-day standard reflects DOC’s minimum expectation. We found that:

- **In fiscal year 2013, about 95 percent of visits to mental health therapists occurred within 90 days of the offender’s previous visit.**

Among individual facilities, the percentage of visits occurring within 90 days ranged from 84 percent (Moose Lake/Willow River) to 99 percent (Oak Park Heights). Another way to look at the timeliness of appointments is the average number of days between appointments, as shown in Exhibit 2.3. By this measure, facilities in fiscal year 2013 ranged from an average of 8 days between appointments (Oak Park Heights) to 53 days (Moose Lake/Willow River). Overall, the data suggest that DOC has sufficient staffing to provide basic levels of therapy to the typical inmate needing these services.

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### **Exhibit 2.3: Average Days Between Patient Encounters with Mental Health Therapists, Fiscal Year 2013**

<u>DOC Correctional Facility</u>	<u>Average Days Between Appointments</u>
Faribault	33
Lino Lakes	25
Moose Lake/Willow River	53
Oak Park Heights	8
Rush City	23
St. Cloud	21
Shakopee	14
Stillwater	24
TOTAL	21

NOTE: Exhibit shows average days between mental health therapist encounters for offenders on the mental health caseload as of June 2013.

SOURCE: Office of the Legislative Auditor, analysis of Department of Corrections data.

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## **Other Routine Care Concerns**

### **Nursing Protocols**

Nursing staff play a critical role in prison-based health services in Minnesota. They conduct the largest share of the medical visits, and they determine whether and when visits with physicians should be scheduled. But, in our view,

- **DOC has not provided sufficient guidance to nurses making decisions in response to inmate requests.**

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<sup>44</sup> National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-G-04 (Basic Mental Health Services).

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**DOC should provide its nurses with clear direction about which manuals or resource materials to consult when responding to inmates' medical conditions.**

DOC policy says nurses will make decisions on offender requests “using a priority system,” although the basis for these priorities is not stated.<sup>45</sup> Another DOC policy that was in effect until November 2013 required the department to maintain physician standing orders and a nursing protocol manual to address specific medical conditions that may arise.<sup>46</sup> DOC has physician-approved standing orders on certain conditions—for example, authorizing nurses to give oxygen or inhalers to patients having asthma attacks.<sup>47</sup> However, in mid-2013, DOC discontinued use of its more extensive nursing protocol manual, which had provided guidance to nurses when assessing a wide range of common health conditions.<sup>48</sup> The manual was removed from a DOC internal Web site, and DOC policy was amended in November 2013 to eliminate references to the manual. DOC’s nursing protocol manual had apparently not been revised since 2008, and DOC staff told us there were no formal training courses on the protocols.

The absence of clear DOC direction to nurses on which protocols to use contradicts professional standards, as did DOC’s failure to update previous protocols or provide training on them.<sup>49</sup> DOC officials told us they are looking for nursing protocols developed by other organizations that could be used by DOC, stating that it has been difficult for DOC to keep such protocols up-to-date on its own. Also, DOC provides its nurses with many helpful references at its online “resource center” for nurses. But, by removing the nursing protocol manual from the DOC internal Web site in mid-2013 before alternative resources could be specified, DOC did not comply with professional standards and its own policy, until that policy’s recent amendment. Moreover, in the absence of the manual or some direction on a replacement, nurses have not had clear guidance about which protocols to use in their daily decisions.

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### RECOMMENDATION

***Department of Corrections policy should provide guidance to nursing staff regarding the protocols or resources that should be used when making care decisions.***

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Nurses have training to address a wide range of conditions, but they also rely on guidance from professional resources. Even if DOC chooses to use protocols developed by other organizations, it should adopt policies that give clear, consistent direction to nurses about which protocols would be most appropriate.

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<sup>45</sup> DOC Division Directive 500.250 (Offender Sick Call).

<sup>46</sup> DOC Division Directive 500.040 (Standing Orders/Nursing Protocol Manuals), which was in effect until November 2013. This was replaced by a policy that eliminated any reference to the nursing protocol manual.

<sup>47</sup> The standing orders are authorized by DOC’s medical director and may be initiated only by registered nurses.

<sup>48</sup> DOC removed the nursing protocol manual from its Nursing Resource Center Web site, which provides various documents to help nurses perform their duties.

<sup>49</sup> National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-E-11 (Nursing Assessment Protocols).

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**Minnesota prisons often provide a reasonable level of privacy for patients, but some locations do not.**

### Offender Privacy

Finally, we heard concerns at some facilities about the privacy of offenders' health encounters. Professional standards state that inmate encounters with health care staff should be conducted in a private setting, where discussions cannot be seen or overheard.<sup>50</sup> We found that:

- **Levels of privacy for discussions between offenders and health services staff are inconsistent.**

Many health services areas in Minnesota prisons provide a reasonable level of privacy, but some facilities—and some settings in which offenders are seen by health care staff—do not. Staff at the St. Cloud prison described the walls in some health services rooms as “paper thin,” making it difficult for staff to discuss sensitive topics with offenders. Until recently, evening nurses at the St. Cloud facility saw offenders in their cells, which afforded little privacy. Also, inmates who are being kept in “segregation” units sometimes have limited opportunities for private discussions with health services staff.<sup>51</sup>

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### RECOMMENDATION

*Over time, the Department of Corrections should seek facility improvements that help to ensure patient privacy during encounters with health services staff.*

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There have been many capital improvements to the DOC health services units in recent years, enhancing the suitability of clinical space. Still, there is room for improvement. DOC should consider physical improvements that would better ensure privacy during health services visits, especially in clinical areas and segregation units. The Governor's 2014 capital budget includes a request for funding to construct a new health services unit and intake unit at the St. Cloud prison, partly to address patient privacy issues.<sup>52</sup>

### AFTER-HOURS EMERGENCY CARE

A staffing issue that merits careful consideration is the absence of 24-hour nursing coverage at most DOC facilities. All Minnesota prisons had round-the-clock nursing coverage until around 2000 or 2001, but DOC leadership eliminated it at most facilities in an effort to control costs. Today,

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<sup>50</sup> American Correctional Association, *2012 Standards Supplement* (Alexandria, VA, June 2012), Standard 1-HC-3A-10 (Privacy); and National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-A-09 (Privacy of Care).

<sup>51</sup> Inmates housed in cells that are segregated from the general prison population do not have the opportunity to attend facility-wide sick call. However, medical staff respond to segregated offenders' requests by visiting those offenders in their living areas.

<sup>52</sup> Office of Governor Mark Dayton, “Governor's 2014 Capital Budget Recommendations,” [http://mn.gov/governor/images/20140115\\_bonding\\_narative.pdf](http://mn.gov/governor/images/20140115_bonding_narative.pdf), accessed January 28, 2014.

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**DOC should consider whether to improve overnight nursing coverage as part of an agency-wide staffing plan.**

- **Only two of the eight facilities serving adults—Oak Park Heights and Faribault—have at least one nurse on duty 24 hours a day, 7 days a week.**

Staff with the National Commission on Correctional Health Care told us that 24-hour nursing coverage at facilities is “ideal,” although it is not essential for accreditation purposes. In DOC facilities without 24-hour nursing coverage, overnight security staff (specifically, the watch commanders) bear responsibility for determining whether an offender requires immediate medical care. All DOC facilities have access to on-call physicians who can be reached at any time during the week, including overnight. This service is provided by DOC’s health services contractor. According to DOC’s health services contract, the medical on-call provider must be a physician and is expected to respond to all calls within 15 minutes. Security staff responding to after-hours medical requests are encouraged to call 911 in the case of a true emergency and may do so before calling the on-call physician, if necessary.

In our view, overnight staffing should be considered in the broader context of a health services staffing plan (as we recommend in Chapter 6), but the absence of overnight staffing at some facilities raises important questions. We reviewed records of two recent cases in which inadequate staff consultation with medical personnel during overnight hours may have been a contributing factor to inmate deaths. DOC health services administrators acknowledged that strong arguments could be made for 24-hour nursing coverage at perhaps four additional prisons. In addition to providing on-site nursing services to prisoners experiencing health problems during the night, overnight nurses could conduct activities (such as recording newly arrived medications and transcribing medication orders) that can be challenging to do efficiently during the busier daytime hours. The following comments from two DOC medical staff reflect some of the concerns we heard from staff:

After hours [staffing] has always been an issue.... I feel we really should have 24-hour nursing coverage. Relying on [security] officers to relay information to an on-call doctor who doesn’t have the benefit of talking [to] or visualizing the patient [is] not safe.

I also feel there should be a nurse on 24/7 in all of the prisons, not just a select few. At night, the offenders are at the mercy of non-medical personnel who only know basic first aid. They are not taught what symptoms to look for, which ones are significant, what to make sure the doctor on call is made aware of, etc.

Another important part of ensuring proper access to health services outside of normal business hours is the establishment of clear policies to guide the staff—whether overnight nursing or security staff—in responding to life-threatening offender emergencies. According to National Commission on Correctional Health Care standards, “planning ahead for emergencies can help minimize bad

outcomes.”<sup>53</sup> We evaluated DOC policies related to emergency and after-hours care and found:

- **DOC has not adopted sufficient policies to address emergency health care services, nor to clarify responsibility for health services when medical staff are not on site.**

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**DOC should have clearer policies to address offender medical emergencies and after-hours care.**

While DOC has a policy addressing the emergency medical needs of *staff and visitors*, it does not have cohesive, system-wide policies for responding to *offender* medical emergencies or significant needs that arise when nursing staff are not on duty.<sup>54</sup> Given the lack of centralized policy, we requested that each facility send its “written plan for responding to medical, dental, and mental health emergencies 24 hours a day.” We received several documents from each facility, many of which only addressed small pieces of what professional standards suggest be contained in such a policy. The items we received included several tangentially related DOC policies, which are summarized in Exhibit 2.4. The exhibit demonstrates the difficulty that facilities had responding to our request, due to the lack of cohesive DOC emergency medical policies. Given that facility health services administrators had trouble articulating emergency policies, it is possible that the protocols are equally unclear to the non-medical security staff whose job it is to respond to after-hours medical emergencies.

Facilities also provided us with other documents, including facility-specific instructions on a variety of topics, which varied in usefulness. Among the most useful documents we received was an After-Hours Medical Emergency Form for Non-Medical Staff (which is supposedly used department-wide, but was only provided to us by half the facilities), and an Emergency Medical Special Duty Checklist, provided by the Stillwater facility.

According to DOC health services administrators, all security staff are trained as first responders and should use the After-Hours Medical Emergency Form for Non-Medical Staff to determine if an offender needs medical assistance. In the face of an offender medical emergency, security officers may consult the contractor’s on-call physician. However, without cohesive, system-wide policies for responding to emergencies, it is unclear that security staff have enough information to appropriately use the on-call physicians. Furthermore, DOC’s Health Services Unit does not use electronic medical records and the on-call physicians (who respond to calls from all facilities after physicians have left for the night) do not have direct access to offenders’ medical records.<sup>55</sup> If neither the security staff nor the on-call physician is familiar with a particular offender’s medical history, including medications and diagnoses, the physician might not have enough information to make sound decisions about treatment of offenders experiencing medical duress.

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<sup>53</sup> National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-E-08 (Emergency Services).

<sup>54</sup> DOC Division Directive 500.015 (Employee and Visitor Emergency Health Care).

<sup>55</sup> We discuss the lack of electronic medical records further in Chapter 6.

## Exhibit 2.4: Policies Cited as Related to Emergency Medical Services

DOC Policy	How Policy Related to Emergency or After-Hours Medical Care	Number of Facilities that Cited Policy
Health Services (500.010)	Overarching health services policy makes no mention of after-hours emergency care. <sup>a</sup>	5
Transfer for Needed Care (500.185)	States that necessary medical transfer is available to offenders 24 hours a day. However, the policy's procedures reference many health services positions that are not staffed around the clock at most facilities.	5
Medical Transfer Process (500.180)	No mention of after-hours emergency care.	3
Suicide and Self-Injury Prevention (500.306)	States that in an urgent after-hour situation, the watch commander may place an offender in continuing observation status and call the on-call mental health provider.	3
Mental Health Observation (500.300)	No mention of after-hours emergency care.	2
Mental Health Services On-Call (500.305)	Says that a mental health provider will be available by telephone or pager during non-office hours.	2
Dental Services (500.055)	Explains how dental requests are prioritized, with highest priority given to "emergency dental care," followed by "urgent dental care." The policy does not make clear, however, how emergency care can be accessed after hours.	2
Offender Sick Call (500.250)	No mention of after-hours emergency care.	2

NOTES: We asked each of the eight Minnesota correctional facilities housing primarily adult offenders to provide their "written plan for responding to medical, dental, and mental health emergencies 24 hours a day." This exhibit catalogs the various Department of Corrections policies or directives that the facilities provided, along with our assessment of how they fit into a plan for the emergency medical care of offenders. An additional seven policies (not listed here) were provided by one facility each.

<sup>a</sup> DOC revised this policy in November 2013, several months after we had requested documentation of emergency response plans from facilities. While the revised policy still does not address emergency medical services in the text, a list of attachments to the policy now includes the After-Hours Medical Emergency Form for Non-Medical Staff.

SOURCE: Office of the Legislative Auditor, review of policy documents provided by Minnesota correctional facilities.

### RECOMMENDATION

***The Department of Corrections should develop a system-wide policy for addressing the emergency needs of offenders 24 hours a day.***

DOC should develop and implement a system-wide policy that makes clear how security staff should handle offender medical emergencies when health services staff are not on site. The department should incorporate in its policy the content suggested in the standards developed by the National Commission on Correctional Health Care and the American Correctional Association.<sup>56</sup> A cohesive policy explaining the chain of command for treatment decisions,

<sup>56</sup> American Correctional Association, *2012 Standards Supplement* (Alexandria, VA, June 2012), Standard 1-HC-1A-08 (Emergency Plan); and National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-E-08 (Emergency Services).

information to convey to on-call physicians, and responsibilities in the event of required offender transport could help security staff address after-hours medical emergencies more smoothly.





# Adequacy of Special Services

This chapter discusses health care provided to two groups of high-need offenders. First, offenders with chronic health conditions—such as diabetes, hepatitis C, heart or respiratory diseases, and HIV/AIDS—often require close monitoring and frequent visits with health services staff. Second, offenders with chronic or acute mental health problems can be frequent users of the Department of Corrections (DOC) mental health services. In fiscal year 2013, 26 inmates accounted for 10 percent of all offender encounters with DOC mental health therapists, and 431 inmates accounted for 40 percent of all such encounters.

## SERVICES FOR INMATES WITH CHRONIC MEDICAL CONDITIONS

Chronic conditions are a significant driver of health care costs in both prisons and the community. In prison, offenders with chronic conditions tend to use sick call more often than offenders without these conditions.<sup>1</sup> Failure to properly manage chronic conditions can lead to adverse events such as hospitalizations for uncontrolled asthma, loss of vision or amputations for diabetics, and heart attacks or strokes for persons with high blood pressure or cholesterol.

**Chronic conditions can significantly affect health care costs.**

### Treatment Protocols

Professional standards suggest that prison health authorities develop clinical treatment protocols for chronic conditions that are consistent with national clinical practice guidelines.<sup>2</sup> However, we found that:

- **DOC has not established a sufficiently coordinated, comprehensive approach to care for individuals with chronic conditions.**

DOC has adopted protocols and provided central management of certain chronic diseases—specifically, HIV, hepatitis C, and tuberculosis. These diseases can be acute but together are less common than other chronic illnesses. DOC has adopted national standards for HIV management, and these are updated annually. In addition, DOC has a detailed protocol for hepatitis C treatment, and DOC policy includes detailed protocols for screening, prevention, and treatment of

<sup>1</sup> As described in Chapter 2, “sick call” is the process used by inmates to initiate most non-emergency medical visits.

<sup>2</sup> American Correctional Association, *Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions* (Alexandria, VA, January 2002), Standard 1-HC-1A-16 (Chronic Care); and National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-G-01 (Chronic Disease Services).

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**DOC has not established system-wide guidance for the management of several common chronic illnesses.**

tuberculosis.<sup>3</sup> DOC's medical director also directly supervises and tracks all patients in the DOC system who have been diagnosed with these diseases. DOC's contracted health care vendor through 2013 employed one nurse practitioner who treated all HIV-positive offenders.

In contrast, the DOC central office has not established specific guidelines for the management of many common chronic conditions, including diabetes, asthma, high blood cholesterol or blood pressure, and seizure disorders. Rather than establish central guidelines, DOC staff stated that they prefer that doctors use their individual judgment to determine treatment plans for each offender with a chronic condition. Although DOC's former health services contractor had its physicians follow clinical protocols for chronic conditions, it did not always receive needed cooperation from DOC staff to implement these protocols. DOC nurses are responsible for scheduling follow-up visits with physicians, and ensuring that offenders receive laboratory testing and doctor-ordered monitoring (such as blood pressure checks). Staff from the contractor DOC used through 2013 told us that they sometimes had difficulty getting nurses to schedule offenders for follow-up visits according to the vendor's chronic care guidelines. Due to the division of physician and nursing responsibilities, neither DOC nor the contracted vendor fully assured that DOC facilities implemented chronic care programs for the most common conditions.

In the absence of central guidance, individual DOC facilities have taken various approaches. For example, half of the DOC facilities use checklists or other guides for diabetes care. Some of these facilities use a draft diabetes care protocol that was never centrally adopted. However, most facilities have not developed comprehensive protocols for the most common chronic conditions.

## **Patient Tracking and Frequency of Care**

Professional standards also suggest that each correctional facility maintain a list of chronic care patients.<sup>4</sup> We observed that facilities vary in their ability to track offenders with chronic conditions and ensure timely follow-up. Some facilities have comprehensive tracking sheets for each offender with chronic conditions. These sheets show offenders' lab results (or when lab tests were last performed), dates of the offenders' most recent appointments, and dates when subsequent appointments should occur. However, the lists that several facilities use are incomplete. For example, some facilities generate lists of offenders with chronic conditions from DOC's main offender information system. This system does not identify all offenders with chronic conditions. For example, we found that about a third of offenders incarcerated on July 1, 2013, who received lab tests in the past year for diabetes were not identified in the DOC information system as being diabetic. The system also does not show lab results or follow-up dates.

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<sup>3</sup> DOC Policy 500.520 (Tuberculosis Prevention and Control for Offenders); and Department of Corrections, "Chronic Hepatitis C Management and Procedures," revised August 6, 2012.

<sup>4</sup> National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-G-01 (Chronic Disease Services).

**When an inmate moves to a different prison, DOC policy does not require the transferring facility to notify the receiving facility of the offender’s chronic conditions.**

The fact that DOC’s main information system does not identify all offenders with chronic conditions may result in inadequate follow-up, especially when offenders are transferred between DOC facilities. Such transfer problems have even happened among the small group of HIV-positive offenders in DOC, who are centrally tracked and held in certain Twin Cities area facilities. DOC has no policy that requires the transferring facility to notify the receiving facility of a transferred offender’s chronic conditions.<sup>5</sup>

To help us assess how facilities track and manage offenders with chronic conditions, we examined the frequency of chronic care visits among the DOC facilities. Because DOC’s former health care contractor had clinical guidelines for follow-up times which applied to all DOC facilities, it would be reasonable to expect facilities to have similar average frequencies for chronic care visits. However, we found that:

- **DOC facilities varied considerably in the frequency of chronic care visits for common chronic conditions.**

Exhibit 3.1 shows how care for three common chronic conditions was implemented in each facility. Variation in average chronic care follow-up times would be expected if, on average, offenders in some facilities were sicker and required a higher intensity of care than offenders in other facilities. However, the chronic conditions shown in the exhibit—asthma, diabetes, and hypertension—are not the type which typically results in specialized placements in certain DOC

**Exhibit 3.1: Average Days Between Nursing Visits for Selected Chronic Conditions, Fiscal Years 2008-2013**

DOC Correctional Facility	Average Days Between “Chronic Care Encounters” with Nursing Staff		
	Asthma	Diabetes	Hypertension
Faribault	285	274	165
Lino Lakes	169	104	108
Moose Lake/Willow River	195	32	38
Oak Park Heights	289	142	103
Rush City	326	230	129
St. Cloud	64	31	27
Shakopee	266	334	495
Stillwater	257	285	113

NOTES: A “chronic care encounter” is a nursing visit specifically related to a chronic illness or condition. Offenders with more than one chronic condition were excluded from this analysis because it was unclear which condition was being addressed during a given encounter. DOC does not separately track the chronic care encounters of patients with physicians, so the encounters in this analysis were limited to nursing visits. The St. Cloud prison serves as an intake facility for male offenders entering the prison system, and most offenders remain at that prison for short periods before transferring to other facilities. This may explain the short average chronic care follow-up periods for offenders at this facility.

SOURCE: Office of the Legislative Auditor, analysis of Department of Corrections data.

<sup>5</sup> In contrast, as discussed in the next section, DOC has a policy intended to ensure this type of communication when offenders with mental illness transfer to different facilities.

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**DOC actively monitors the health services provided to HIV-positive offenders.**

facilities.<sup>6</sup> Therefore, differences among facilities in the severity of offenders' chronic conditions probably does not explain most differences in the frequency of chronic care visits shown in the exhibit.

By contrast, the central management and tracking of DOC's HIV program has resulted in a high proportion of HIV-positive offenders being seen by their providers within the time period suggested by DOC's guidelines. DOC's medical director reviews the medical files of all HIV-positive offenders every six months, partly to ensure that they have had follow-up appointments according to DOC's HIV guidelines. DOC's most recent data showed that 90 percent of HIV-positive offenders were seen by their providers within the time periods suggested by DOC guidelines.

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### RECOMMENDATIONS

*The Department of Corrections should:*

- *Require documentation of offenders' chronic conditions in its main offender information system;*
  - *Require transferring facilities to notify receiving facilities when moving offenders with chronic conditions; and*
  - *Implement a comprehensive chronic care program across all facilities that is consistent with professional standards.*
- 

Some facilities record offenders' chronic conditions in DOC's main information system to assure that these offenders can be more easily tracked. However, there is no DOC policy requiring that this information be entered, and some facilities do not do so. To assure appropriate follow-up care, offenders with chronic conditions should be easy to identify and track. As we discuss in Chapter 6, DOC has not yet implemented an electronic health records system. DOC's current offender information system could help facilities track offenders with chronic conditions, but offenders' conditions need to be entered into the system for this to occur.

DOC should also formalize in policy a system of notification between transferring and receiving facilities. Implementing a policy which requires notification when offenders with chronic conditions are transferred will help ensure that offenders receive needed follow-up care. This notification between facilities is especially important because DOC does not centrally track chronic care follow-ups.

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<sup>6</sup> Some facilities have specialized units (like the Linden Unit at Faribault and the Transitional Care Unit at Oak Park Heights) where particularly sick offenders reside. Offenders in need of frequent visits to specialists or hospitals are often placed at Lino Lakes. However, DOC facilities should have a fairly similar composition (in terms of severity of illness) of offenders with the chronic illnesses we evaluated.

DOC should also follow best clinical practices and professional standards for prison health care by implementing system-wide chronic care guidelines for common chronic conditions. Doing so will help to ensure that offenders receive adequate health care. DOC should also ensure that its nursing staff and health care vendor work together to provide care for chronic conditions according to accepted clinical practices.

## SERVICES FOR INMATES WITH ACUTE OR CHRONIC MENTAL ILLNESS

Offenders with major mental illnesses and offenders with cognitive deficits can have particular difficulties in prison. These offenders may have trouble following rules and may be more vulnerable to extortion, abuse, and other victimization. Some offenders may not be able to follow the prison schedule or maintain proper hygiene without help. It can be difficult for security staff to detect exploitation of these offenders or observe their functioning on large prison living units.

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**Offenders with mental illnesses or cognitive deficits can face particular challenges in prison.**

DOC staff conduct mental health screenings and assessments at admission to prison. DOC does not specifically screen or assess for cognitive deficits.<sup>7</sup> Some offenders with mental illness or cognitive deficiencies are not identified until they have problems in prison. Once an offender is identified as having a mental illness or cognitive disability which makes functioning in the general prison population difficult, he or she may be referred to one of two living arrangements discussed below: Supportive Living Services or the Mental Health Unit. About 450 offenders in DOC facilities as of July 1, 2013, had received Supportive Living Services or lived in the Mental Health Unit services between 2010 and mid-2013. Our analysis of DOC data showed that some offenders are placed immediately in these living arrangements, while others spend months or even years in DOC facilities prior to such placements.

### Supportive Living Services

Supportive Living Services (SLS) at five facilities serve offenders with mental illnesses or cognitive impairments which make it difficult for these offenders to function in the general prison population.<sup>8</sup> Exhibit 3.2 describes these programs. According to DOC, the goal of SLS is to help offenders achieve “an adequate level of functioning” so they can return to the general offender population in the facilities.<sup>9</sup> However, some offenders are never able to function or be safe in the general prison population and serve out their sentences in SLS. DOC places

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<sup>7</sup> DOC has brief screening questions regarding cognitive functioning on its standard screening form. In addition, as of August 2013 and the implementation of the federal Prison Rape Elimination Act, offenders are asked if they have a cognitive disability, and screeners are asked to note if an offender appears to have a cognitive disability. However, these screening methods detect only the most obvious or profound cognitive disabilities.

<sup>8</sup> Offenders in the Faribault SLS and Shakopee’s regular Women of Wellness programs do not necessarily need to have a severe mental illness or cognitive impairment. As shown in Exhibit 3.2, these programs are short-term, skill-based programs.

<sup>9</sup> DOC, Referral for Supportive Living Services form, February 2011.

Some prisons have living areas that provide additional protection to vulnerable inmates.

### Exhibit 3.2: Supportive Living Services (SLS) and Women of Wellness Programs

Program Name and Brief Description	Number of Offenders in Program <sup>a</sup>	Average Days in Program <sup>b</sup>
<b>Rush City SLS:</b> For offenders with major mental illness and/or cognitive problems	29	132
<b>Stillwater SLS:</b> For offenders with major mental illness and/or cognitive problems	6	145
<b>Stillwater Transition Services:</b> For offenders with major mental illness	9	213
<b>Lino Lakes SLS:</b> For offenders with major mental illness and/or cognitive problems	9	141
<b>Faribault SLS:</b> Short-term, skills-based program for offenders who wish to work on personal issues in a supportive environment	9	40
<b>Shakopee Women of Wellness Program:</b> Short-term program for offenders who wish to work on personal issues in a supportive environment	58	36
<b>Shakopee Women of Wellness Extended Program:</b> Supportive living with no time limit for women with severe mental illness or cognitive problems	3	112

NOTE: Lino Lakes also has an SLS program for offenders with dual diagnoses of chemical dependency and major mental illness; we did not evaluate this program.

<sup>a</sup> Offenders in program as of September 6, 2013.

<sup>b</sup> Represents the average days in the program for offenders admitted to the program in 2012 and discharged prior to September 6, 2013.

SOURCES: Office of the Legislative Auditor, analysis of DOC data and program descriptions from DOC Supportive Living Services referral form.

offenders in SLS based on their custody level, type of impairment, and level of impairment.<sup>10</sup> Some offenders are placed in SLS when transitioning from more intensive residential services in the Mental Health Unit.

Supportive Living Services is not a residential mental health treatment program. Some mental health directors described SLS as more like protective custody than a treatment program. Offenders in SLS live on a regular living unit, but typically reside in adjacent cells close to the security desk. Offenders employed as mentors also live on the unit to help SLS participants with cleaning and other tasks. Offenders receive a minimum of one to two hours of group therapy per week and may also see a therapist individually.

<sup>10</sup> DOC has developed a tool used to identify offenders' impairments in the areas of mental status, mood regulation, danger to self or others, social functioning, ability to follow prison rules, hygiene, compliance with prescribed medications, coping skills, and ability or willingness to participate in prison programming (such as work, education, or treatment).

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**The 1978 Legislature created a special prison unit for inmates with severe mental illness.**

DOC staff stated that there is a great need for more SLS beds for men.<sup>11</sup> In contrast, staff told us that the SLS program for women has never been full. Staff said that women with mental illness or low cognitive abilities can often function and be safe in the general population because the women's prison is more supportive and less dangerous than most men's prisons.

## Mental Health Unit

The Mental Health Unit (MHU) is a living unit within the Oak Park Heights maximum security prison that was established by the 1978 Legislature for severely mentally ill inmates who cannot be placed elsewhere at DOC or are in crisis.<sup>12</sup> MHU has 47 beds, 6 of which are reserved for non-mentally ill offenders employed as mentors or janitors. The average daily MHU census between August and October 2013 was 35. The average length of stay for patients admitted to MHU in 2010 was 218 days; that declined to 118 days for patients admitted in 2012.<sup>13</sup>

The MHU living unit includes a small room where group programming and individual therapy can be offered. MHU offers three to four hours of group programming per day in the living unit; a large group space separate from the living unit offers programming 15 hours per week.<sup>14</sup>

MHU is staffed to provide intensive residential care to offenders. Each clinician has six or seven offenders on his or her caseload. This allows clinicians to meet individually with offenders on a daily basis, if needed.

MHU is designed to be similar in many ways to inpatient mental health treatment found outside of DOC. However, we found that:

- **DOC's Mental Health Unit has increasingly provided crisis and stabilization services rather than therapeutic treatment.**

MHU's focus on crisis intervention has occurred due to an increase in the number of offenders in MHU with violent or uncontrolled behaviors and those

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<sup>11</sup> DOC staff told us that when an offender needs placement in SLS but there is no bed available, they try to place the offender in a cell adjacent to the SLS cells to help security officers better monitor the offender's safety. However, such an offender would not participate in group therapy with the SLS participants.

<sup>12</sup> *Laws of Minnesota* 1978, chapter 707, sec. 1. Women offenders cannot be placed in MHU. Women inmates suffering from acute mental health crises may be transferred to Hennepin County Medical Center; women needing inpatient treatment are sent to the Minnesota Security Hospital or a community hospital. Staff at the Shakopee prison said they have had considerable success convincing women in crisis to take antipsychotic medication to stabilize their illnesses.

<sup>13</sup> These figures exclude one inmate admitted to MHU in 2010 and two inmates admitted in 2012 who, as of January 2014, had not yet been discharged from MHU.

<sup>14</sup> The group therapy space is very therapeutic in appearance and distinctly unlike other parts of the prison. This space is used for psychoeducation, group therapy, education, and more general skill-building groups (on topics such as hygiene, relaxation, and art).

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**The difficult behaviors of some inmates make it hard for DOC to provide mental health treatment.**

refusing psychotropic medications.<sup>15</sup> Some offenders in MHU have such difficult behaviors that their access to mental health programming is limited. Some are not allowed to leave their cells for therapy; others refuse therapy altogether. Clinicians assigned to these offenders talk with them at their cell doors, but such encounters are not private and may not be considered “therapy.”

MHU’s physical structure further curtails treatment of these inmates. There is only one room on the MHU living unit where therapists can meet privately with offenders; this limits how much therapy offenders can receive. Many offenders with difficult or violent behaviors also cannot leave the living unit to attend programming in the large MHU group room.

Difficult behaviors may sometimes be controlled or limited by taking medications. When offenders refuse to comply with prescribed antipsychotic medication, MHU staff may seek court orders that allow involuntary administration of the medication. However, according to DOC staff,

- **Court hearings for inmates refusing medications do not always comply with the statutory timelines.**

Exhibit 3.3 shows DOC petitions for court orders that would allow involuntary administration of antipsychotic medications to MHU residents; there was a particular increase in 2012.<sup>16</sup>

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**Exhibit 3.3: Mental Health Unit Population and Offenders with Behavioral Control Plans or Court Orders, 2010-2013**

Calendar Year	Average MHU Population	Average Number of Offenders with Behavioral Control Plans <sup>a</sup>	Number of Petitions for Court Orders
2010 <sup>b</sup>	42.3	14.8	13
2011	41.7	16.9	11
2012	37.5	18.1	30
2013 <sup>c</sup>	36.3	22.7	17

NOTES: MHU census and behavioral control plan data for a given year represents the average of that year’s monthly averages. The number of petitions for court orders shown reflects new petitions filed in the calendar year that related to (or included a request for) a court order for involuntary administration of medication of offenders in MHU.

<sup>a</sup> Behavioral control plans are used for offenders whose behavior threatens MHU residents or staff, making it unsafe for them to fully participate in treatment. These plans restrict offenders’ access to programming and when they can be out of their cells.

<sup>b</sup> MHU census and behavioral control plan data were not available for January 2010.

<sup>c</sup> Data were not available for December 2013.

SOURCE: Office of the Legislative Auditor, analysis of Department of Corrections data.

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<sup>15</sup> Mental health staff in the maximum security prison (Oak Park Heights) refer more offenders to MHU than any other facility. Staff told us that some offenders sent to Oak Park Heights in recent years for their behaviors in prison have been found to be mentally ill and in need of treatment.

<sup>16</sup> DOC provided us with information on its number of petitions for court orders rather than the number of court orders granted. Staff told us they almost always receive a court order when they make a petition. According to DOC, the court denied a petition only once in recent memory.



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**When DOC asks for authority to administer an inmate's medications involuntarily, the courts do not always hear these petitions in a timely manner.**

Staff said that in some cases they have waited close to a year for a petition to be heard by a court. Time spent waiting for court hearings contributes to the use of MHU as a crisis center rather than a treatment center. Minnesota law requires court hearings for a patient refusing medication to be heard within 14 days of the request, and the court may extend the hearing date by an additional 30 days.<sup>17</sup> Staff stated that, because there is a shortage of court-appointed mental health examiners, the court routinely delays these hearings. The result is that offenders who refuse to take medications may remain in MHU for months when they are not stable enough to participate in treatment.

When there are too many offenders with behavioral issues in MHU, the unit may be functionally full even if there are empty beds. For example, offenders who are required to be in restraints to leave their cells cannot be moved when other offenders are out of their cells (the shackled offender would be vulnerable to attack). If many offenders must be restrained when they leave their cells, it can be difficult for DOC to have enough hours in the day to get each offender out of his cell individually.<sup>18</sup> As shown in Exhibit 3.3, as MHU's number of offenders with difficult behaviors and in need of involuntary administration of medication has increased, the number of offenders on the unit has decreased.

Paradoxically, some offenders who become stable enough to receive treatment in MHU may be sent to other DOC facilities' SLS or general living units rather than staying in MHU to receive treatment. According to DOC staff, SLS programs have developed capacity to treat some offenders with less severe behaviors, but SLS does not offer the level of programming that MHU does. Staff said an intermediate level of service—between SLS and MHU—might be helpful. Because MHU is located at the maximum security prison, this unit is better equipped than other facilities to handle offenders with very difficult behaviors.

One other consequence of the increase in extreme behaviors in MHU has been:

- **Some very mentally ill offenders are held in extreme isolation in the Administrative Control Unit (ACU) of the Oak Park Heights prison.**

ACU is a high-security unit for offenders sentenced to long periods of segregation.<sup>19</sup> ACU cells are extremely isolating. Offenders can communicate with staff through an intercom. Offenders sometimes yell through the area on the wall where the intercom is located to talk to an offender in an adjacent cell.<sup>20</sup> An

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<sup>17</sup> *Minnesota Statutes* 2013, 253B.092, subd. 8.

<sup>18</sup> If the offender is only exercising, that offender may be allowed to do so only in a designated area out of his individual cell. This allows MHU a little more flexibility when there are many offenders with difficult behaviors.

<sup>19</sup> ACU is also used for offenders on administrative segregation, which is a way to hold offenders to keep them safe from other offenders or to isolate them during investigations. In addition, ACU is used to hold offenders on Administrative Control Status. This is a rarely-used status for offenders who have served their segregation time but still constitute a threat to others. Offenders who are mentally ill cannot, by DOC Policy 301.087, be held on Administrative Control Status. However, they can be held in ACU.

<sup>20</sup> There is not as much concrete between the cells where the intercom is located, making it possible to hear a person in an adjacent cell.

anteroom between each cell and ACU's main hallway effectively seals each cell off from hearing or communicating with anyone walking through the hall.<sup>21</sup>

Some severely mentally ill offenders are transferred from the Mental Health Unit to ACU due to extreme behaviors. These offenders continue to be assaultive despite involuntary administration of medication. They receive treatment from an MHU clinician while in ACU and are often transferred back and forth between MHU and ACU, depending on their behaviors.

Mental health staff have more access to offenders in ACU than they would have to offenders in other prison segregation units (or even than they would have, at times, in MHU) due to the ability to use the anteroom attached to each cell as a protective chamber. The anterooms enable therapists to talk privately with offenders without having to remove the offenders from their cells, and without placing therapists or offenders at risk of assault from offenders being moved through the ACU hallway.

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## RECOMMENDATIONS

*The Department of Corrections should:*

- *Consider ways to maximize the therapeutic potential of its existing Mental Health Unit, which may require exploring other options for addressing mentally ill offenders with difficult behaviors; and*
  - *Work with the courts to help ensure that court hearings related to involuntary administration of medication occur in a timely manner.*
- 

**DOC's Mental Health Unit lacks sufficient private space for therapists to meet individually with offenders.**

DOC's MHU includes a therapeutic treatment space where hours of group treatment and programming can take place. MHU has the staffing to provide a significant amount of individual and group therapy. However, increasing numbers of offenders in crisis and with severe behaviors has limited how much programming can be delivered. The lack of private space to meet with offenders individually makes it difficult for therapists to develop the relationships they may need to convince offenders to take medication voluntarily or participate in treatment. Further, because of MHU's physical structure, DOC has needed to use the Administrative Control Unit for some very mentally ill offenders with persistent extreme behaviors. DOC has considered options for remodeling existing MHU space or other DOC space which would allow more treatment of offenders with difficult behaviors, but has not reached a satisfactory solution.

Addressing the long wait time for court hearings may help MHU stabilize some offenders more quickly. So long as there are offenders in MHU awaiting orders for involuntary administration of medication, there will be offenders in the unit whose behaviors have not yet been controlled. However, a court cannot order involuntary administration of medication to offenders who are competent to

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<sup>21</sup> In contrast, in one segregation unit we visited, offenders were playing chess with one another by yelling out their moves through the cell door. This would not be possible in ACU.

refuse their medication. Thus, addressing the timeliness of court hearings would probably reduce some of MHU's challenges but, by itself, would not solve them.

## Mental Health Care in Segregation Units

Segregation units are parts of prison in which offenders are kept separate from the rest of the prison population, typically for disciplinary purposes or to allow close observation. Conditions in segregation can be isolating because offenders are kept in single cells and generally cannot participate in programming outside of their cells. Offenders leave their cells for exercise for a maximum of seven hours per week, and are sometimes isolated even then. Some offenders spend long periods of time—even years—in segregation.

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**Research suggests that placing inmates in segregation can make their mental illnesses worse.**

There is growing concern that isolating persons with mental illness can make these illnesses worse. Researchers have found that inmates can develop mental health symptoms as a result of the isolation in some segregation units.<sup>22</sup> Some researchers and professionals have expressed particular concern about the impact of segregation on persons with mental illness.<sup>23</sup> The American Psychiatric Association has adopted the position that (1) prolonged segregation of inmates with mental illness should, with rare exceptions, be avoided and (2) segregated inmates with mental illness should have access to adequate mental health programming and recreation.<sup>24</sup> Professional standards advise against placing inmates with mental illness in conditions of extreme isolation, and they suggest frequent monitoring by mental health staff of inmates in segregation.<sup>25</sup> National

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<sup>22</sup> For example, see Stuart Grassian, "Psychiatric Effects of Solitary Confinement," *Journal of Law & Policy* 22 (2006): 325-383.

<sup>23</sup> For example, see: Jeffrey Metzner and Jamie Fellner, "Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics," *The Journal of the American Academy of Psychiatry and the Law* 38, no. 1 (2010): 104-108. A recent study found that administrative segregation in Colorado did not worsen symptoms of mental illness in the mentally ill (Maureen O'Keefe and others, *One Year Longitudinal Study of the Psychological Effects of Administrative Segregation*, (2010)). However, the study's methods have been criticized by some, and whether the results are replicable in other prisons remains unclear (Ann Rocheleau, "Examining the Details of Supermax Confinement: Commentary on a One Year Longitudinal Study of the Psychological Effects of Administrative Segregation," *Corrections & Mental Health: An Update of the National Institute of Corrections*, <http://community.nicic.gov/blogs/mentalhealth/archive/2011/06/21/examining-conditions-of-confinement-in-studies-of-supermax-prisons-commentary-on-one-year-longitudinal-study-of-the-psychological-effects-of-administrative-segregation.aspx>, accessed December 21, 2013.

<sup>24</sup> American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness* (2012).

<sup>25</sup> National Commission on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (Chicago, 2008), Standard MH-E-07 (Segregated Inmates).

and international agencies have questioned whether use of segregation violates the rights of offenders with and without mental illness.<sup>26</sup>

In addition, court cases across the country have examined whether the conditions in prison segregation units are unacceptably harmful to prisoners. Courts have required monitoring the mental health of persons with mental illness in segregation and placed limits on who can be placed in prolonged isolation.<sup>27</sup> In response to actions brought by prisoners, some prison systems around the country have agreed to limit the use of segregation, especially with mentally ill inmates.<sup>28</sup>

In interviews, DOC staff acknowledged that segregation can worsen the mental health symptoms of some mentally ill offenders. Some segregated offenders withdraw or exhibit catatonic behaviors. Some respond to the stress of segregation by acting out further, resulting in more segregation time. On the other hand, staff said that some mentally ill offenders prefer to be in segregation and purposely get segregation sentences because these units are safer and quieter than most general living units.

### Discipline of Mentally Ill Offenders

DOC may impose segregation to discipline offenders who break prison rules. Many offenders have anti-social tendencies and do not obey the rules. However, it can be difficult for prison staff to determine whether offenders are willfully breaking rules and deserve to be punished, or if offenders are unable to adjust to prison life and rules due to mental illness or cognitive deficiency.

It is important for DOC to consider—difficult as it is—whether mental illness plays a role in rule breaking. We found:

- **Mentally ill offenders spend more time in segregation than other offenders.**

Our analysis showed that the offenders who have received Supportive Living Services or spent time in the Mental Health Unit spent 2.4 times more days in

<sup>26</sup> Thomas Perez, Assistant Attorney General, United States Department of Justice, Civil Rights Division, and David Hickton, United States Attorney, United States Attorney's Office, Western District of Pennsylvania, letter to Governor Tom Corbett of Pennsylvania, "Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation," May 31, 2013; Government Accountability Office, *Improvements Needed in Bureau of Prisons' Monitoring and Evaluation of Impact of Segregated Housing* (Washington, DC, 2013); and United Nations General Assembly, *Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment* (New York, 2011).

<sup>27</sup> *Coleman v. Wilson*, 912 F. Supp. 1282 (E.D. Cal. 1995); *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995); and *Hadix v. Caruso*, 465 F. Supp.2d 776 (W.D. Mich. 2006).

<sup>28</sup> For example, see: *Settlement Agreement, Disability Law Center, Inc. v. Massachusetts Department of Correction, et al.* (No. 07-10463 D. Mass. April 12, 2012); *Private Settlement Agreement, Disability Advocates, Inc. v. New York State Office of Mental Health, et al.* (02 Civ 4002 S.D. N.Y. April 2007); *Consent Decree, C.B. by and through his next friend Charleston DePriest, et al., v. Walnut Grove Correctional Authority, et al.* (No. 3:10cv663 S.D. Miss. February 3, 2012); *Consent Decree, Presley v. Epps* (4:05CV148-JAD N.D. Miss. February 15, 2006); and *Supplemental Consent Decree on Mental Health Care, Use of Force and Classification, Presley v. Epps* (4:05CV148-JAD N.D. Miss. November 13, 2007).

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**Inmates with mental illness spent a higher proportion of their prison days in segregated cells than other inmates.**

segregation as a proportion of their total days in DOC than other offenders.<sup>29</sup> Past DOC policy may have contributed to the disproportionate time mentally ill offenders spent in segregation. Prior to mid-2013, DOC policy did not specifically require consideration of mental health when DOC was determining whether to discipline an offender.<sup>30</sup> In practice, mental health staff could request a departure from normal discipline if an offender's behavior was related to mental illness or if segregation time would be harmful to the offender; however, the DOC policy did not discuss the possibility of such departures.<sup>31</sup>

A policy that took effect in Summer 2013 requires DOC discipline officers to consider a mental health assessment in the discipline hearing. A new mental health assessment form attached to the policy asks whether mental illness affected the offender's actions and, if so, whether any form of discipline would be inadvisable.

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### RECOMMENDATION

*The Department of Corrections should (1) monitor the extent to which segregation is used for offenders with mental illness and (2) consider ways to reduce the disproportionate use of segregation for such offenders, where appropriate.*

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DOC mental health leadership is aware of the disparity in the time spent by offenders with and without mental illness in segregation, but there is not currently an agency-wide initiative to address the issue.<sup>32</sup> As discussed earlier, the isolation of segregation may be detrimental to mentally ill offenders. In certain cases, Supportive Living Services (or another type of protective custody) may be the more appropriate place for mentally ill offenders who are vulnerable or have difficulties living in general population units.<sup>33</sup>

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<sup>29</sup> Some of the days spent in segregation may be in "continuing observation status" cells. These are cells in segregation units used to monitor offenders in mental health crises. This status is discussed in the next section.

<sup>30</sup> DOC Policy 303.010 (Offender Discipline), in effect until July 2013. The mental health assessment required in policy was used to assess whether offenders could understand and participate in disciplinary hearings.

<sup>31</sup> Attached to the policy (but not addressed in the policy) was a mental health assessment form. It asked whether an offender's behavior was "volitional." Mental health staff told us that waiver of discipline was only considered if an offender had no control over his actions due to mental illness. The staff said this was a very high standard.

<sup>32</sup> DOC staff said that discipline is appropriate for mentally ill offenders whose rule infractions were not directly caused by mental illness.

<sup>33</sup> In addition, mentally ill offenders who spend time in segregation may be subsequently required to live in higher custody levels and may have to spend more time in prison due to loss of "good time" (for prisoners sentenced for crimes committed prior to August 1993) or loss of time on supervised release (for offenders sentenced for crimes committed on or after August 1, 1993). Offenders generally serve two-thirds of their sentence in prison and one-third on supervised release. Offenders who have disciplinary infractions in prison may have the in-prison portion of their sentence extended (and the supervised release portion reduced). See *Minnesota Statutes* 2013, 244.04 and 244.05; and DOC Policy 303.010 (Offender Discipline).

DOC's 2013 policy change was a good first step to addressing the disparity between offenders with and without mental illness. Under the new policy, staff may seek waivers from discipline for certain offenders with mental illnesses, referring them instead to mental health programs. Disciplinary staff's decisions must include consideration of the impact of mental illness on an offender's infractions. DOC should monitor the implementation of this policy system-wide.

### Access to Mental Health Care in Segregation

Although mental health therapists regularly visit DOC's segregation units,

- **Offenders have less access to mental health care in segregation than in the prison's general population.**

**It is hard to provide therapeutic mental health services to offenders housed in segregation units.**

DOC mental health staff told us that it is difficult—if not impossible—to have truly therapeutic mental health encounters on segregation units. They said their encounters with offenders in segregation are usually brief, sometimes consisting of a few words at the cell door.<sup>34</sup> Staff sometimes schedule visits with offenders in a segregation interview room, but these visits may be shorter and less frequent than the offender would receive in the general prison population. This is partly because the interview room in a segregation unit may also be used by other staff who need to meet with offenders. In addition, the amount of time mental health staff can spend in the segregation unit is strictly limited by the segregation unit schedule.

DOC policy requires mental health staff to perform an assessment of all offenders who remain in segregation for more than 30 days and to reassess them every 90 days thereafter.<sup>35</sup> In most cases, DOC mental health staff have complied with the department's policies regarding assessment of offenders placed in segregation. As shown in Exhibit 3.4, most first mental health assessments in fiscal years 2008 to 2013 took place within 31 days of placement in segregation. The Oak Park Heights facility had the lowest percentage (64 percent). For subsequent mental health assessments of offenders in segregation, 96 percent occurred within 90 days of the preceding assessment in segregation.

Professional standards for mental health care in prisons state that offenders in "extreme isolation" should be seen by mental health staff at least weekly.<sup>36</sup> Offenders in segregation who have "limited contact" with staff and fellow inmates should be seen by mental health or medical personnel three days per

<sup>34</sup> This is not true for offenders serving segregation sentences while in the Mental Health Unit. Offenders may participate in all the therapeutic programming their behavior will allow when in the Mental Health Unit. Although these offenders are participating in programming and may be out of their cells and not "segregated," they still receive credit for serving their segregation time in the Mental Health Unit.

<sup>35</sup> DOC Policy 301.083 (Segregation Unit Management).

<sup>36</sup> National Commission on Correctional Health Care, *Standards for Mental Health Services in Correctional Facilities* (Chicago, 2008), Standard MH-E-07 (Segregated Inmates). Extreme isolation is when offenders are seen by staff or other inmates fewer than three times a day.

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### Exhibit 3.4: Timeliness of Mental Health Assessments and Visits for Offenders in Segregation, Fiscal Years 2008-2013

DOC Correctional Facility	Percentage of Offenders Assessed within 31 Days of Placement in Segregation <sup>a</sup>	Percentage of Subsequent Mental Health Assessments Performed within 90 Days <sup>a</sup>	Average Days Between Visits by Mental Health Staff
Faribault	72%	100%	11
Lino Lakes	84	100	8
Moose Lake/Willow River	81	100	9
Oak Park Heights	64	92	28
Rush City	71	97	18
St. Cloud	86	95	18
Shakopee	91	99	6
Stillwater	70	98	18
TOTAL	72%	96%	18

<sup>a</sup> For the first two columns, we analyzed only those instances in which the offender remained in segregation long enough to require an assessment (a minimum of 31 days).

SOURCE: Office of the Legislative Auditor, analysis of Department of Corrections data.

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week, according to professional standards.<sup>37</sup> As shown in Exhibit 3.4, mental health staff in less than half the DOC facilities visited offenders in segregation on a near-weekly basis, on average. However, nursing staff visit all segregation units several times per day for distribution of medication.

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#### RECOMMENDATION

*The Department of Corrections should explore ways to improve access to mental health care for mentally ill offenders in segregation.*

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Offenders with mental illness should receive ongoing attention from DOC mental health staff while in segregation. Some DOC facilities have experimented with removing offenders from segregation in order to participate briefly in outside programming or therapy. Such efforts should be done with careful consideration of the need to maintain proper security. In light of the research showing the deleterious effects of segregation on the mentally ill, DOC should explore options to increase access to mental health care to offenders in segregation.

### Emergency Mental Health Services

When offenders exhibit unusual behaviors or are potentially suicidal, there is a need for mental health and prison staff to act immediately. Some of the types of incidents that constitute a mental health emergency include: offenders who state

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<sup>37</sup> *Ibid.*

**DOC policies are largely consistent with professional standards for emergency mental health services.**

they want to (or actually attempt to) kill themselves, offenders hearing voices or experiencing other hallucinations, and offenders who are intoxicated or have overdosed. DOC staff recorded 644 reports of mental health emergencies in fiscal year 2013.

Professional standards require a comprehensive suicide prevention policy and annual training of staff, intensive monitoring of suicidal offenders and offenders suffering from mental health crises, and availability of inpatient psychiatric care.<sup>38</sup> DOC policies and guidelines are generally consistent with these standards. On-call psychologists are available to direct security officers' response to offender crises after hours when no mental health staff are present in the facility.<sup>39</sup> When an offender has an acute mental health crisis which cannot be resolved at the facility, mental health staff can refer that offender to the Mental Health Unit.<sup>40</sup> DOC mental health guidelines suggest that referrals of offenders for urgent mental health needs should result in staff visits on the day of the referral.<sup>41</sup> Suicide prevention training must be delivered every year to staff who have direct contact with offenders.<sup>42</sup> Suicidal offenders and offenders in crisis are required to be placed on "continuing observation status" in designated cells, often in segregation units.<sup>43</sup> Mental health staff must visit offenders on continuing observation status on a daily basis.<sup>44</sup>

In addition to meeting the basic requirements of professional standards as described above, we found that:

- **DOC has established strong mechanisms for monitoring and following up on individuals who have experienced mental health crises, although some facilities' practices could be improved.**

<sup>38</sup> American Correctional Association, *2012 Standards Supplement* (Alexandria, VA, June 2012), Standard 1-HC-1A-25 (Mental Health Program); American Correctional Association, *Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions* (Alexandria, VA, January 2002), Standards 1-HC-1A-30 (Suicide Prevention and Intervention) and 1-HC-1A-31 (Mental Illness and Developmental Disability); and National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standards P-G-04 (Basic Mental Health Services) and P-G-05 (Suicide Prevention Program).

<sup>39</sup> DOC Policy 500.305 (Mental Health Services On-Call).

<sup>40</sup> Female offenders do not have access to the Mental Health Unit.

<sup>41</sup> Department of Corrections, *Core Expectations for Mental Health Providers*, downloaded from DOC intranet site July 30, 2013.

<sup>42</sup> DOC Policies 500.306 (Suicide and Self-Injury Prevention) and 103.420 (Pre-Service and Orientation Training). In addition, DOC's annual training plan requires staff who have contact with offenders to receive suicide prevention training every year.

<sup>43</sup> DOC Policy 500.300 (Mental Health Observation). Offenders on continuing observation status are generally placed in a segregation room with a camera and monitored every 15 minutes. (The Transitional Care and Mental Health units at Oak Park Heights have these cells in the unit rather than in a separate segregation unit.) On the most restrictive level of continuing observation status, all offender clothes and possessions are removed and the offender wears a tear-proof Kevlar gown to prevent suicide. Offenders may be placed in less-restrictive continuing observation status if mental health staff determine these offenders are at less risk of hurting themselves or others. This less restrictive status may allow offenders to wear clothes and have sheets on their beds, and offenders may be moved back to a regular living unit in a cell close to the security desk.

<sup>44</sup> DOC Policy 500.300 (Mental Health Observation).



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**Mental health staff do not always conduct timely visits with offenders following their release from “continuing observation status.”**

Mental health staff maintain two tracking logs which are accessible to and viewable by mental health staff in all DOC facilities. When an event is recorded in the on-call psychologist log, an e-mail is automatically sent to all mental health staff at the facility where the offender is located. In addition, mental health staff maintain a “significant incidents log.” This central log documents suicide attempts, drug overdoses, and mental health emergencies—both during regular hours and after hours. This log is a useful index of an offender’s mental health emergencies. It can be particularly useful when mental health staff do not have immediate access to an offender’s mental health record.

DOC policy requires mental health staff to visit offenders on continuing observation status daily and have a follow-up visit with them within one week of release from this status. Our review of DOC records showed a wide range in facilities’ compliance with the follow-up policy: from 44 percent of offenders receiving follow-up within one week at one facility to 85 percent of offenders at another facility. For some offenders, there was no documentation of follow-up at all following removal from continuing observation status.<sup>45</sup>

Mental health staff have also implemented a policy to ensure that offenders on the mental health caseload are not overlooked when they are transferred from one DOC facility to another. This is particularly important when offenders have had mental health emergencies. DOC policy requires mental health staff at the transferring facility to: (1) review the file of any offender who is being transferred and (2) notify mental health and nursing staff at the receiving facility that the offender will be transferred, indicating whether the offender has any specific mental health concerns of which staff should be aware.<sup>46</sup>

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<sup>45</sup> Mental health supervisors use a log to monitor whether staff follow up with offenders within one week of release from continuing observation status. DOC did not provide us with individual-level data for two facilities, so our review was based on six facilities.

<sup>46</sup> DOC Policy 500.302 (Mental Health Continuity of Care).



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# Oversight, Accountability, and Quality Improvement

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**Existing mechanisms for overseeing, holding accountable, and improving the quality of DOC health services are insufficient.**

In this chapter, we focus on mechanisms for oversight, accountability, and quality improvement in prison-based health services. We considered the extent to which the Department of Corrections (DOC) health services have been independently reviewed for purposes of licensure or accreditation. We examined the options that inmates may pursue if they have concerns about health services, such as filing grievances, submitting complaints to state boards that regulate medical professionals, and pursuing litigation. We examined quality control mechanisms mandated by state laws and recommended by professional standards. We also examined the extent to which prison-based health care professionals have been subject to disciplinary actions.

These mechanisms are important because problems can and do occur in health services delivery. While some problems result in minor delays or inconvenience, others may significantly affect patient well-being. Inmates—unlike most people in the community—have little ability to choose their health care providers. Overall, we concluded that existing mechanisms for oversight, accountability, and quality improvement do not adequately ensure quality or provide recourse when concerns about the quality of prison-based health care arise.

## LICENSING AND INSPECTION REVIEWS

Many public and private health care facilities and programs in Minnesota are subject to state regulation. They are granted licenses by state agencies if they meet minimum standards, and state agencies periodically inspect the facilities and programs to ensure their ongoing compliance. For example, the Minnesota Department of Human Services operates various mental health hospitals and residential facilities, which are subject to regulation by that department's Licensing Division and the Minnesota Department of Health. Privately operated nursing homes and health care facilities are also subject to state licensure and inspection. We found that:

- **The Department of Corrections does not license the facilities it operates, and state statutes are not sufficiently clear regarding whether DOC facilities are supposed to be licensed.**

At first glance, the law appears to be clear. Minnesota law requires the Department of Corrections to “inspect and license all correctional facilities throughout the state, whether public or private, established and operated for the detention and confinement of persons detained or confined therein according to

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**Minnesota state prisons are not licensed.**

law.”<sup>1</sup> The statutory definition of correctional facilities in this law does not specifically exclude facilities operated by DOC.<sup>2</sup> The law also requires the department to promulgate state rules that set minimum standards for these facilities, including standards relating to offender health and treatment.

In practice, DOC does not license its own facilities. It licenses local correctional facilities, such as jails and detention centers, and it has developed standards in state rules for local facilities. State law exempts DOC from having to use the state’s formal rule-making process to develop policies governing the management of its state-run facilities, and DOC told us it is unclear whether this exemption was intended to also exempt DOC facilities from state licensure.<sup>3</sup> In addition, DOC officials said there might be a conflict of interest if the department were to license its own facilities. We agree that this type of licensing arrangement would have potential pitfalls, but there is a precedent for it within state government. Notably, the Minnesota Department of Human Services licenses a wide range of treatment facilities and group homes that it also operates. To address possible concerns about conflicts of interest, the licensing function in the Department of Human Services is organizationally separate from the unit within the department that operates these facilities. Similarly, the DOC Inspection and Enforcement Unit (which licenses local corrections facilities) is organizationally separate from the part of DOC that operates state prisons.<sup>4</sup>

The Department of Corrections’ Inspections and Enforcement Unit conducts some inspections of state-run correctional facilities, but these inspections have given limited attention to health services. Rather, the primary focus of these inspections has been on security issues. Most of the health services issues reviewed during these inspections relate to proper control and security of medical instruments (such as syringes) and medications. The DOC inspections director told us that the components of the inspections related to health services are “minimal,” and he would like to revise the standards and inspection procedures to include a larger focus on health services. Aside from these inspections,

- **Some of DOC’s health services activities undergo ongoing state regulatory review, but most do not.**

The department’s sex offender and chemical dependency programs undergo formal regulatory reviews.<sup>5</sup> State rules require sex offender treatment programs

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<sup>1</sup> *Minnesota Statutes* 2013, 241.021, subd. 1. The law exempts correctional facilities from DOC inspection and licensure “to the extent that they are inspected or licensed by other state regulating agencies.”

<sup>2</sup> In fact, this statute as originally passed in 1961 required DOC to investigate “the whole system of correctional institutions in the state, especially prisons and jails.” In a 1976 amendment, this language was changed to “all correctional facilities throughout the state.”

<sup>3</sup> *Minnesota Statutes* 2013, 14.03, subd. 3(b)(1), excludes the department from having to promulgate state rules under *Minnesota Statutes*, chapter 14, for the “internal management of institutions under the [commissioner of corrections’] control.”

<sup>4</sup> DOC’s Inspection and Enforcement Unit reports to the deputy commissioner for community services, while the deputy commissioner for facilities oversees state prison operations.

<sup>5</sup> These programs accounted for 16 percent of DOC health services spending in fiscal year 2013.

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**DOC's sex offender and chemical dependency programs are reviewed by state regulators, but the department's medical and mental health programs are not.**

at state prisons to be “certified” by the Department of Corrections.<sup>6</sup> State law requires chemical dependency treatment programs at state prisons to comply with standards developed jointly by the departments of Human Services, Public Safety, and Corrections, and representatives of those agencies audit the compliance of DOC programs every three years.<sup>7</sup>

Other parts of DOC health services generally do not have oversight by regulatory agencies. For example, state law requires DOC's Mental Health Unit at the Oak Park Heights prison to operate in accordance with “applicable rules and standards prescribed by the Department of Human Services” (DHS).<sup>8</sup> DHS told us it neither licenses nor inspects this unit, citing statutory language that exempts DOC-licensed programs from DHS licensure.<sup>9</sup> Likewise, two DOC medical units—the Transitional Care Unit at the Oak Park Heights prison and the Linden Unit at the Faribault prison—provide services similar to health care facilities regulated by the Minnesota Department of Health.<sup>10</sup> However, the Department of Health does not license or inspect these units, citing statutory language that requires DOC to license its own facilities. As noted earlier, however, DOC does not license its facilities.

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## RECOMMENDATIONS

*The Legislature should amend state law to:*

- *Require the Department of Human Services (DHS) to periodically determine the compliance of DOC's Mental Health Unit with applicable DHS rules; and*
- *Require the Department of Health to periodically determine whether the Oak Park Heights correctional facility's Transitional Care Unit and the Faribault correctional facility's Linden Unit comply with applicable Department of Health rules.*

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<sup>6</sup> *Minnesota Rules*, 2965.0010, posted October 8, 2007.

<sup>7</sup> *Minnesota Statutes* 2013, 241.021, subd. 4a, requires DOC chemical dependency treatment programs to comply with DHS rules unless DOC and DHS agree that the rules cannot reasonably apply to DOC programs. In fact, DOC and DHS agreed that existing rules should not apply and thus developed alternative standards.

<sup>8</sup> *Minnesota Statutes* 2013, 241.69, subd. 1. DOC told us that the relevant DHS rules are those pertaining to residential programs for adults who are mentally ill (*Minnesota Rules* 9520.0500 to 9520.0670, posted October 16, 2013). However, there has been no clear specification of which of these rules apply—or do not apply—to DOC's Mental Health Unit.

<sup>9</sup> *Minnesota Statutes* 2013, 245A.03, subd. 2(a)(10), exempts DOC-licensed programs from DHS licensure. In addition, both DHS and the Department of Health referenced the requirement in *Minnesota Statutes* 2013, 241.021, subd. 1, for DOC to license all correctional facilities in the state.

<sup>10</sup> The Transitional Care Unit provides intensive medical care, including wound care, IV therapy, pre- and post-operative care, hospice care, and management of complex medical conditions. The Linden Unit addresses geriatric conditions, such as dementia and pulmonary conditions, assists with activities of daily living, and provides intensive medical care.

These recommendations do not address the more general question of whether DOC should license its own correctional facilities. We return to that issue later in this chapter. But we think it is important—regardless of whether entire facilities are subject to licensure—for certain DOC health care programs to be subject to periodic outside review. The DOC Mental Health Unit, Transitional Care Unit, and Linden Unit have similarities to health care programs that are operated in the community. The Legislature should require DOC to work with the regulatory agencies (Human Services and Health) to determine which standards should be applied to these DOC units, and the regulatory agencies should then incorporate inspections of these DOC units into their schedule of periodic compliance reviews.

## ACCREDITATION

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**Minnesota state correctional facilities were last accredited about ten years ago.**

Accreditation is a process for reviewing an organization’s compliance with generally accepted professional standards. Two main bodies have developed standards for prison-based correctional health services and accredit correctional facilities using these standards: the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC).<sup>11</sup>

Accreditation is a voluntary process; there is no requirement that Minnesota correctional facilities seek accreditation. To accredit a correctional facility, a team of experts from the accrediting agency conducts an on-site audit to determine compliance with standards. Both ACA and NCCHC grant accreditation to facilities for three-year periods. We found that:

- **Most states have some or all of their state correctional facilities accredited by an independent organization, but Minnesota does not.**

We obtained information from ACA and NCCHC on the facilities they accredit. As of August 2013, 24 states had some or all of their state-run prisons accredited by ACA, and 16 states had some or all of their prisons accredited by NCCHC.<sup>12</sup>

The Department of Corrections’ policy manual lists the ACA standards that relate to each DOC policy, and the department’s Web site says: “All of the department’s correctional institutions meet standards established by the American Correctional Association (ACA).”<sup>13</sup> However, there has been no recent independent review of DOC facilities’ compliance with the ACA standards. Minnesota’s state-run correctional facilities were ACA-accredited until about ten years ago. DOC officials told us the department stopped seeking accreditation at that time as a way to save money. If DOC obtained accreditation from ACA today, the ongoing cost of accreditation per Minnesota prison would

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<sup>11</sup> The ACA’s standards have been developed for all aspects of correctional facilities, including health care. In contrast, the sole focus of the NCCHC’s standards is on health care in correctional settings.

<sup>12</sup> Four states had facilities that were accredited by both ACA and NCCHC. Thus, a total of 36 states had facilities with ACA or NCCHC accreditation, or both.

<sup>13</sup> Minnesota Department of Corrections, <http://www.doc.state.mn.us/aboutdoc/agencybackground.htm>, accessed October 22, 2013.

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**DOC health services policies comply with many, but not all, of the standards of accrediting bodies.**

be about \$4,000 annually.<sup>14</sup> Later in this chapter, we suggest that the Legislature consider requiring DOC to seek external accreditation of DOC's health services activities.

We examined DOC compliance with selected professional standards. We focused on standards that related to overall health services administration, access to medical and mental health services, and delivery of these services. Some of the standards we did not examine included those related to: staff safety; federal sexual assault reporting; staff credentialing, orientation, and professional development; patient transportation; promotion of healthy diets and lifestyles; and management of offenders' health records. Because DOC facilities are accredited by neither the ACA or NCCHC, we made our own judgments regarding DOC's compliance with professional standards. At a minimum, we examined whether DOC's written policies reflected the standards. Where practical, we also looked at the compliance of DOC practices with these standards. We found that:

- **The Department of Corrections' compliance with professional standards is uneven.**

We observed many instances in which DOC's written policies and procedures comply with professional standards. For example, the department has established release planning policies and procedures for inmates with serious health care needs whose release from prison is imminent. Consistent with professional standards, the department has policies and procedures that provide pregnant offenders with access to prenatal and postpartum care. The department has policies intended to prevent inmate suicides. As noted in Chapter 2, the department has various policies that specify time frames and components of offender screening, assessment, and evaluation.

But we also saw many instances in which DOC policies and procedures did not, in our view, adequately address the standards. In some of these cases, actual practices in the prisons appeared to be fairly consistent with the standards, while in other cases they were not. Exhibit 4.1 lists examples of compliance issues we identified, some of which we discussed in chapters 2 and 3.

Our finding raises questions about whether DOC's facilities would pass an accrediting body's review.<sup>15</sup> DOC told us it encourages key officials in the department to monitor changes in accreditation standards and determine whether DOC policies need revisions to comply with them. But this informal process has produced inconsistent results. Some policies and procedures do not comply with generally accepted practices in the correctional health care field. In Chapter 6, we recommend that DOC amend its health services policies to ensure that professional standards are appropriately reflected.

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<sup>14</sup> A preliminary fee estimate we obtained from NCCHC suggested that the ongoing annual accreditation fee from that organization would average about \$5,000 per DOC prison, but fees in the initial year of accreditation would be about double the ongoing annual fees. Actual fees might vary from these preliminary estimates once NCCHC examined prison characteristics in more detail.

<sup>15</sup> ACA accreditation would be based on compliance with a wide range of correctional standards, not just those related to health care.

## Exhibit 4.1: Selected Areas in Which Minnesota’s Correctional Health Policies or Practices Do Not Comply with Professional Standards

	Applicable Standards <sup>a</sup>
DOC does not have system-wide, measurable health services goals and objectives, updated annually. (See Chapter 6.)	ACA 1-HC-7-01
DOC does not develop an annual health services staffing plan regarding the number and type of needed staff. (See Chapter 6.)	ACA 1-HC-4A-05; NCCHC P-C-07
The NCCHC standard requires health services assessments within 7 days of initial intake, while the ACA standard allows up to 30 days. DOC policy is consistent with the ACA standard. In practice, DOC rarely meets the NCCHC and ACA standards in its women’s prison; in the men’s prisons, DOC’s assessments usually meet the ACA standard but often do not meet the NCCHC standard. (See Chapter 2.)	ACA 1-HC-1A-22; NCCHC P-E-04
ACA and NCCHC standards both require a dental exam within 30 days of intake, but DOC policy requires a dental exam within 120 days of intake. DOC almost always does dental exams within 30 days at men’s facilities but not at its women’s facility. (See Chapter 2.)	ACA 1-HC-1A-17; NCCHC P-E-06;
Nursing protocols—that is, written instructions or guidelines for evaluating patients and provide health care interventions—should be developed, reviewed annually, and the subject of regular training, according to NCCHC. DOC policy no longer specifies the use of nursing protocols, and the protocols specified in policy until 2013 were not reviewed annually nor the subject of formal training. (See Chapter 2.)	NCCHC P-E-11
NCCHC recommends that correctional agencies have reporting systems for errors that affect patient safety. DOC centrally tracks medication errors, but it does not have comparable tracking for treatment errors.	NCCHC P-B-02
DOC does not have a cohesive policy addressing emergency medical treatment of offenders. (See Chapter 2.)	ACA 1-HC-1A-08; NCCHC P-E-08
ACA requires facilities to provide offenders with information about copayment policies. The information provided by some DOC facilities is truncated or inaccurate. (See Chapter 5.)	ACA 1-HC-1A-02
Professional standards suggest that correctional agencies should follow protocols for chronic diseases that are consistent with accepted clinical practice guidelines. DOC’s current and former contractors have used chronic care protocols, but DOC has not established a sufficiently coordinated, comprehensive approach to care for management of diabetes, asthma, high blood cholesterol or blood pressure, and seizure disorders. (See Chapter 3.)	ACA 1-HC-1A-16; NCCHC P-G-01
Professional standards require treatment planning for inmates with significant medical or mental health needs to help ensure that they receive appropriate, multidisciplinary care. DOC policy does not clearly specify the circumstances in which treatment plans should be developed for individuals.	ACA 1-HC-1A-07 and 1-HC-1A-16; NCCHC P-G-02
DOC does not complete mortality reviews within 30 days of a death, and actions taken in response to these reviews are not systematically tracked. (See Chapter 4.)	NCCHC P-A-10
Professional standards require the establishment of a multidisciplinary quality improvement committee. DOC’s system-wide quality improvement committee was inactive for an extended period, and the committee only includes nursing staff. (See Chapter 4.)	ACA 1-HC-4A-03; NCCHC P-A-06
According to ACA, each health care policy should be reviewed at least annually, with revisions if necessary. In fiscal year 2013, DOC did not review most of its health services policies. (See Chapter 6.)	ACA 1-HC-7A-03

<sup>a</sup>“Applicable standards” indicates the professional standards most relevant to the issue identified. In some cases, one accrediting organization has an applicable standard but the other does not.

SOURCE: Office of the Legislative Auditor, based on review of compliance of Department of Corrections policies and practices with: American Correctional Association (ACA), *Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions* (Alexandria, VA, January 2002) and 2012 Standards Supplement (Alexandria, VA, June 2012); and National Commission on Correctional Health Care (NCCHC), *Standards for Health Services in Prisons* (Chicago, 2008).



## QUALITY IMPROVEMENT ACTIVITIES

According to professional standards, it is essential for correctional facilities to have ongoing quality improvement programs that monitor the delivery of health care and identify possible improvements.<sup>16</sup> Often these are called “continuous quality improvement” activities. We found that:

- **The Department of Corrections and its adult correctional facilities have not had adequate continuous quality improvement programs for health services activities.**

State law requires DOC to establish a health care peer review committee, primarily to facilitate improvements in the quality of health care services.<sup>17</sup> The law says: “The committee shall gather, review, and evaluate information relating to the on-site and off-site quality of care and treatment of offenders.”<sup>18</sup> DOC policy says this committee may review patients’ medical records, examine prescribing practices and medication administration, and investigate offender complaints and grievances regarding health care. According to DOC policy, the committee may also make recommendations regarding treatment interventions. DOC policy mandates this committee to review each offender death and prepare a report for the department’s health services director.

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**DOC’s quality improvement activities have been limited.**

However, the DOC Peer Review Committee has limited itself almost entirely to cases involving inmate deaths, rather than reviewing quality of care in general. In recent years, the committee has examined only one case that did not involve an inmate death. Aside from looking at these cases, the committee has not rendered judgments on the quality of on-site or off-site care, nor has it reviewed prescribing practices, medication administration, or grievances.

To address quality improvements more generally, the DOC Health Services Unit several years ago established an agency-wide Continuous Quality Improvement Steering Committee to monitor and improve health services, particularly the management of serious and infectious diseases. Professional standards call for quality improvement committees that are multidisciplinary in nature, but this committee is composed entirely of nursing staff. More important, from March 2011 through August 2013, there was only one meeting of this steering committee. DOC officials told us that this committee was inactive until the

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<sup>16</sup> American Correctional Association, *Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions* (Alexandria, VA, January 2002), Standard 1-HC-4A-03 (Internal Review and Quality Assurance); and National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-A-06 (Continuous Quality Improvement Program).

<sup>17</sup> *Minnesota Statutes* 2013, 241.021, subd. 4b. According to law, the committee must include DOC’s director of health services, medical director, and director of nursing; the regional medical director of DOC’s health services contractor; a physician from a contracting hospital provider; and a physician who provides on-site care to offenders at a correctional facility. DOC Policy 500.011 also requires the department’s behavioral health services director to serve on this committee. *Minnesota Statutes* 2013, 145.61, subd. 5, sets forth various purposes of this committee and other “review organizations” like it.

<sup>18</sup> *Minnesota Statutes* 2013, 241.021, subd. 4b.

central office created and filled a new position—assistant director of nursing—that could devote time to quality improvement issues.

DOC’s system-wide health services quality improvement activities have been limited in number and scope. Since 2008, the central office has initiated several “continuous quality improvement” audits at some or all prisons. The largest was a 2013 audit of the information gathered during more than 1,200 sick-call visits at all correctional facilities for adults.<sup>19</sup> Aside from these quality improvement projects, it is worth noting that DOC requires monthly visits to each facility by a consulting pharmacist, who reviews medication administration, storage, inventory, refrigeration, and labeling.<sup>20</sup>

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**DOC has initiated some quality improvement audits, most of which have focused on health care processes rather than outcomes.**

Quality improvement activities initiated at the facility level have been sporadic and do not appear to have been sufficient to meet professional standards. None of the DOC facilities have multi-disciplinary quality improvement committees. The National Commission on Correctional Health Care has established benchmarks for the number of reports that should be prepared by facilities’ quality improvement committees, but the quality improvement activities of DOC facilities appear to have been short of these standards. According to the commission, a facility with an average daily population of more than 500 inmates—which characterizes six of DOC’s eight facilities for adults—should conduct at least two studies of health care processes annually and two studies of health care outcomes annually. Facilities with 500 or fewer inmates are supposed to conduct one of each type of study annually.<sup>21</sup>

Even in cases where DOC has undertaken useful activities to look at the quality of its services, we saw limited documentation of impacts. For the most part, DOC’s written summaries of past quality improvement projects have not discussed the acceptability of existing performance levels, nor specified plans for improvement. Furthermore, DOC’s quality improvement activities have focused largely on health care processes (for example, identifying which activities nurses perform during sick-call appointments) rather than health care outcomes (such as the number of inmates who need urgent visits for asthma attacks, or the percentage of inmates with hypertension who have acceptable blood pressure).

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## RECOMMENDATION

***The Department of Corrections should ensure that (1) its facilities collect sufficient data on health services processes and outcomes and (2) staff prepare plans that outline ways to achieve improvements in performance.***

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<sup>19</sup> This audit examined the extent to which each sick-call visit collected information on the patient’s temperature, pulse, respirations, blood pressure, and weight; whether a pain scale was used to assess the patient’s symptoms; and whether certain items (such as practitioner name) were entered in the patient’s medical chart. Chapter 2 discussed the nature of sick call at DOC facilities.

<sup>20</sup> DOC requires its health services contractor to provide a consulting pharmacist for this purpose.

<sup>21</sup> National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-A-06 (Continuous Quality Improvement Program).

DOC officials told us that the hiring of an assistant director of nursing in 2013 will enable the agency to focus more attention on quality improvement activities. We saw some evidence that this has started to occur. For example, DOC's Continuous Quality Improvement Steering Committee began meeting monthly in late 2013. Also, nurse supervisors at DOC facilities started conducting weekly audits of selected activities in late 2013.

## Mortality Reviews

We examined all DOC Peer Review Committee reports (often called "mortality reviews") on deaths that occurred between January 2008 and early 2013 in which the committee made at least one recommendation for improvements in practices or areas for staff education; this was nearly half of the reports. In general, we think the mortality reviews prepared by the committee are useful documents. They provide a concise description of services that were provided to the deceased offender and raise questions, where appropriate, about clinical or other decisions that were made.

There have been many cases in which the committee said the inmate deaths were expected and the care provided was appropriate. In some cases, however, the committee has identified service delivery problems that may have contributed to deaths or at least hindered the provision of timely, appropriate health care. We cannot discuss these cases in detail, due to the nonpublic status of the records. But some mortality reviews have described inadequate patient evaluation, treatment, or follow-up; inadequate communication among staff; mistakes in medication administration or prescription; and insufficient documentation. The issues raised by the Peer Review Committee related to various staff: physicians, nurses, other medical staff, and security personnel.

The mortality reviews are a reminder of the important part staff play in the health care of inmates. Decisions by staff sometimes can make the difference between life and death, or can affect the quality of life individuals experience prior to death. For this reason, we are concerned by several shortcomings of the mortality reviews:

- **The mortality reviews have taken longer to complete than recommended by professional standards.**
- **The mortality reviews are not necessarily shared with the health services staff whose performance was reviewed.**
- **The Department of Corrections has not systematically tracked the implementation of recommendations in these reports.**

The National Commission on Correctional Health Care (NCCHC) says that any prison death should be followed by both an administrative and clinical review of the death, and these should be completed no later than 30 days after the death.<sup>22</sup>

<sup>22</sup> National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-A-10 (Procedure in the Event of an Inmate Death).

**Mortality reviews have sometimes cited instances of inadequate health care evaluation, treatment, communication, and documentation.**

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**Most DOC mortality reviews take longer to complete than the standard recommended by a national accrediting organization.**

According to DOC policy, however, clinical reviews should be convened within 90 days of an offender's death, or when necessary records become available.<sup>23</sup>

We reviewed the timeliness of the clinical reviews by the Peer Review Committee. We found that 12 percent were conducted within the 30-day period prescribed by NCCHC, and 82 percent were conducted within the 90-day period referenced in DOC policy.

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### RECOMMENDATION

*The Department of Corrections should amend its policy and practice so that clinical mortality reviews are completed within 30 days of offender deaths.*

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One reason DOC's mortality reviews have taken longer to complete is that autopsies are conducted by medical examiners in some cases, and the mortality reviews are not undertaken prior to completion of the autopsy. However, according to NCCHC,

The clinical mortality review should not be delayed due to a pending medical autopsy. When a medical autopsy is completed after the clinical mortality review, the clinical review should be appended with information from the autopsy report.<sup>24</sup>

We also have concerns about the communication of mortality review results to affected staff. According to NCCHC standards, the results of a mortality review should be communicated to the staff who provided care to the offender.<sup>25</sup> However, DOC policy only requires the department's medical director to provide the written report to DOC's director of health services, and the policy has no provisions for communicating findings or recommendations to other health services staff who provided care.<sup>26</sup>

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### RECOMMENDATION

*The Department of Corrections should amend its policy to ensure that staff who were involved with the care of an individual who died are informed of key conclusions and recommendations of the mortality review.*

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<sup>23</sup> DOC Policy 500.220 (Medical Death Review).

<sup>24</sup> National Commission on Correctional Health Care, *Procedure in the Event of an Inmate Death* <http://www.ncchc.org/spotlight-on-the-standards-23-3>, accessed December 4, 2013.

<sup>25</sup> National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-A-10 (Procedure in the Event of an Inmate Death).

<sup>26</sup> DOC Policy 500.220 (Medical Death Review). The DOC mortality review reports do not contain the names of any staff. Department officials told us that if someone reading the mortality reviews was interested in determining the identities of specific staff referenced in a given report, they could find this information by going to the offender's medical records. But, in our view, including the names of key staff in the report would help the department ensure that recommendations related to those individuals have been implemented.

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**DOC should systematically track actions taken in response to mortality review recommendations.**

DOC officials told us that a copy of a mortality review recommendation might be sent to a person to whom the recommendation is directed, but the full reports are not usually shared with staff. In our view, sharing not-public information from the mortality review report with staff who provided care—for purposes of quality improvement and accountability—would be consistent with the law that mandates these reviews.<sup>27</sup>

In addition, DOC has not systematically tracked the recommendations made by the Peer Review Committee or the extent of their implementation. Again, this is contrary to the NCCHC standards.<sup>28</sup>

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**RECOMMENDATION**

*The Department of Corrections should retain a list of all mortality review recommendations and systematically collect information that documents implementation of these recommendations.*

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Although DOC officials told us they informally monitor actions taken in response to mortality reviews, we think it is critical for DOC to systematically ensure that timely actions address the concerns raised by the Peer Review Committee.

## **Public Reporting on Service Adequacy**

We are also concerned that:

- **There is limited information available to the public regarding deaths or serious injuries in DOC facilities.**

According to the statutes governing the DOC Peer Review Committee, “data and information acquired by a review organization...shall be held in confidence, shall not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and shall not be subject to subpoena or discovery.”<sup>29</sup> Thus, the reports of DOC’s Peer Review Committee have not been public documents.

In addition to mortality reviews conducted by the Peer Review Committee, the DOC Office of Special Investigations investigates each death that occurs in a DOC facility and prepares a report. DOC policy requires this office to determine the cause, manner, and circumstances surrounding the death.<sup>30</sup> This office’s

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<sup>27</sup> *Minnesota Statutes* 2013, 145.64, subd. 1, prohibits disclosure of a review organization’s actions except to the extent this is necessary to fulfill the organization’s purposes. Providing an employee with feedback on the care the employee provided could, in our view, fulfill such purposes.

<sup>28</sup> National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-A-10 (Procedure in the Event of an Inmate Death).

<sup>29</sup> *Minnesota Statutes* 2013, 145.64, subd. 1.

<sup>30</sup> DOC Policy 203.230 (Death of an Offender).

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**Minnesota no longer has a corrections ombudsman.**

reports are public documents, with the exception of data that are classified by law as not public.<sup>31</sup> However, the investigators in this office do not have the clinical expertise of the DOC Peer Review Committee.<sup>32</sup>

As a point of contrast, it is worth considering what happens when deaths occur in facilities operated by the Department of Human Services (DHS). That department prepares reports on deaths and—like the DOC mortality reviews—these reports are prepared for internal purposes and are not made available to the general public. However, the state Ombudsman for Mental Health and Developmental Disabilities has statutory authority to independently review cases of deaths or other events in DHS-operated facilities and issue public reports.<sup>33</sup> The ombudsman’s office has a Medical Review Subcommittee that regularly reviews cases involving deaths or serious injuries.

An ombudsman is a public official who investigates complaints about services with a significant amount of independence from the entities providing services. Minnesota has several ombudsman offices in human services areas: the Ombudsman for Mental Health and Developmental Disabilities, the Ombudsman for Long-Term Care, and the Ombudsman for State Managed Health Care Programs. The Minnesota Department of Transportation has an ombudsman who conducts fact-finding and dispute resolution on certain transportation issues. However,

- **Minnesota does not have an ombudsman who is statutorily designated to investigate complaints of offenders in prison.**

Minnesota had a corrections ombudsman from 1973 until 2003, when the office was eliminated by the Legislature. The corrections ombudsman office had authority to “investigate decisions, acts, and other matters of the department of corrections so as to promote the highest attainable standards of competence, efficiency, and justice.”<sup>34</sup> A 2002 report evaluated the office and concluded that it served an important purpose but should make changes to improve its effectiveness.<sup>35</sup>

Later in this chapter, we discuss the merits of restoring a corrections ombudsman office. Without an ombudsman office, the main options for an inmate with an unresolved health care complaint are filing a grievance, filing a complaint with a state professional board, and filing a lawsuit.

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<sup>31</sup> *Minnesota Statutes* 2013, 13.85, subd. 2, classifies inmates’ medical and mental health records as private data. In addition, according to *Minnesota Statutes* 2013, 13.39, subd. 2, information gathered by a government entity as part of an active investigation related to pending civil litigation is classified as not public.

<sup>32</sup> Where appropriate, the Office of Special Investigations reports identify possible improvements in facility operations, policies, or procedures.

<sup>33</sup> *Minnesota Statutes* 2013, 245.94, subds. 1 and 2.

<sup>34</sup> *Minnesota Statutes* 2002, 241.41.

<sup>35</sup> Minnesota Department of Administration, Management Analysis Division, *Ombudsman for Corrections: Report to the Minnesota Legislature* (St. Paul, 2002).

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## RECOMMENDATION

*If the Legislature does not create a corrections ombudsman, it should consider whether reports of the Department of Corrections health services Peer Review Committee should be classified in law as public documents.*

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**Making DOC mortality reviews public could improve accountability, but some think this change would make staff less willing to share information with the committee conducting the reviews.**

As noted earlier, the reports of the DOC Peer Review Committee are not public documents. Some people expressed to us the opinion that reports prepared by review organizations for public agencies (such as the departments of Corrections or Human Services) should be classified in law as public documents. They said it is appropriate to have a higher level of transparency for review organizations serving public agencies than for those serving private health care organizations. However, other people expressed concern that making any portions of these reports public would have a chilling effect on the willingness of medical or other staff to provide candid information to the review organization.

The issue of how review organizations' data should be classified is a complex one, potentially affecting more than just the Department of Corrections. If the Legislature were to create a corrections ombudsman, this would address the need for public reporting on adverse health events that occur in state prisons. If the Legislature does not create an ombudsman, it should consider whether to amend statutes so that the DOC Peer Review Committee reports fulfill a public accountability purpose in addition to fulfilling an internal quality improvement purpose. If these reports were to be classified as public documents, the Legislature may wish to statutorily authorize DOC to redact staff names.

## GRIEVANCES AND COMPLAINTS

Even in the best health care systems, there will be occasions when patients have concerns about the care they receive. In this section, we discuss options available to inmates in Minnesota prisons.

### DOC Grievance Procedure

Professional standards suggest that correctional agencies should have formal grievance procedures for addressing offender complaints in a timely manner.<sup>36</sup> We found that:

- **DOC has established a reasonable procedure for formal grievances, but the procedure is used infrequently for health services issues and offenders at some facilities might not be fully aware of it.**

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<sup>36</sup> American Correctional Association, *Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions* (Alexandria, VA, January 2002), Standard 1-HC-3A-01 (Grievances); and National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-A-11 (Grievance Mechanism for Health Complaints).

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**Eight percent of inmate grievances related to health care were affirmed by DOC officials.**

According to DOC policy, offenders must try to resolve concerns informally prior to initiating the formal grievance process.<sup>37</sup> In the informal process, offenders must send written messages to staff that convey their concerns. Staff must be contacted one at a time, and the formal grievance process cannot begin until the offender has communicated with all individuals in the chain of command. The offender may then submit a completed grievance form, outlining his or her concerns and attaching correspondence that shows prior efforts to resolve the issue informally. The prison warden (or designee) may dismiss or affirm the grievance. This decision must occur within 20 working days of the grievance's receipt (unless an extension was approved). DOC policy also establishes a procedure for inmates to appeal grievance decisions to the DOC central office.

We examined formal grievances filed from January 2008 through June 2013. Although grievances may be filed on any topic, we limited our review to those classified by DOC as related to medical, mental health, or dental services. Over this 66-month period, a total of 309 grievances related to health services were filed throughout the entire DOC system. One facility (Lino Lakes) had only eight health services grievances, while another (Shakopee) had only ten.

Professional standards suggest that information on grievance procedures should be given to offenders upon arrival at a correctional facility.<sup>38</sup> We reviewed handbooks and orientation materials distributed to new inmates at each adult correctional facility, and only one facility had a complete description of the grievance process; a majority of the facilities distributed materials that did not mention the process at all.<sup>39</sup>

Most of the health services grievances filed by inmates have been dismissed—in other words, DOC found them to be without merit. Among health services grievances filed from 2008 to 2013, 8 percent were affirmed by DOC officials.”<sup>40</sup>

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## RECOMMENDATION

***The Department of Corrections should ensure that each of its correctional facilities provides inmates with information on the grievance process at the time they enter the facility.***

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The DOC grievance procedure has multiple steps, and some inmates with complaints may choose not to formally file grievances. But the National Commission on Correctional Health Care says grievance mechanisms are “an

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<sup>37</sup> DOC Policy 303.100 (Grievance Procedure).

<sup>38</sup> National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-E-01 (Information on Health Services).

<sup>39</sup> The St. Cloud prison's handbook had a complete description of the grievance procedure. In addition, a DOC-wide offender handbook is distributed to male inmates initially entering the prison system at St. Cloud, and this document includes information on the grievance procedure.

<sup>40</sup> Some of the 8 percent of affirmed grievances were affirmed “with modifications.” This means that DOC did not grant the grievant the full resolution he or she was seeking.



important component of a facility’s quality improvement program,” even if many inmate complaints are not well founded.<sup>41</sup> The department should ensure that inmates receive complete and user-friendly written materials outlining the grievance process at each state correctional facility they enter.

## Complaints Filed with State Boards That Oversee Medical Professionals

State professional boards are intended to protect public health and safety by assuring that individual professionals are competent. However, it is worth noting that these boards are, by nature, reactive, responding only to complaints about individual medical staff that have been filed. The boards do not oversee DOC services in a comprehensive way.

We reviewed all complaints about health care professionals from (and regarding) DOC inmates that were made to the Minnesota Board of Nursing and the Minnesota Board of Medical Practice since 2008.<sup>42</sup> We found that:

- **State professional boards determined that few of the inmate complaints filed against DOC doctors and nurses in recent years warranted disciplinary actions.**

We reviewed 114 complaints regarding DOC health services filed with the Board of Medical Practice since 2008. None resulted in disciplinary actions; five resulted in efforts to educate rather than discipline the practitioner. Board of Medical Practice staff described most of the complaints as “frivolous.” One prison doctor told us it is demoralizing to be the subject of groundless complaints. DOC staff stated that the process of responding to these complaints is time-consuming and difficult for medical staff.

Some complaints may have involved valid concerns about care, but the Board of Medical Practice generally does not discipline individual physicians for cases involving denials of coverage or organizations’ policy decisions. About one-fifth of the complaints—including two that resulted in efforts to educate the practitioner—were related to denied or delayed referrals to outside specialists or services.

We also reviewed 96 complaints filed since 2008 with the Board of Nursing. Three of these complaints resulted in disciplinary actions by the board and one complaint resulted in an agreement for corrective action (an administrative alternative to formal discipline).

The agreement for corrective action involved a 2011 incident in the Stillwater facility. An insulin-dependent diabetic offender at that facility had potentially dangerous high blood sugar levels overnight after the nurse failed to assess him

<sup>41</sup> National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-A-11 (Grievance Mechanism for Health Complaints).

<sup>42</sup> We reviewed those complaints within jurisdiction of the Boards. For example, we did not review complaints made to the Board of Medical Practice regarding dentists.

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**The state boards of Medical Practice and Nursing investigate complaints about individual professionals, but they generally do not rule on issues related to policy decisions or access to care.**

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**Few complaints regarding prison medical staff have resulted in disciplinary actions or educational meetings by the state boards of Medical Practice or Nursing.**

or provide him insulin prior to leaving the facility at the end of her shift.<sup>43</sup> In another case, a nurse voluntarily surrendered her license in response to 2010 and 2011 complaints for failure to respond to multiple medical emergencies at DOC facilities.<sup>44</sup> Another nurse received a stayed suspension for multiple medication errors, including some involving narcotic medications, at both DOC and a long-term care facility between 2011 and 2013. Another nurse voluntarily surrendered his license in 2013 for drinking alcohol while on duty in a DOC facility.

The Board of Nursing conducted educational meetings in response to another five complaints involving prison health services. The board held four meetings with individual nurses regarding breakdowns in emergency or after-hours care, and one meeting was related to mishandling of narcotics.

Decisions from cases involving complaints to the Board of Medical Practice and Board of Nursing provide limited insight into the adequacy of prison-based health services. Staff from these boards said that when patient safety can be protected through educational meetings or other non-disciplinary means, the boards may choose not to discipline a doctor or nurse. And, as noted earlier, (1) the boards generally do not discipline doctors and nurses in cases involving denials of coverage or the application of organizational policies and (2) the boards' duties are case-specific and reactive, rather than providing comprehensive oversight of medical and nursing practices.

## LITIGATION

Inmates or their families with complaints about DOC health services may file civil actions in court alleging constitutional violations or medical malpractice. In Chapter 2, we noted that courts have imposed a high standard for demonstrating a violation of the U.S. Constitution's Eighth Amendment. However, health care providers may be liable for malpractice or negligence in cases that do not meet the standard for deprivation of a constitutional right.<sup>45</sup>

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<sup>43</sup> No overnight nursing staff were present at the facility.

<sup>44</sup> In the emergency situations, the nurse failed to respond once because she believed the offender was faking her symptoms; failed to assist an inmate with chest pain and a headache because the incident occurred 20 minutes prior to the end of the nurse's shift; and failed to assist an offender in medical distress because the nurse was on her dinner break. In addition, the complaint cited the nurse's failure to assess an offender after a seizure; failure to assess an offender during heart problems which resulted in hospitalization; and failure to respond when a pregnant offender complained she felt no fetal movement for three days. This nurse also committed numerous medication errors, including some involving medications that may be abused.

<sup>45</sup> When a court determines whether there has been a breach of duty in a medical malpractice case, it considers whether the defendant departed from the standard of care that represents the customary practice in the community.

We identified and reviewed 26 separate cases related to medical care at DOC that were filed between January 2008 and June 2013.<sup>46</sup> Nine cases were still unresolved as of August 2013. We found that:

- **Court cases alleging health services problems by DOC or its contractor have been relatively infrequent, although settlements in individual cases can be substantial.**

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**Settlement agreements in lawsuits related to DOC health services are rare but can be costly.**

Over the 66-month period we examined, the total number of cases filed equaled fewer than 3 cases per 1,000 current inmates. Although the majority of cases which are now closed were dismissed by the courts, DOC reached settlement agreements in three cases, for amounts totaling about \$700,000. DOC's health services contractor also settled in two of these cases for undisclosed amounts. In settlement agreements, the department has agreed to provide compensation to the aggrieved party while admitting to no liability.

The settled cases appear to have reflected serious lapses in care. Settlement agreements were reached in the case of one offender who died after suffering a series of seizures overnight. In another settled case, medical staff failed to diagnose an inmate's terminal cancer despite the inmate's symptoms. In the final settlement, an offender suffered a rare and life-threatening adverse reaction to a prescription medication. In that case, the on-call physician and on-site nursing staff failed to identify the adverse reaction until the offender became permanently disabled.

Our review also showed that many of the cases involved complaints that did not appear to reflect serious problems with medical care. For example, one case involved an offender who complained about his medication being crushed after he was alleged to be abusing it. In another case, the judge characterized as "frivolous" an offender's complaint that denial of shoes that fit his orthotic inserts constituted an Eighth Amendment violation.

We also observed that some cases were dismissed by the court for technical reasons, prior to full consideration of the merits of the case. Some of these cases alleged significant care problems. For example, a case in which an offender developed an infection and whose care was allegedly delayed was dismissed because the offender had failed to exhaust DOC's internal grievance procedures prior to filing the court complaint. This case was filed with a federal court and was required to meet various conditions that would not apply to cases filed in a state court. In another case we reviewed, an offender alleged medical malpractice for denial of access to physical therapy, pain medication, medical equipment, and other health services after back surgery. The case was dismissed for failure to meet technical requirements for filing a malpractice claim under Minnesota law.

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<sup>46</sup> We requested copies of court documents in all medical-related lawsuits since 2008 from DOC and its health services contractor. DOC and the contractor identified 24 cases. We identified an additional two cases, and it is possible there are additional cases that we did not find. Our review generally did not include cases in which the allegations regarding medical services appeared to be a minor part of a larger lawsuit.

Overall, litigation can be a mechanism for holding DOC or its contractor accountable for problems with health care services, but it has resulted in the payment of monetary damages in a limited number of cases. This may suggest that serious problems in the delivery of health care services are rare; it may also reflect the high standards and significant technical requirements that courts apply to certain cases.

## DISCIPLINARY ACTIONS

We also looked at the extent to which DOC and its health services contractor have taken disciplinary actions against their staff. Such actions provide an indication of the frequency of personnel-related problems, but they also provide evidence of management actions to address these problems. We found that:

- **The Department of Corrections and its contractor have disciplined a substantial number of health services staff, sometimes for job performance issues that could directly affect patient care.**

**Disciplinary actions against DOC health services staff range from written reprimands to termination.**

Between January 2008 and mid-2013, DOC took 93 separate disciplinary actions against 50 different health services employees. These actions ranged from written reprimands to terminations. Some of these actions were for employee behaviors that may not have directly affected patient health care—such as improperly using leave time or losing the keys to a secure area. But there were also disciplinary actions against employees who failed to make proper patient assessments or interventions, or who acted in an unprofessional way toward coworkers or patients. For example:

DOC fired a therapist for argumentative, sarcastic, and intimidating behaviors. DOC said that his refusal to follow supervisory direction “significantly compromises the care and treatment of offenders.”

DOC suspended a nurse who “did not provide adequate nursing assessment” to an offender who had been assaulted. This resulted in the offender being sent to two hospitals to be stabilized and then to receive trauma care.

DOC reprimanded a nurse who decided that an offender being kept in segregation “could wait til tomorrow” to receive his medications because the offender did not always take them. DOC said this “demonstrates poor decision making and falls outside your scope of practice.”

DOC suspended a nurse who did not obtain sufficient medical information on an offender following seizures. She left the security officer with the impression the seizures were not serious, but the offender died two days later.

During the 2008 to 2013 period, DOC’s contractor took disciplinary actions against at least seven of its employees serving Minnesota correctional facilities,

including two terminations.<sup>47</sup> Based on information provided by the vendor, the extent to which these actions related to patient care is unclear.

Also during the 2008 to 2013 time period, DOC's health services vendor terminated seven doctors whom it had hired as independent contractors rather than employees. In several cases, this occurred because DOC was dissatisfied with the doctor's performance and denied the doctor's access to DOC facilities. There is little written documentation by DOC or its contractor of the specific concerns that led to these actions, so it is difficult to judge the impact (if any) of these behaviors on patient care.

On the one hand, the disciplinary actions discussed above show that DOC and its contractor held staff accountable for inappropriate behaviors. On the other hand, these actions are a reminder that health services employees sometimes make mistakes with potentially serious consequences.

## DISCUSSION

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**Health care in correctional settings requires oversight and accountability, due to inmates' constitutional rights to adequate care and necessary limits on the health care choices of inmates.**

Health services, by their nature, require a significant level of oversight and accountability. While many parts of health care service delivery are fairly routine, others involve decisions that may directly affect the duration and quality of patients' lives. There can be differences of opinion about which treatments or medications are the most cost-effective. And, in certain circumstances, a patient's well-being may depend on the skill, knowledge, and judgment of individual professionals—doctors, nurses, psychiatrists, therapists, and others.

There is a particular need for oversight and accountability of health care in a correctional setting. Inmates often do not have opportunities to choose their providers or obtain second opinions, so the decisions of health care providers in prison settings bear considerable weight. Inmates tend to be less healthy than individuals in the general population, and they live in institutions in which there can be significant risks of illness. Furthermore, the courts have established the right of inmates to adequate health care, and failure to provide such services can result in settlements or court decisions with significant public costs.

For these reasons, we are concerned that:

- **There is relatively little external review of the services provided by the Department of Corrections Health Services Unit.**

The department does not license its own correctional facilities, and the health services provided in these facilities are subject to minimal review by the department's Enforcement and Inspection unit. The state departments of Human Services and Health do not license or inspect certain parts of DOC Health Services because they believe that DOC—not their agencies—have this responsibility. Unlike practices in many states, prisons in Minnesota are not accredited, and there has been no independent determination for many years of the extent to which prison health services in Minnesota comply with professional

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<sup>47</sup> The contractor was unable to find discipline records for some employees who left the company.

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**The options of licensure, accreditation, and creation of an independent ombudsman merit consideration.**

standards. Minnesota no longer has an ombudsman for corrections who can conduct independent investigations on behalf of the public or inmates. The state boards of Nursing and Medical Practice can investigate complaints about individual medical professionals who provide services to inmates, but the boards do not have jurisdiction to determine problems in department policies or systems.

In addition, the DOC Health Services Unit's reviews of its own activities have not been sufficient. The department's Peer Review Committee produces reports on inmate deaths that are useful for internal purposes, but the not-public reports do not provide sufficient public accountability. The department's mechanisms for continuous quality improvement have been weak. The department has a formal grievance process for inmates, but it is infrequently used for health services complaints.

In this chapter, we have offered several recommendations intended to improve oversight of the DOC Health Services Unit, accountability for its practices, or the quality of its services. But there are larger options that the Legislature should also consider, as shown in Exhibit 4.2.

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**RECOMMENDATION**

*The Legislature should improve oversight of Department of Corrections health services by (1) requiring DOC to license its state-run correctional facilities, (2) requiring DOC to seek accreditation of entire facilities or those facilities' health services activities, or (3) establishing a state ombudsman for corrections.*

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It is useful to think of facility licensure, facility accreditation, and the creation of an ombudsman office as three distinct options for improved oversight of DOC health services activities. These options are not mutually exclusive; the Legislature could consider requiring any or all of them. Exhibit 4.2 discusses issues the Legislature should consider regarding these options.

Potentially, all of these options could affect oversight of DOC activities beyond health services. A requirement for DOC to license each of its own facilities would require DOC to conduct facility-wide compliance reviews, and examinations of health services would be one part of these reviews. A requirement for DOC to seek external accreditation of its facilities could be done broadly (through accreditation of entire facilities by the American Correctional Association) or more narrowly (through accreditation of health services activities by the National Commission on Correctional Health Care). DOC could also seek accreditation without the Legislature requiring it to do so, and DOC officials expressed to us an interest in doing so. Creation of a state ombudsman would result in independent review and investigation of a wide range of DOC activities, including those related to health care.

Our preference is for independent oversight by persons with specialized expertise in correctional health care. In our view, accreditation by an organization with

## Exhibit 4.2: Options for Improving Oversight of DOC Health Services

Option	Description	Considerations
<b>Option 1: Require Licensure of DOC Facilities</b>	DOC's licensing unit would periodically license and inspect DOC-operated facilities, based on their compliance with state requirements.	<ul style="list-style-type: none"> <li>• State statutes require DOC to license all correctional facilities in the state, but DOC says that excluding DOC facilities from this requirement is a reasonable interpretation of the law. If the Legislature wants DOC to license DOC facilities, it should clarify this in the statutes.</li> <li>• If DOC were to license its own facilities, the staff who conduct licensure reviews should be organizationally separate from staff responsible for facility operations. Still, some people might question DOC's independence when reviewing its own facilities.</li> <li>• DOC's Inspection and Enforcement Unit looks at facility compliance with a limited number of health services policies. Expanding compliance reviews to a broader range of policies would involve additional expense, but it is unclear how much.</li> </ul>
<b>Option 2: Seek Accreditation of DOC Facilities</b>	DOC facilities would seek accreditation every three years from the American Correctional Association (ACA) or National Commission on Correctional Health Care (NCCHC).	<ul style="list-style-type: none"> <li>• DOC purports to follow ACA standards for all its operations. However, DOC facilities have not sought accreditation for many years.</li> <li>• A key decision would be whether to seek accreditation for all parts of facility operations (by the ACA) or just for health services (by the NCCHC). NCCHC standards and guidance tend to be more detailed than ACA standards regarding health care services.</li> <li>• There is a cost to accreditation. If DOC sought ACA accreditation for all ten adult and juvenile correctional facilities, the total cost might be around \$40,000 per year. Preliminary estimates of ongoing NCCHC accreditation fees suggest that they might be somewhat higher per facility than the ACA fees, particularly in the first year.</li> </ul>
<b>Option 3: Establish a Corrections Ombudsman</b>	An ombudsman office would provide independent, ongoing oversight of activities in DOC facilities, regarding health care and other issues. The office would have investigatory powers and would issue public reports.	<ul style="list-style-type: none"> <li>• Inmates can now file grievances to address complaints, but decisions in these cases rest with DOC. Inmates can pursue litigation, but it can be difficult to retain legal counsel.</li> <li>• Ombudsman offices have been implemented successfully elsewhere in Minnesota state government.</li> <li>• Creating a correctional ombudsman office would probably cost the state at least \$250,000 annually, depending on the office's staffing level.</li> </ul>

SOURCE: Office of the Legislative Auditor.

knowledge of correctional health care or the creation of a state ombudsman office would seem most appropriate. In both cases, reviews of DOC health services would be conducted by experts in health care practices, which would not necessarily be true of more broadly based licensure or accreditation reviews. (In the case of an ombudsman office, we envision that such an office would have a health services review committee of experts, similar to the committee that serves

the Minnesota Ombudsman for Mental Health and Developmental Disabilities.) However, if the Legislature or DOC wish to pursue facility licensure or accreditation that is not specific to health services, such options are also available.



# Financial Issues

Health services expenditures represented about 20 percent of all expenditures at Department of Corrections (DOC) facilities in fiscal year 2013. That year, the department spent nearly \$68 million providing or contracting for these services. This chapter examines selected issues related to health services finances. We analyzed DOC's health services expenditures relative to inflation and the department's budgets, and we compared Minnesota with other states. In addition, we looked at a policy issue in which the Legislature has played a direct role: the establishment of copayment rates for inmate health services. Finally, we examined one important element of health services costs—the purchase of pharmaceuticals—to determine overall spending trends and provide a comparison between the prices paid for Minnesota inmates' medications and those paid by another pharmaceutical purchasing organization.

## OVERALL COSTS

### Spending Changes

Inflation has affected the cost of providing health services in prisons, just as it has affected all forms of health care. A recent national report analyzed changes in total prison health care spending in 44 states between 2001 and 2008.<sup>1</sup> The study found that, after adjusting for inflation, the median change in state prison health care spending per inmate during that period was a 32 percent increase.<sup>2</sup> It reported that Minnesota's increase over this period was 15 percent.

We conducted our own analysis of spending trends in Minnesota's prison health services, focusing on changes since fiscal year 2007. We found that:

- **Health services expenditures in Minnesota prisons have risen faster than the rate of inflation since 2007, with increases since 2009 mainly due to increases in the prison population.**

Between fiscal years 2007 and 2013, DOC's health services expenditures—not adjusted for inflation—increased by an average annual growth rate of 5.3 percent. Growth in DOC's total health services expenditures was greater in the early part of this period than in the latter part. Unadjusted for inflation, the average annual growth rate in expenditures was 8.8 percent between fiscal years 2007 and 2009, compared with 3.7 percent between fiscal years 2009 and 2013.

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**Since fiscal year 2007, DOC health services expenditures have increased by 5 percent annually.**

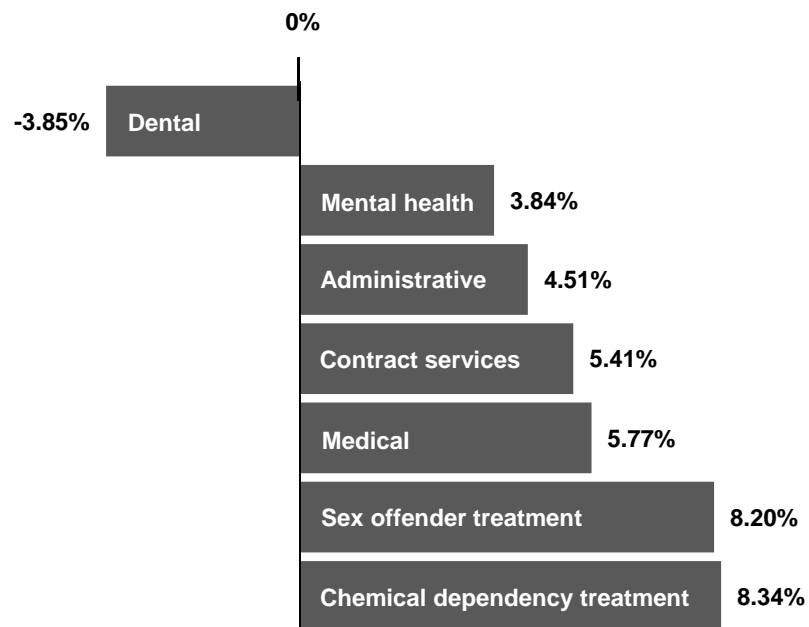
<sup>1</sup> The Pew Charitable Trusts and MacArthur Foundation, *Managing Prison Health Care Spending* (October 2013), 5.

<sup>2</sup> Expenditures in this study were adjusted for inflation using the Implicit Price Deflator for state and local government consumption expenditures and gross investment included in the U.S. Bureau of Economic Analysis' National Income and Product Accounts.

Exhibit 5.1 shows the growth in various components of DOC's health services expenditures during this period. Unadjusted for inflation, the highest growth rates were for chemical dependency treatment and sex offender treatment (each grew more than 8 percent annually, on average). In contrast, expenditures for dental services decreased over this period by an average of nearly 4 percent annually.

### Exhibit 5.1: Average Annual Percentage Change in Spending, Fiscal Years 2007-2013, by Health Services Category

Spending for prison dental services has declined, while spending for other health services in prisons has increased.



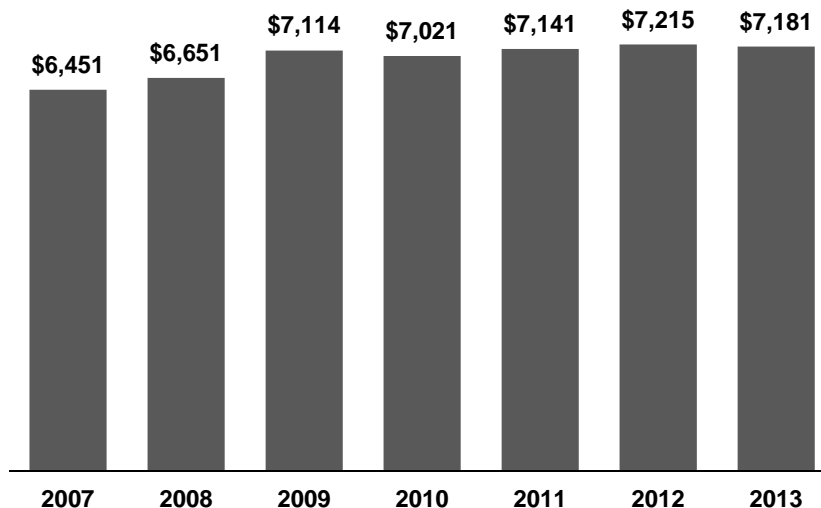
NOTES: The percentage changes reflect the average annual growth rates in spending, not adjusted for inflation. Except for the category "contract services," all of the spending categories in the chart represent services primarily provided by DOC employees. The "sex offender treatment" category does not include a "central office sex offender treatment" category, for which expenditures totaled about \$192,000 in fiscal year 2013 and which grew 31 percent between fiscal years 2007 and 2013.

SOURCE: Office of the Legislative Auditor, analysis of Department of Corrections data.

Most of the increase in DOC's health services expenditures reflected health care inflation and increases in the prison population, as shown in Exhibit 5.2. We computed the annual health services expenditures in 2013 dollars per incarcerated offender. Between fiscal years 2007 and 2013, the average annual growth rate in the health services cost per offender was 1.8 percent. Since 2009, however, the average annual growth rate was 0.2 percent.

**Exhibit 5.2: Department of Corrections' Health Services Spending per Inmate, Fiscal Years 2007-2013, in Fiscal Year 2013 Dollars**

**Health care inflation and prison population growth explained most of DOC's increases in health services spending.**



NOTES: We adjusted for inflation using an index of personal health care expenditures maintained by the federal Center for Medicare and Medicaid Services. This index is constructed using a variety of types of health care spending, such as hospital services, clinical services, and pharmaceuticals. For the two most recent fiscal years, we used the federal government's *projections* for this index. For the prison population in each fiscal year, we used DOC's average daily population of incarcerated adults and juveniles. These population data exclude offenders on work release.

SOURCE: Office of the Legislative Auditor, analysis of Department of Corrections data.

**Spending Compared with Budget**

We examined how DOC's health services expenditures have compared with the department's annual budgets. We observed that:

- **DOC's health services expenditures exceeded the department's budget in fiscal year 2013, the first time in recent years there has been a shortfall.**

Between fiscal years 2007 and 2012, DOC's health services expenditures were lower than the health services budget by an average of \$1.3 million annually. In fiscal year 2013, expenditures exceeded the budget by nearly \$1.5 million, or 2.2 percent of the total budget.

DOC officials told us the fiscal year 2013 shortfall reflected legislative underfunding of the entire agency during the most recent biennium, which then resulted in an underfunded budget for the department's Health Services Unit. The department's fiscal year 2012 and 2013 budgets for health services (\$66.3 million each year) were smaller than the fiscal year 2011 budget (\$67.5 million). DOC officials said they faced increasing health care costs over

the period covering fiscal years 2012 and 2013—for example, DOC employees received their first salary increases in several years during fiscal year 2013.

The fiscal year 2014 budget for DOC health services (\$67.6 million) represents a 1.9 percent increase over the previous year’s budget. This budget is just below fiscal year 2013’s actual expenditures (\$67.8 million).

## Spending Compared with Other States

The American Correctional Association publishes a journal that periodically includes, among other things, comparative information collected from state correctional agencies. This organization’s most recent national survey on prison health care indicated that:

- **Minnesota’s health services cost per inmate was higher than most reporting states.**

The journal’s most recent survey indicated that Minnesota’s 2009 health services cost per inmate (\$6,679) was fifth highest of the 39 reporting states.<sup>3</sup> Some states did not report certain costs that Minnesota included, such as chemical dependency and sex offender treatment costs. When we limited the comparison to 15 states that reported similar categories of expenditures, Minnesota had the second highest health services cost per inmate.

It is difficult to draw conclusions about effectiveness or efficiency based solely on aggregate health services expenditures per inmate. Minnesota’s relatively high cost per inmate could indicate that Minnesota provides more extensive access to inmate health services than other states providing the same categories of services. Alternatively, the data could indicate that Minnesota spends more to provide a level of health services that is similar to other states.<sup>4</sup> States differ in the health characteristics of their inmates and in the mix of services they provide, and it is not possible to fully account for these differences. The data simply show that Minnesota spends more per inmate than most states, and this is one among many reasons to expect a high level of accountability for health services expenditures.

## Utilization Management

In Chapter 1, we noted that DOC’s decision to develop a system-wide contract for certain medical services in 1998 was driven partly by a desire to contain costs. Prior to 1998, DOC facilities individually arranged for doctor and hospital

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**Minnesota’s above-average health services spending per inmate is one among many reasons to expect a high degree of accountability.**

<sup>3</sup> Cece Hill, “Inmate Health Care and Communicable Diseases,” *Corrections Compendium* (Winter 2010), 14-37. Cost per inmate was calculated based on the average daily inmate population over the course of the year.

<sup>4</sup> For the general population of the state, Minnesota’s 2009 per capita public and private health care spending was 9 percent above the national average, according to the Kaiser Family Foundation. Thus, somewhat higher health care costs in the state as a whole could have been one factor in Minnesota’s higher spending for prison-based health care.

services, and there was limited central office oversight of health services activities.

There is no way to conclusively determine the impact of DOC's health services contract on costs; it is impossible to know what costs would have been in the contract's absence. However, DOC told us that, before 1998, there was little "utilization management" in the department's health care services. Utilization management is a standard part of managed health care services in the public and private sectors, and it involves efforts to ensure that the care provided is necessary and appropriate.

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**Doctor recommendations for off-site care are subject to review by DOC and its contractor's utilization management staff.**

The DOC health services contract requires the vendor to arrange for offender appointments at off-site locations. When a doctor requests off-site care or consultation, the request is reviewed by the contractor's utilization review staff and perhaps the contractor's medical director. Any decision by the vendor about an inmate's need for care may be overridden by DOC's medical director or the physician who requested the service.

Some DOC medical staff expressed concern to us about medical interventions provided to inmates that the staff considered unnecessary or fiscally irresponsible, such as certain surgeries or medications. We did not have the expertise to evaluate the clinical judgments made by medical professionals. However, we observed that there was some decline in the amount of monthly claims for off-site care for which DOC's health services contractor was paid in recent years: from an average of \$1.1 million per month in calendar years 2010 and 2011 to an average of \$966,000 per month in the next two calendar years.<sup>5</sup>

DOC officials told us there is room for some debate about which services are medically necessary or required to meet DOC's constitutional obligation to provide health care to inmates. People may have differing opinions on whether an inmate should be prescribed a very expensive or experimental pharmaceutical, or whether the frequency of some medical treatments should be restricted. Those types of questions have no easy answers, and there is no DOC policy that provides clear guidance. In general, however, the contractor's utilization review process and DOC's authority to review or even overrule contractor decisions allow for scrutiny of significant health care decisions by multiple individuals. Furthermore, DOC's contractual limit on the aggregate amount it will pay its health services vendor for expenditure "claims" in a given year establishes financial incentives for the vendor to control the cost of off-site services.<sup>6</sup>

## COPAYMENTS

Copayments are a common provision of public and private health insurance coverage. When an individual visits a doctor or uses some other covered service, the person may be charged an amount to be paid out-of-pocket. Generally, the

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<sup>5</sup> We examined paid claims through September 2013. The totals were not adjusted for inflation.

<sup>6</sup> In DOC's health services contract, the department reimburses the contractor for 100 percent of paid claims up to an agreed-upon level. After that point, DOC and the contractor share equal responsibility for these costs.

purpose of copayments has been to discourage individuals from unnecessary use of services. We examined several issues related to inmate copayments.

## Consistency of DOC Policy with Statutes

From 1996 to 2011, Minnesota law set copayments in state correctional facilities at \$3 for applicable visits. Since 2011, Minnesota law has had the following provision:

Any inmate of an adult correctional facility under the control of the commissioner of corrections shall incur co-payment obligations for health care services provided. The co-payment shall be at least \$5 per visit to a health care provider.<sup>7</sup>

We found that:

- **Department of Corrections policy has applied health care copayments to a more limited set of circumstances than indicated by a literal reading of Minnesota statutes.**

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**State law does not explicitly authorize the exemptions from inmate copayments DOC has adopted.**

When the 1996 Legislature directed DOC to charge a \$3 copayment, the Legislature said DOC was required to charge a copayment “each time medical, dental, or mental health care services are provided to an inmate *at the initiation of an inmate*” (emphasis added).<sup>8</sup> According to Minnesota Office of the Revisor staff, the 1996 language outlining the circumstances in which copayments were required did not simply apply to the biennium in which the law was passed. The language remained in effect from 1996 until at least 2011, when the Legislature changed the minimum amount of the copayment. Staff from the Office of the Revisor said that it would be necessary to review the discussions that occurred during the 2011 legislative session related to passage of the \$5 copayment provision to determine whether the Legislature intended to nullify the 1996 language regarding the circumstances in which copayments must be assessed.

Current DOC policy requires the assessment of copayments only for offender-initiated visits, and the policy sets forth some additional instances in which copayments will not be assessed—for example, visits to address chronic illnesses or communicable diseases.<sup>9</sup> However, the law that now requires a copayment of at least \$5 “per visit” does not explicitly exclude provider-initiated visits, and it is debatable whether the 1996 law that excluded copayments for provider-initiated visits remains in effect. Furthermore, DOC policy only requires copayments for patient’s visits with “health care practitioners,” and the policy’s definition of this term does not include mental health providers (such as psychiatrists and therapists). DOC’s exclusion of mental health visits from copayments is not

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<sup>7</sup> *Minnesota Statutes* 2013, 243.212.

<sup>8</sup> *Laws of Minnesota* 1996, chapter 408, art. 1, sec. 6, subd. 3.

<sup>9</sup> DOC Division Directive 500.100 (Offender Co-Payment for Health Services). The policy lists ten instances in which copayments will not be assessed. Also, the policy says that if offenders have insufficient funds or are classified as indigent, they will not be denied care. The copayment is charged to the offender’s spending account until the offender has available funds to cover it.

**If authorized by the Legislature, DOC's exclusion of provider-initiated visits and mental health visits from copayment requirements would be a reasonable policy.**

specifically authorized in state law. In addition, the law does not authorize the exemptions from copayments for indigent offenders that are in DOC's copayment policy.

## RECOMMENDATION

*The Legislature should clarify in Minnesota Statutes 243.212 the Department of Corrections' authority to adopt exemptions to the statute's general copayment requirement of \$5 per visit.*

Based on a review of practices in other states and guidance from a national organization, we think DOC's exclusion of certain types of visits from copayment requirements is defensible. For example, a position statement by the National Commission on Correctional Health Care says that provider-initiated visits and mental health care visits should be exempt from copayment requirements.<sup>10</sup> The statement also says—similar to DOC policy—that inmates should not be denied care due to inability to pay for services.

## Reasonableness of Copayment Amounts

Some people contend that charging a \$5 copayment per visit may discourage some inmates from seeking necessary health care. Many inmates have minimal financial assets, and their earnings from employment in prison are limited. For example, the starting hourly wage in DOC facilities is 25 cents an hour. However, we found that:

- **The size of Minnesota's health services copayment per inmate visit is generally comparable to the copayments in other states.**

Previous national surveys—conducted in 2009 and 2010—showed that responding states with inmate copayments typically had charges in the \$3 to \$5 range per visit with a practitioner. In the most recent survey, 38 of 44 responding states reported charging copayments for at least some health care visits.

But, as the Legislature and DOC consider how inmate copayments should be applied, they may wish to review the reasonableness of some existing practices. For example, DOC has determined that Minnesota inmates who make medical visits in response to sports-related injuries are exempt from copayments. DOC policy says copayments will not be assessed “for initial evaluation and treatment of injuries resulting from...sports activity reported at the time of the injury.”<sup>11</sup> The National Commission on Correctional Health Care has identified circumstances that should be exempted from copayments, and sports injuries are

<sup>10</sup> National Commission on Correctional Health Care, *Position Statement: Charging Inmates a Fee for Health Care Services*, revised October 2012, <http://www.ncchc.org/charging-inmates-a-fee-for-health-care-services>, accessed January 29, 2014. We also reviewed national surveys on copayments, and many other states' exempted provider-initiated visits.

<sup>11</sup> DOC Policy 500.100 (Offender Co-Payment for Health Services).

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**The amount of Minnesota's basic copayment charge is similar to those charged to inmates in other states.**

not specifically mentioned.<sup>12</sup> Minnesota's exemption from copayments for inmates' sports injuries seems inconsistent with general copayment practices in the community. Typically, individuals who are not in prison would be responsible for a copayment if they saw a doctor related to a sports-related ankle sprain or knee injury, for instance.

One other exemption from copayments that merits consideration is the exemption for prescription medications. Minnesota law only requires copayments for health care "visits," and DOC policy does not require copayments for prescription medications. However, it is common for people in the community with health care coverage to have copayments for medications. Quite a few DOC nurses suggested to us that copayments be applied to medications—to foster inmate compliance with prescriptions and reduce medication abuse. Also, we are aware of at least nine states that require copayments for some or all inmate medications.<sup>13</sup> On the other hand, as discussed above, inmates typically have limited financial resources, and ongoing payments for required medications might discourage compliance with prescriptions.

Overall, Minnesota's copayment charge per visit is generally comparable to the charges adopted in other states, but some of Minnesota's exemptions deserve review. As the Legislature and DOC consider copayment policies, they should ensure that any changes do not threaten reasonable health care access.

## Consistency of Copayment Collections

According to state law, inmate copayment revenues are appropriated to the commissioner of corrections for the delivery of health care to inmates.<sup>14</sup> The amounts collected from copayments system-wide are a relatively modest part of DOC's total health services expenditures, totaling about \$75,000 in fiscal year 2013.

Exhibit 5.3 shows that the copayment revenues collected per inmate vary across DOC facilities. In fiscal year 2013, the Shakopee correctional facility collected about \$17 per inmate; this was more than double the amounts collected at several other facilities. Shakopee's high copayment revenues probably reflect the fact that female offenders (who are served at Shakopee) have more frequent health services appointments than male inmates.<sup>15</sup> Among facilities serving men, the

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<sup>12</sup> The National Commission on Correctional Health Care suggests that emergencies and trauma care should be exempt from copayments; DOC policy has a copayment exemption for emergency care, separate from its exemption for sports injuries.

<sup>13</sup> Association of State Correctional Administrators, *ASCA Responses: Inmate Medical Co-Payment Survey* (September 2009), [http://www.asca.net/system/assets/attachments/1649/Inmate\\_Medical\\_Co-Pay\\_Survey.pdf](http://www.asca.net/system/assets/attachments/1649/Inmate_Medical_Co-Pay_Survey.pdf), accessed October 30, 2013. Some states' responses did not directly address whether copayments were charged for medications, but the following states mentioned medication copayments: Idaho, Indiana, Louisiana, New Jersey, Pennsylvania, Rhode Island, South Carolina, Virginia, and West Virginia. In some of these states, copayments were not applied to prescription refills or to certain types of medications.

<sup>14</sup> *Minnesota Statutes* 2013, 243.212.

<sup>15</sup> In fiscal year 2013, Shakopee inmates had 2.9 physician "encounters" per inmate, while other facilities for adults ranged from 1.0 (Lino Lakes) to 1.9 (Oak Park Heights).



**Exhibit 5.3: Health Services Copayment Revenues**

**Revenues from inmate health services copayments totaled about \$75,000 in fiscal year 2013.**

DOC Correctional Facility	FY 2013 Copayment Revenues	Number of Inmates, as of 1/1/2013	FY 2013 Copayment Revenues per 1/1/2013 Inmate	Percentage Change in Copayment Revenues, FY 2007-2013
Faribault	\$18,875	1,987	\$ 9.50	58%
Lino Lakes	8,837	1,307	6.76	10
Moose Lake/Willow River	8,470	1,209	7.01	35
Oak Park Heights	3,520	443	7.95	-27
Rush City	6,205	979	6.34	-22
St. Cloud	8,655	985	8.79	10
Shakopee	10,635	627	16.96	93
Stillwater	<u>9,850</u>	<u>1,605</u>	6.14	117
TOTAL	\$75,047	9,142	\$ 8.21	32%

NOTES: Does not include copayments from offenders at the Red Wing and Togo facilities, which totaled about \$818 in fiscal year 2013. Data on percentage changes were not based on inflation-adjusted amounts.

SOURCE: Office of the Legislative Auditor, analysis of Department of Corrections data.

copayment revenues per inmate ranged from \$6.14 (Stillwater) to \$9.50 (Faribault). Of greater significance,

- **There are indications that copayments may have been inconsistently collected by DOC facilities.**

We examined the change in prisons’ copayment revenues between fiscal years 2007 and 2013.<sup>16</sup> During this period, the Legislature increased the size of the basic copayment rate from \$3 per visit to \$5 per visit. Several institutions had little or no increase in copayment revenues during this period, including Oak Park Heights (a 27 percent decrease), Rush City (a 22 percent decrease), and Lino Lakes and St. Cloud (each with a 10 percent increase). On the other hand, some facilities had much larger increases in copayment revenues, including Stillwater (a 117 percent increase) and Shakopee (a 93 percent increase).

Some DOC medical staff expressed concerns to us about inconsistencies in collection of copayments. For example, two staff made the following comments:

I feel that co-pays need to be charged whenever appropriate. We have some nurses that don’t charge a co-pay according to the policy.

[N]ot all supervisory staff handles [the copayment policy] uniformly and the policy is loosely interpreted.

<sup>16</sup> We did not examine a sample of health care visits to determine whether DOC properly assessed copayments. Our finding was based on a review of trends in aggregate copayment revenues, concerns expressed by some staff, and a review of copayment information given to inmates.

Similarly, some supervisory DOC staff told us that former supervisors at one prison were inconsistent in administering the copayment policy—not collecting copayments that should have been collected and granting refunds of copayments too readily.

We also examined the written information about health services copayments that eight facilities provided to inmates upon arrival at the facility. We thought facilities may be more likely to consistently administer copayment policies if the information they provided to inmates was complete and accurate. Our review indicated that the Shakopee and Faribault prisons provided the most complete information, closely mirroring DOC’s formal policy. However,

- **Information provided to inmates about DOC’s copayment policy by most prisons was brief and sometimes inaccurate.**

The Shakopee and Faribault prisons were the only ones that distributed materials containing a complete list of health care visits that, according to DOC policy, were exempt from copayments.<sup>17</sup> On the other hand, the Stillwater offender handbook—most recently revised in 2013—says that offender copayments are \$3 per visit, not the \$5 charge per visit that has been required by law since 2011. In addition, the Stillwater health services staff’s outline for offender orientation incorrectly says that “annual/bi-annual exams” and appointments to refill prescriptions are exempt from copayments.<sup>18</sup>

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## RECOMMENDATIONS

*The Department of Corrections should ensure that:*

- *Copayment policies are well understood by facility staff and consistently applied; and*
  - *Orientation materials given to offenders at each facility contain a complete and accurate overview of DOC’s copayment policy.*
- 

There is, by necessity, some room for facility staff to interpret DOC policy about copayments. Health services administrative staff should periodically review samples of cases to ensure that copayments are being properly assessed.

The distribution of incomplete and sometimes inaccurate information on DOC’s copayment policy at certain facilities may confuse or mislead offenders. Disputes about copayments are one of the most common reasons for health

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<sup>17</sup> The Faribault prison distributed a two-page health services handout that had a complete list of the copayment exemptions. But this prison’s orientation handbook had a list that was not complete.

<sup>18</sup> DOC policy says that offender-initiated visits for physical examinations are chargeable, and this would include the annual or biennial physical examinations allowed by DOC policy. Appointments to renew medications are chargeable, according to DOC policy, except for those involving “renewal of life-sustaining medications necessary for the management of long-term medical problems.”

services grievances. DOC officials should ensure that offenders and staff have a clear understanding of the circumstances in which copayments should be applied.

## PHARMACEUTICAL USE AND COSTS

Sixty-one percent of inmates in Minnesota prisons had an active medication order, as of June 2013. Pharmaceuticals are both an important part of health care treatment and a significant component of overall costs. The total cost of pharmaceuticals for DOC inmates in calendar year 2012 was about \$5.6 million, or more than 8 percent of the total DOC health services budget. We cannot offer judgments on the appropriateness of prescribing practices for inmates. However, we examined various issues related to pharmaceutical costs.

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**Over 60 percent of inmates have active medication orders.**

Under DOC's previous and current contracts with a health services vendor, pharmaceutical purchases are the responsibility of the vendor. The contracts state that the contractor shall "provide all prescription pharmaceuticals for the offenders prescribed by the contractor's personnel or eligible DOC health care staff."<sup>19</sup> These contracts have made the vendor responsible for all pharmaceutical costs until the total of these costs and other health services claims expenses reach a threshold amount specified in the contract; after that point, DOC and the vendor share financial responsibility for additional claims expenses. Thus, pharmaceutical costs are covered by the capitated payment DOC makes to its vendor, but DOC can be responsible for additional costs if cumulative claims expenditures exceed a certain sum.

### Trends

Some health services staff at DOC facilities told us that practitioners have prescribed too many medications for inmates, and that offenders should be expected to purchase more of their medications "over the counter" at prison canteens. However, we found that:

- **The total cost of pharmaceuticals dispensed to DOC inmates declined somewhat in recent years.**

We compared data on pharmaceutical orders for DOC inmates from the first six months of 2010 with the first six months of 2013. System-wide, the number of orders processed declined by 11 percent, and the cost of these orders declined by 12 percent. The total pharmaceutical cost per inmate per month declined from \$48.07 in January 2010 to \$42.75 in June 2013.

One factor in this decline has been reduced use of "non-formulary" medications. A drug formulary is a list of preferred medications, presumably based on consideration of drug cost, effectiveness, and safety.<sup>20</sup> The DOC Pharmaceutical

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<sup>19</sup> DOC's health services vendor (Corizon) through December 31, 2013, relied on its in-house pharmacy—called PharmaCorr—to provide pharmaceuticals. The vendor (Centurion) whose contract began January 1, 2014, uses Diamond Pharmacy to provide and dispense pharmaceuticals.

<sup>20</sup> The purpose of DOC's formulary and the factors to be considered when decisions are made about inclusion of a drug in the formulary are not explicitly addressed by DOC policy.

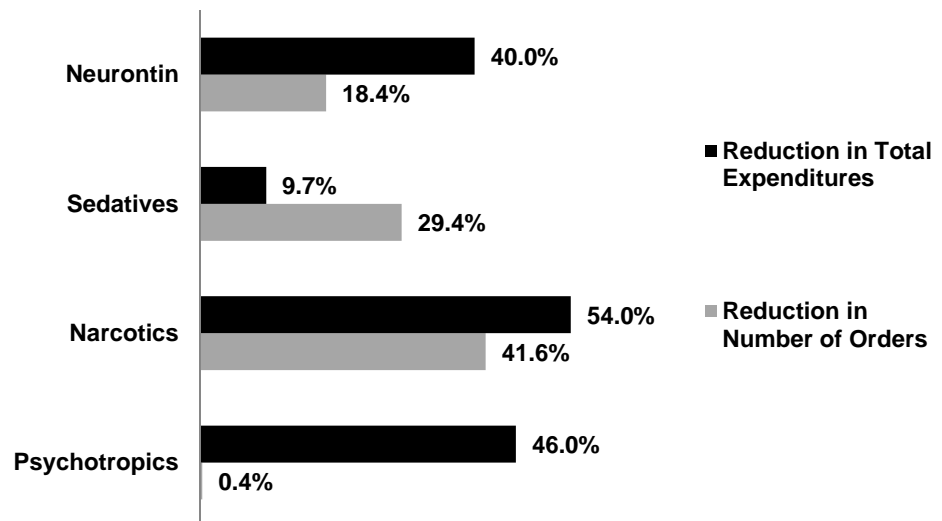
and Therapeutic Committee—which includes representatives of DOC and its contractor—determines which drugs should be included in the formulary. Practitioners may prescribe medications that are not in the formulary, but only after receiving supervisor approvals. We found that expenditures for non-formulary orders declined by 30 percent over a three-year period, reflecting a greater reliance on medications available from the formulary.

We also examined trends in particular categories of pharmaceuticals in recent years. Some medical staff at DOC facilities told us that offenders were receiving too many prescriptions for psychotropic drugs, narcotics, sedatives, and a pain reliever called gabapentin (or Neurontin). We examined system-wide trends in the number of orders for these medications from the first six months of 2010 to the first six months of 2013. Exhibit 5.4 shows the overall trends. In each of these cases, total costs for these pharmaceuticals declined between 2010 and 2013. In addition, the number of pharmaceutical orders declined for each of these categories, although the reduction in psychotropic medication orders was minimal.

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### Exhibit 5.4: Percentage Reduction in Expenditures and Orders of Selected Pharmaceuticals in Prisons, from January-June 2010 to January-June 2013

**Expenditures for key types of pharmaceuticals declined in recent years.**



NOTE: Expenditure data were not adjusted for inflation.

SOURCE: Office of the Legislative Auditor, analysis of Corizon Health, Inc., data.

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There were some exceptions to the overall downward trends in pharmaceutical costs and orders. For example, the St. Cloud prison's expenditures for Neurontin prescriptions increased 94 percent over the period we examined, and the Moose Lake/Willow River expenditures for psychotropic drugs increased 107 percent over this period. Thus, there may be differences in the prescription patterns of individual practitioners that require additional attention. But, in general, the

concerns we heard about escalating use and cost of prescription pharmaceuticals were not borne out by our review of system-wide data.

We offer no judgments about the appropriateness of prescription practices from a clinical perspective. Some medical staff expressed concern to us that the prisons rely too much on medications and not enough on patient education, or that the formulary medications are less effective or have more adverse side effects than alternatives that are not on the formulary. There may be valid concerns about the merits of particular medications prescribed to offenders, but we did not have the expertise to explore them.

## Pharmaceutical Prices

**For items on which direct comparisons could be made, a Minnesota pharmaceutical purchasing alliance would have spent less, in aggregate, on medications than did DOC's former health services contractor.**

We examined the reasonableness of the prices paid by DOC's contractor to purchase pharmaceuticals in calendar year 2012. We did this through a comparison of the contractor's prices and those paid by the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP). MMCAP is a free, voluntary group-purchasing organization for government facilities that provide health care services. It is operated by the Minnesota Department of Administration. MMCAP purchases pharmaceuticals for state correctional agencies in about half of the states, but not for the Minnesota Department of Corrections. We found that:

- **The pharmaceutical prices paid by the Department of Corrections' health services contractor in 2012 appear to have been higher than those paid by a multistate purchasing organization operated by the State of Minnesota.**

For each 2012 pharmaceutical purchase made by DOC's health services vendor (Corizon), we asked MMCAP staff to determine what MMCAP's purchase price would have been for the same drug or its generic therapeutic equivalent on the date when DOC's vendor made its purchase. Cases in which MMCAP staff could not determine a comparable pharmaceutical or packaging type were excluded from the analysis.<sup>21</sup> For those items in which a direct comparison could be made, MMCAP would have provided a cumulative 10 percent savings over the cost of Corizon's pharmaceutical purchases.

When DOC solicited bids in 2013 for its health services contract, the pharmaceutical portion of Corizon's bid was higher than those of the other two bidding vendors. Corizon proposed cumulative pharmaceutical spending over the course of the contract of \$15.9 million, which was 13 percent higher than the \$14.1 million proposal of the vendor awarded the contract. A consultant who compared the cost of the proposals said, "Corizon's drug costs are the highest among all vendors."<sup>22</sup> The consultant said Corizon's acquisition prices for

<sup>21</sup> MMCAP made comparisons for 93 percent of the more than 300,000 calendar year 2012 invoices, and these invoices accounted for 66 percent of the pharmaceutical costs incurred in that year.

<sup>22</sup> Deloitte Consulting LLP, *Vendor Cost Proposal Analysis*, August 5, 2013, 9.

common pharmaceuticals were usually lower than those of the competing bidders, but Corizon's cost for dispensing these medications was higher.

The analysis showing advantageous pharmaceutical prices for MMCAP compared with Corizon addressed only invoices for 2012, but this—in combination with the recent bids for DOC's health services contract—raise questions about past pharmaceutical expenditures. We asked Department of Corrections officials why they do not purchase pharmaceuticals from MMCAP. MMCAP is operated by the State of Minnesota, purchases pharmaceuticals for publicly operated facilities in most states, and appears to have favorable pricing. DOC told us that MMCAP has lacked the “infrastructure” it needed, such as the ability to dispense, package, or transport medications. However, MMCAP staff told us that it can arrange for such services and does so in many of its contracts.

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### RECOMMENDATION

*The Department of Corrections should periodically solicit information from the Minnesota Multistate Contracting Alliance for Pharmacy to determine the competitiveness of pharmacy prices paid by the department's contractor.*

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DOC's new health services contract may provide more favorable pharmaceutical pricing in aggregate than DOC previously received. However, DOC had not solicited comparative data on its previous vendor's pharmaceutical pricing in recent years, and it should do this more frequently in the future. Having an organization like MMCAP in state government provides a good resource for determining possible opportunities for pharmaceutical cost savings.

# Management Issues

This chapter focuses on several management issues faced by the Department of Corrections (DOC) that we have not addressed in previous chapters. We discuss the need for clear organizational direction, the challenge of providing services with a combination of state employees and contractors, the need for active oversight of a health services contractor, and the difficulties of providing services without electronic health records.

## STAFFING

For the most part, accrediting organizations have not established quantitative standards for the number of health services staff needed in correctional settings. However, the standards require (as does DOC policy) a “staffing plan” that specifies in detail what staff are needed and how care will be provided if some positions are unfilled.<sup>1</sup> We found that:

- **DOC has not developed a formal, comprehensive staffing plan for health services.**

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**According to national standards, the department should annually assess health services staffing in prisons, but it has not formally done so.**

Department policy says: “The director of health services determines essential positions needed to perform the defined scope of health services, developing and implementing a staffing plan and annually reviewing the staffing plan to ensure adequacy of number and type of staff.”<sup>2</sup> However, DOC does not have such a plan. DOC’s contract with its health services vendor specifies the number of hours required weekly at each facility for the professional staff employed by the vendor. But DOC relies on a more informal approach to assess the need for its own employees. DOC officials told us there are differences among facilities—for example, in custody levels, building layouts, and the types of offenders—that make it difficult to plan for staffing in a standardized way. Still, we think that periodic staffing analyses could acknowledge these differences while assessing the adequacy of staffing at facilities. A written staffing plan might also make staffing decisions more transparent; some facility staff told us they did not understand the basis for the central office’s staffing allocations among facilities.<sup>3</sup>

In the absence of a staffing plan, some DOC staffing issues have lingered for extended periods without adequate resolution. In Chapter 2, we discussed the absence of 24-hour nursing coverage at most DOC prisons. Another example—

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<sup>1</sup> American Correctional Association, *2012 Standards Supplement* (Alexandria, VA, June 2012), Standard 1-HC-4A-05 (Staffing); and National Commission on Correctional Health Care, *Standards for Health Services in Prisons* (Chicago, 2008), Standard P-C-07 (Staffing).

<sup>2</sup> DOC Policy 500.011 (Health Services Review and Assessment).

<sup>3</sup> DOC has an analytical tool for assessing the number of mental health staff needed at its various facilities. This tool has not been used to determine the need for staff reallocations since 2008, although DOC officials said they intend to use it for this purpose in 2014.

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**DOC health care employees have questioned the adequacy of some staffing levels—for example, in dental services.**

for a single facility—has been ongoing concern about medical staffing at the Stillwater prison. DOC contracted for 40 hours of physician time per week at Stillwater prison for more than five years, despite staff concerns that this amount of time was inadequate due to the size and health needs of Stillwater’s inmate population. DOC changed this requirement to 80 hours per week, effective January 2014, but adoption of annual staffing plans would have provided opportunities to consider incremental increases in Stillwater’s doctor staffing in recent years. In addition, the Stillwater prison has used a sizable and growing amount of overtime to cover its nursing shifts. Over the four most recent fiscal years, overtime hours comprised 6.5 percent of all hours among Stillwater’s nursing staff, which was well above the percentages of other DOC facilities. In fiscal year 2013, overtime was 7.6 percent of Stillwater’s total nursing hours. Again, a staffing plan might have focused attention on this issue sooner and explored possible options for addressing Stillwater’s overtime use.

Some DOC staff also raised concerns about the adequacy of dental staffing. In Chapter 1, we noted that dental services were the only area of DOC health services staffing that declined between fiscal years 2007 and 2013. The department eliminated some dental positions (mostly hygienists) several years ago, resulting in a 35 percent decrease in full-time-equivalent dental staff over the period we examined. One of DOC’s dental staff offered the following comments that echoed others we heard:

For the most part, the current system [of sharing dental staff among facilities] works out fairly well but, unfortunately, due to time constraints, we are not able to offer routine care to the offenders.... By not being able to provide routine care, routine problems become urgent problems and often result in teeth being extracted rather than restored.

DOC policy requires the provision of emergency and urgent dental care to offenders, with “routine” dental care “provided as availability permits.”<sup>4</sup> As a general rule, routine dental care is only available to offenders who have completed 36 months of their current sentence and have at least 12 months remaining on a current sentence. Based on comments we heard from health care staff and offenders, as well as our analysis of data on the frequency of dental appointments, it appears that offenders’ access to care for non-urgent dental needs is limited.<sup>5</sup>

Aside from the specific concerns mentioned above, we heard various comments about staffing in our surveys of health services staff. The comments we heard were mixed, perhaps reflecting differences among facilities and types of positions. Some people told us that staffing levels were adequate, as expressed in the following comment: “The management in my work area has always worked hard to ensure our staffing numbers are where we need them to function

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<sup>4</sup> DOC Division Directive 500.055 (Dental Services).

<sup>5</sup> We examined how long it took for offenders to be seen in response to their requests for routine dental care. Offenders seen in fiscal year 2013 had waited an average of 1,003 days, according to DOC records. Offenders become eligible to request routine dental services when they have served 36 months of their sentences and have at least 12 months remaining.



properly.” But we also heard from staff who described inadequate staffing in various positions, including doctors, mental health therapists, registered nurses, licensed practical nurses, physical therapists, and nurse practitioners. Examples of the comments we heard included:

At [my facility], we have been short-staffed on nurses for as long as I have worked here. Although the nurses I work with are stellar and complete tasks efficiently and safely and provide good nursing care, we are unable at times to create care plans, conduct chronic care clinic education, and follow up appropriately.

At [my facility], there is a chronic shortage of all personnel. As a physician I spend a large portion of my day dealing with inmate paperwork as opposed to patient care.

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### RECOMMENDATION

*The Department of Corrections should develop and annually update a health services staffing plan.*

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**A health services staffing plan could help DOC make staffing decisions in a more transparent way.**

In part, the department should develop a staffing plan to comply with its own policy and professional standards. But, more important, a staffing plan would help DOC to address in a more transparent way the adequacy of its health services staffing levels and the rationale for distribution of existing staff. A plan might help DOC discuss and prioritize options, such as hiring overnight nurses at additional facilities, assigning additional staff to the women’s prison to address problems with the timeliness of appointments and examinations, or increasing dental staffing. If some actions would require additional state funding, a staffing plan could help build the case before the department submits a formal budget request to the Governor and Legislature.

## STRATEGIC MANAGEMENT

DOC’s Health Services Unit has had considerable stability in its central office administrative leadership. The director of this unit has held this position since 1999. The department’s medical director has worked for DOC since 1980, and the department’s two directors of nursing have held their positions since 1999 and 2006, respectively.<sup>6</sup> This leadership team brings a high level of expertise, commitment, and professionalism to the department’s health services activities.

However, we observed opportunities for improvement in the leadership’s overall strategic management. Of particular note,

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<sup>6</sup> The medical director is an employee of the Department of Human Services, but DOC contracts for his services for 50 percent of his time. The nursing supervisors are classified as “corrections health program directors,” but they function as DOC’s directors of nursing.

- **The department’s Health Services Unit has not regularly established goals and measurable objectives for health services.**

The American Correctional Association says that a correctional agency’s health services program should have measurable goals and objectives that are reviewed at least annually.<sup>7</sup> Consistent with this, DOC health services policy says:

The director of health services establishes measurable goals and objectives as part of the strategic plan. The director of health services specifies a system to annually assess achievement of goals and objectives, administering program changes as necessary.<sup>8</sup>

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**DOC does not have a strategic plan that addresses system-wide issues and priorities in prison health services.**

However, the DOC Health Services Unit does not have a strategic plan, nor has it annually established system-wide goals and measurable objectives. DOC’s health services director told us that previous efforts to develop a strategic plan for the unit stalled due to turnover in key staff responsible for this task. She said the Health Services Unit operates under DOC’s agency-wide strategic plan. But, as of January 2014, the agency-wide plan has not been updated for several years and has little discussion of health services.<sup>9</sup> Also, although DOC is required by law to prepare an agency-wide performance report each biennium, this report has provided limited information on health services.<sup>10</sup>

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## RECOMMENDATION

***The Department of Corrections should develop a health services strategic plan with goals and measurable objectives, and annually measure progress toward these goals and objectives.***

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In Chapter 4, we said that the DOC Health Services Unit’s “quality improvement” efforts have been inadequate. The absence of a health services strategic plan is a related issue, but one that is more central to the overall direction of health services activities. A strategic plan would provide a framework for the entire Health Services Unit, while quality improvement activities would provide initiatives to address certain key areas of service.

A strategic plan for the Health Services Unit would identify key challenges facing the unit, including services provided by employees as well as by contract staff. Although some individual managers and supervisors currently develop goals for their areas, it is important to have a unit-wide statement of strategic

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<sup>7</sup> American Correctional Association, *Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions*, 1<sup>st</sup> ed. (Alexandria, VA, January 2002), Standard 1-HC-7A-01 (General Administration).

<sup>8</sup> DOC Policy 500.011 (Health Services Review and Assessment).

<sup>9</sup> The strategic plan on the department’s Web site as of January 2014 was issued in 2010.

<sup>10</sup> *Minnesota Statutes* 2013, 241.016, subd. 1, requires DOC to prepare a biennial performance report for the Legislature. The fiscal year 2012 report discussed the performance of mental health services but not medical services.

priorities, anticipated steps to achieve them, and measures of success. This would be consistent with professional standards and DOC policy.

Effective management of health services also requires having good practices for reviewing department policies. In our view,

- **DOC management has not adequately assured that health services policies are comprehensive, reflect professional standards, and are up-to-date.**

In earlier chapters, we noted that there are various areas in which DOC's policies do not align with professional standards. For example, DOC policy requires initial dental exams of offenders within 120 days of intake, rather than the 30 days suggested by professional standards. DOC policy does not specify protocols for the management of diabetes, asthma, high blood cholesterol or pressure, or seizure disorders, and its management of chronic illnesses has not been sufficiently coordinated and comprehensive. DOC does not complete mortality reviews within 30 days, and actions taken in response to these reviews are not systematically tracked. These and other examples suggest a need for stronger DOC efforts to develop comprehensive policies.

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**DOC's health services policies should be updated to better align with professional standards.**

In addition, DOC has not always reviewed in a timely manner its existing health services policies. According to DOC's policy manual, "All policies, division directives, instructions, and security instructions are reviewed annually."<sup>11</sup> Staff who oversee this process told us that each DOC policy is supposed to be reviewed for possible changes in each fiscal year. Such a review may or may not result in changes to the policy, but designated staff must certify each fiscal year that the review of a policy has occurred. In September 2013, we reviewed DOC records for each system-wide health services policy or directive, and we found that 77 percent had not been reviewed since the end of June 2012.<sup>12</sup>

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## RECOMMENDATION

***The Department of Corrections should (1) amend health services policies as appropriate to conform more fully to professional standards and (2) ensure that each health services policy is reviewed annually.***

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Regardless of whether DOC seeks accreditation of its facilities from professional organizations, it should carefully consider standards that have been adopted by experts in the correctional health services field. Where reasonable, DOC should ensure that its policies are consistent with these standards. Consistent with DOC requirements, all health services policies should be reviewed for possible changes in a timely manner.

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<sup>11</sup> DOC Policy 100.100 (Policy Manual Maintenance).

<sup>12</sup> Most of the policies that had not been reviewed in fiscal 2013 or 2014 had been reviewed in fiscal year 2012.

## CONTRACT MANAGEMENT

In the opening chapter of this report, Exhibit 1.1 showed how Minnesota prisons depend on a combination of DOC employees and contractor staff to provide health services to inmates. Nurses and mental health therapists in the prisons are employed by DOC, while doctors and psychiatrists in the prisons are employed by DOC's health services contractor. The past and current Department of Corrections' contracts have given the health services vendor responsibility for a wide range of services, shown in Exhibit 6.1.

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### Exhibit 6.1: Services Provided or Arranged by the Department of Corrections' Health Services Contractor

- Intake health care screenings
- Initial and periodic physical examinations
- Clinical services for offenders signed up for "sick call"
- Medical transfers by ambulance or medi-van
- Electrocardiogram services
- Imaging and x-ray services
- Medical laboratory services
- Phlebotomy services
- Dialysis
- Screening and treatment of HIV/AIDS
- Physical examinations and daily practitioner rounds for patients in the Oak Park Heights facility's Transitional Care Unit
- Physical examinations and on-call coverage for patients in the Oak Park Heights facility's Mental Health Unit
- Monthly rounds by primary care providers for patients in the Faribault facility's Linden Unit, in addition to scheduled appointments
- Specialized health care services
- Off-site services, such as emergency room visits or hospital stays
- Emergency medical care for correctional facility employees
- Offender-specific medical supplies, equipment, and therapeutic medical diets, as appropriate
- Vision care services
- Prescription pharmaceuticals for offenders
- Diagnosis and treatment of hepatitis C patients
- Comprehensive continuity of operations plan
- Dental consultation regarding staffing, quality of care, and equipment needs
- Psychiatric services

SOURCE: Office of the Legislative Auditor, analysis of Department of Corrections health services contract.

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The department used the same health services contractor—Correctional Medical Service, which later merged with another company to become Corizon Health, Inc.—from 1998 through 2013. In 2013, DOC solicited bids for a new contract, to begin in 2014. The department received three proposals that covered the full

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**DOC began contracting with a new health services vendor in 2014.**

range of services which DOC was seeking to purchase.<sup>13</sup> DOC told us they selected Centurion Managed Care—which submitted a bid that was slightly higher than Corizon’s bid—based on the overall strength of its proposal.<sup>14</sup> For example, DOC said it liked Centurion’s experience in mental health services and understanding of Medicaid, as well as Centurion’s proposal to place a utilization management nurse and quality assurance nurse in its Minnesota office. In addition, Centurion agreed to give DOC an increased share of the money saved if the total cost of claims falls below a contract-specified amount.<sup>15</sup>

Below, we discuss three issues related to contract management: (1) the challenges of a service delivery system that relies on a blend of DOC and contractor staff, (2) DOC’s monitoring of contractor administrative costs and profits, and (3) DOC’s oversight of contractor performance.

## “Blended” Service Delivery

Most states use contracted services for prison health care to some extent. According to a 2010 survey of state correctional agencies, 70 percent of responding states reported contracting for physicians, while 60 percent said they contracted for nurses.<sup>16</sup> The company (Corizon) with which DOC contracted for health services through December 2013 told us that most of the states for which it has worked have had “comprehensive” contracts for medical services. In these states, the contractor provided all of the medical services at a given site (including both doctors and nurses). Thus, it said, Minnesota’s division of responsibilities was unusual.

We found that:

- **An arrangement that blends contractor and state employee staff in health care service delivery presents some challenges, although the Department of Corrections views this as a desirable approach.**

Department of Corrections officials told us that a blended service arrangement has provided a healthy “check and balance” on the quality of care. They said DOC’s health services contractor has alerted the department about its concerns regarding the quality of care, and DOC has informed the contractor about its own concerns. DOC’s contracts have clearly stated that the department retains

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<sup>13</sup> DOC also received two “partial” proposals. One vendor made a proposal for prescription drug management only, and another vendor submitted a proposal for medical claims only.

<sup>14</sup> The proposed total expenses in Centurion’s bid for the 30-month contract period were \$67,208,618, compared with \$67,086,965 for Corizon and \$73,111,558 for Wexford Health Source, Inc.

<sup>15</sup> The contract specifies a “risk pool attachment point.” Under DOC’s previous contract, if claims were below this point, DOC and the contractor shared the savings equally. Under the new contract, DOC will receive 75 percent of the savings.

<sup>16</sup> Cece Hill, “Survey Summary: Inmate Health Care and Communicable Diseases,” *Corrections Compendium* (Winter 2010), 20-21. A total of 43 states responded to this portion of the survey. The survey did not ask states to report the extent of their contracting for a particular position, so it is unclear, for example, whether states that said they contracted for physicians contracted for all of their physicians.

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**Providing health services with a blend of state employees and contracted staff has presented some challenges.**

ultimate responsibility for the health care services provided to inmates. DOC officials told us that the department would be “at the mercy” of the contractor if the contractor provided all health care services.

However, both DOC and its former contractor expressed concerns about the challenge of providing consistent, adequate care with split responsibilities. DOC and contractor staff told us that the perspectives of DOC staff and contractor doctors have not been sufficiently integrated, resulting in divergent views about treatment approaches and medication practices. Some DOC staff expressed concern that certain contract physicians were not seeing enough patients each day. On the other hand, contractor staff told us that DOC staff have sometimes ignored doctors’ suggestions regarding the timing of patients’ follow-up appointments. Also, DOC’s former health services contractor expressed concern that it could not always obtain medical records from DOC that it viewed as essential to reviewing the work of its practitioners. A number of contractor and DOC staff told us the DOC-contractor relationship was not sufficiently collegial and cohesive.

DOC’s choice of a new health services contractor, effective January 2014, provides an opportunity for a fresh start. On the other hand, many of the medical and mental health practitioners who worked for the former contractor might also work for the new contractor, and staff tensions that existed previously might remain. Furthermore, perhaps some past difficulties have resulted not from staff incompatibilities but from Minnesota’s blended form of service delivery.

We offer no recommendation for changing the blended service delivery model at a time when DOC has just entered into a new contract. However, the challenges presented by this arrangement deserve DOC’s continued attention in the future.

DOC could move away from a blended service delivery system. Under one approach, DOC would rely on a contractor to provide all health services (including nursing and therapy now provided by DOC). But if DOC were to consider contracting for all health services, it would face statutory restrictions. State law says: “Executive agencies. . . must demonstrate that they cannot use available staff before hiring outside consultants or services.”<sup>17</sup> Also, before entering a professional/technical contract, an agency is required by state law to certify that “no current state employee is able and available to perform the services called for by the contract.”<sup>18</sup>

The alternative—hiring doctors and psychiatrists as state employees rather than contracting for them—would not have these statutory issues. The Department of Human Services (DHS) told us that hiring doctors and psychiatrists as employees for its state-operated services has been more cost-effective than contracting for them, although recruitment challenges can be substantial. DHS said that, in its experience, employees are more invested in their work than contractors (who may work for multiple entities), and the agency can control the actions of employees more directly. Furthermore, as we discuss in the next section, relying

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<sup>17</sup> *Minnesota Statutes* 2013, 43A.047.

<sup>18</sup> *Minnesota Statutes* 2013, 16C.08, subd. 2(b)(1).

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**DOC prefers to contract for some specialized functions, rather than providing these with its own employees.**

on a private contractor presumes the payment of some state funds for contractor profit that might otherwise be available for direct services.

DOC officials, however, spoke favorably about contracting for health services. For example, they said it might be challenging to build the administrative infrastructure necessary to recruit and manage doctors and psychiatrists, or to provide specialized health care services with DOC staff, such as utilization management or pharmacy administration. Also, DOC said it is advantageous to have contractors that are responsible for the legal defense of doctors.<sup>19</sup>

## **Contractor Profits and Administrative Overhead**

DOC's health services contracts have established a structure for paying the contractor, authorizing "base" amounts for three categories of costs: (1) claims expenses, (2) administrative expenses (including contractor profit), and (3) staffing expenses.<sup>20</sup> The contracts have assumed a specified system-wide inmate population, and they have required supplemental DOC payments to the contractor if the prison population exceeds this threshold. We found that:

- **The Department of Corrections has not regularly obtained information on the actual administrative overhead and profits of its health services contractor, and it awarded its most recent contract to a vendor whose bid included a large profit margin.**

DOC's definition of administrative expenses has included profits in addition to administrative overhead costs. DOC does not regularly collect information on its health services contractor's past levels of profitability or administrative overhead. This is in contrast to practices for health plans serving the state's publicly funded health care programs for low-income individuals. These health plans are required by state law to report quarterly to the Department of Human Services (DHS) regarding profits, administrative expenses, and other information.<sup>21</sup> In 2011, in response to concerns that the health plans serving low-income populations were experiencing high profit levels, DHS negotiated contract amendments that required the contractors to return to DHS net income in excess of 1 percent of total premium revenues. In addition, state law has limited the amount of increase in actual year-to-year administrative expenses by health plans

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<sup>19</sup> DOC officials asserted that state-employed doctors would have to arrange for their own legal defense. This would be true if a tort claim arose from an instance in which the doctor acted outside the scope of his or her employment. For claims arising from instances in which the doctor acted within the scope of employment, the Office of the Attorney General would provide legal defense.

<sup>20</sup> The contractor is responsible for all claims expenditures up to a level specified in the contract; after that point, the claims costs are shared by the contractor and DOC. As the term "claims" is used in the contract, this category includes items not provided by contractor staff, such as the cost of off-site care and pharmaceuticals. DOC retains all funds designated for contractor staffing that were not spent in a given year.

<sup>21</sup> *Minnesota Statutes* 2013, 256B.69, subd. 9c(b).

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**DOC's health services contractor anticipates that its profits will amount to 8 percent of total contract costs.**

serving low-income populations.<sup>22</sup> Such limits do not apply to DOC's health services contractor.

When DOC solicited bids in 2013 for its health services contract, it required interested vendors to indicate their proposed total administrative expenses. DOC's request for proposals did not specifically require bidders to disclose the amount of profit they expected to make over the course of the 30-month contract. However, a subsequent DOC request asked each of the bidders to provide information that distinguished two main categories of proposed administrative expenses: (1) administrative overhead and (2) profits (or return on contract). The firm to which DOC awarded the contract (Centurion) said it anticipated \$5.3 million in profit over the 30-month contract, which represented 7.9 percent of this vendor's proposed total costs. In contrast, the current contractor (Corizon) proposed \$2.8 million in profit over the contract, or 4.2 percent of its proposed total costs.<sup>23</sup> Although the aggregate cost of Centurion's bid was similar to Corizon's, Centurion proposed a significantly higher level of profit.

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### RECOMMENDATION

*The Department of Corrections should periodically collect information on the actual expenditures of its health services contractor, including the contractor's operating profits and various types of administrative expenses.*

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DOC has not been required by law to obtain information on actual administrative overhead expenditures or profit levels of its contractor, but we think such information could be valuable. Having this type of information may help DOC in its negotiations of future contracts (or contract amendments). We do not know whether DOC could have negotiated a contract with Centurion that had a smaller profit level than the one agreed to. However, Centurion's relatively large proposed profit (as compared with the proposals of other bidders and with recent state managed care contracts for health care to low-income individuals) suggests that DOC may have had leverage to pursue a better deal for the state.

At this time, we do not see a need for the Legislature to place statutory limits on growth in administrative expenses in DOC's health services contract, as it has done in the state's publicly funded health care programs. But DOC should monitor actual administrative spending and, where necessary, proscribe in its contract any types of inappropriate administrative spending.<sup>24</sup>

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<sup>22</sup> *Minnesota Statutes* 2013, 256B.69, subd. 5i.

<sup>23</sup> The third bidder (Wexford Health Sources, Inc.) proposed \$4.7 million in profit, or 6.4 percent of its proposed total costs.

<sup>24</sup> The definition of "administrative expenses" in the contract is broad. It includes the contractor's regional office "and other contract costs," as well as the contractor's corporate management, risk premium, and contract return costs.



## Sanctions for Noncompliance

DOC's health services contract identifies about a dozen requirements for which DOC may impose financial sanctions (also called "liquidated damages") if the contractor does not comply. For example, DOC may impose a \$250 sanction each time a non-urgent off-site appointment does not occur within the time frame specified by the treating practitioner.<sup>25</sup> We found that:

- **The department has rarely sanctioned its health services contractor for noncompliance with the contract, and documentation regarding the extent of noncompliance is incomplete.**

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**In recent years, DOC has not sanctioned its health services contractor for late medical appointments.**

We reviewed sanctions imposed by DOC between January 2008 and late 2013. During this period, there were three sanctions. In 2008, the contractor's regional medical director provided more hours of direct care than allowed by the contract; the amount of the sanction was \$7,395. In 2008, the contractor failed to provide the agreed-upon amount of staff coverage at two facilities, resulting in a \$6,456 sanction. In 2013, the contractor retained a temporary provider for a longer period than allowed by the contract, resulting in a \$31,497 sanction.<sup>26</sup>

From 2008 to 2013, the contractor was never sanctioned by DOC for problems with the timeliness of appointments. Nevertheless, DOC's contract manager in 2009 expressed "long-standing concerns with off-site appointment scheduling in the areas of timeliness of scheduling and of completing appointments in compliance with contract terms."<sup>27</sup> At that time, he said the process for scheduling off-site health care consultations was "grossly inefficient, duplicative, and needlessly work intensive" for both DOC and the contractor.<sup>28</sup> The contract manager said DOC shared responsibility for these problems with the contractor.

DOC's contract manager told us the department considered levying sanctions for timeliness issues in 2010, but changes in the contractor's personnel and practices convinced DOC that this was not necessary.<sup>29</sup> He told us that, since 2010, "scheduling has been performed within the requirements of the contract, save for infrequent human error." As we discussed in Chapter 2, our analysis of DOC's off-site scheduling log identified many appointments from 2012 and 2013 that initially appeared to be tardy. We explored a limited sample of these cases to

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<sup>25</sup> The contract authorizes liquidated damages ranging from \$100 to \$1,000 per incident. For noncompliance with certain staffing requirements, the amount of the liquidated damages is computed based on the hours of required services that were not provided.

<sup>26</sup> In addition, there was one instance in 2012 in which DOC thought the contractor inappropriately charged \$42,000 to "staffing" expenses; the contractor disagreed with DOC's interpretation. DOC said it had decided not to seek a recovery of these funds, but the contractor offered to pay back \$21,000 and DOC accepted this.

<sup>27</sup> Mike Hermerding, Department of Corrections, letter to Dale Poliak, Correctional Medical Services, *Off-Site Appointments*, July 22, 2009.

<sup>28</sup> *Ibid.*

<sup>29</sup> In 2010 DOC asked the contractor to add a second scheduler for medical appointments. This was not a sanction specified in the contract, but the contractor agreed to add a scheduler at a cost of more than \$30,000 annually.

consider whether there were valid explanations for seemingly late appointments.<sup>30</sup> DOC and its contractor provided documentation for some cases that showed doctor-authorized waivers of the appointment deadlines—for example, because the next available opening with the provider was not until after the deadline. In some other cases, we were told that cases marked “urgent” on the scheduling log were not actually urgent, or that the log misrepresented cases involving a series of related appointments. Overall, we found it difficult to use DOC’s scheduling log and related records to independently document the actual extent of noncompliance with contractual scheduling requirements.<sup>31</sup>

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## RECOMMENDATION

*The Department of Corrections should improve recordkeeping for decisions related to off-site appointments, both to facilitate timely scheduling and ensure accountability for contract requirements.*

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DOC told us that its goal in managing the health services contract has been to ensure that proper care is provided to inmates, not to collect revenues from the contractor for noncompliance. This is a reasonable perspective. But we also think DOC should assess sanctions when appropriate. The DOC scheduling log has had a history of problems, and it still has significant limitations. For example, this log does not adequately track instances in which a single doctor order results in multiple off-site appointments, and it does not adequately document the reasons for seemingly late appointments. DOC should consider ways to improve this scheduling and accountability tool.

## HEALTH RECORDS

The Department of Corrections maintains an extensive electronic database with information about all offenders in prison.<sup>32</sup> This database contains descriptive information regarding inmates, their criminal sentences, and their living unit assignments in prison. The database also contains records of inmates’ “encounters”—typically, face-to-face meetings—with health services professionals employed by DOC or its health services contractor. We used data from this system to examine the frequency and timing of offender screenings,

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<sup>30</sup> The DOC health services contract says that DOC need not apply sanctions for late appointments if these occurred because of “unusual circumstances” (as determined through consultations with the contractor and DOC medical director), patient noncooperation, or security concerns. We reviewed random samples of 20 urgent and 20 non-urgent appointments that did not appear to meet the contractual requirements for timeliness.

<sup>31</sup> We originally intended to examine trends in off-site appointment timeliness since 2010, but we learned that DOC’s database no longer contained valid dates for many of these appointments. For the one-year period of data we analyzed, we also observed that many cases in DOC’s database had implausible dates. For example, among cases that appeared to have useable dates to analyze, more than 10 percent of cases had date issues. The problems were either (1) the date of the contractor’s utilization review was shown as occurring before the date when the appointment was requested or (2) the date when the appointment was scheduled was shown as occurring before the utilization review decision occurred.

<sup>32</sup> This is DOC’s Correctional Operational Management System.

examinations, and other appointments related to medical, dental, or mental health issues. This information system helps DOC to manage its offender population for a variety of purposes. But we also observed that:

- **Proper management of offenders' health care is hindered by the inadequacy of health records transmitted to DOC when offenders enter prison.**

Inmates typically enter prison following transfers of custody from local jails. State rules for jails require the following:

Summaries or copies of the health record must be sent to the facility to which the inmate is transferred.... The facility administrator or designee, which may include the responsible physician, health care personnel, or health-trained staff of the facility from which the inmate is being transferred, shall minimally share with the facility administrator of the facility designated to receive the inmate information regarding the inmate's medical management, security, and ability to participate in programs.<sup>33</sup>

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**According to DOC, most counties provide the state with little or no medical information about inmates transferred from jail to prison.**

However, the health services administrator at DOC's primary intake facility for offenders estimated that fewer than 10 percent of local jails provide DOC with summaries or copies of the health record at the time an inmate transfers to prison. This is contrary to the requirements of state rules and complicates DOC's task of determining whether offenders have health problems that need immediate attention. The administrator described a recent case in which a county transported a paraplegic offender with open sores to the DOC intake facility without advance notice of the offender's health issues, and the facility had to immediately arrange for the offender's transfer to a different prison that could address his medical needs.

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## RECOMMENDATION

*As part of licensing and inspection reviews, the Department of Corrections should ensure that local correctional facilities are complying with state requirements for those facilities to transmit offenders' health records at the time of transfer to a new facility.*

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DOC's Inspection and Enforcement Unit periodically examines the compliance of local correctional facilities with state rules. These reviews offer an opportunity for DOC to improve the health services reporting practices of local facilities.

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<sup>33</sup> *Minnesota Rules* 2911.6200, subp. 6, posted October 8, 2007.

An additional issue we observed is that:

- **Portions of inmate health records are not in DOC’s main information system, and it can be challenging for DOC to retrieve and transmit such information in a timely manner.**

This is particularly true of detailed notes by medical or mental health providers, which are often kept in a paper version rather than electronically. When an offender returns to prison for a violation of supervised release, DOC officials told us it sometimes takes time to locate paper copies of the offender’s prior DOC medical records and transport them to the offender’s new location. Likewise, a DOC nurse expressed the following concern:

We spend a lot of time handling [health services] charts and searching for charts due to the large volume of offenders who are seeking medical and psychological care on a daily basis because many of those offenders have appointments with so many different people: physical therapist, nurse, doctor, psychiatrist, HIV specialist, hepatitis specialist, medical records, dentist. There is only one chart and there is a core of inmates who are frequently seeing many different people for many different problems.

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**Electronic health records might help DOC manage offender care, but DOC has not yet obtained funding for such a system.**

State law requires each Minnesota health care provider—including the Department of Corrections—to have an “interoperable electronic health records system” in place by January 1, 2015.<sup>34</sup> The department began working toward electronic health records with the creation in 2009 of an Electronic Health Records Workgroup. The department entered into a contract in 2012 for various planning activities that were intended to lead to the selection of a vendor to implement an electronic health records system. However, the department’s request for funding for an electronic health records system was not included in the Governor’s biennial budget request, submitted to the Legislature in 2013. DOC recently issued a request for information to solicit descriptions of electronic health records systems developed elsewhere.<sup>35</sup> DOC hopes to obtain funding for the system from the 2014 Legislature.

We offer no recommendation on the department’s still-evolving plan for electronic health records. The department needs to make a convincing proposal to the executive and legislative branches for a system that would cost several million dollars to develop. However, implementation of electronic health records has the potential to help DOC better manage offender care. For example, electronic health records would enable DOC’s on-call providers to make decisions about emergency care with more complete information on a patient’s health history. Also, electronic health records might enable DOC to pursue greater use of telemedicine, which various reports have identified as a possible

<sup>34</sup> *Minnesota Statutes* 2013, 62J.495, subd. 1.

<sup>35</sup> *Minnesota State Register* 38, No. 18 (October 28, 2013), 565-566.

cost saving measure in correctional health care.<sup>36</sup> Telemedicine would enable doctors and psychiatrists to see certain patients without face-to-face meetings within prison walls. DOC officials told us that past efforts to try telemedicine proved time-intensive and cost-prohibitive, due to the need to fax or electronically scan offender records to practitioners prior to telemedicine visits.

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<sup>36</sup> For example, see: The Pew Charitable Trusts and McArthur Foundation, *Managing Prison Health Care Spending* (October 2013); Phil Schaenman, Elizabeth Davies, Reed Jordan, and Reena Chakraborty, *Opportunities for Cost Savings in Corrections Without Sacrificing Service Quality: Inmate Health Care* (Urban Institution, February 2013); and Chad Kinsella, *Corrections Health Care Costs* (Council of State Governments, January 2004).



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# List of Recommendations

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- The Department of Corrections (DOC) should:
  - Establish a fifth day of sick call per week at the Shakopee and Moose Lake prisons;
  - Adopt policies that limit the instances in which non-health care staff may transmit inmate requests to see health care staff; and
  - Adopt a policy that requires DOC facilities to maintain documentation of sick-call requests for at least 90 days. (p. 21)
- DOC's tracking log for off-site appointments should indicate when and why DOC has authorized exceptions to contractual requirements. (p. 26)
- DOC should centrally track the dates of psychiatric appointments and monitor their frequency. (p. 28)
- DOC policy should provide guidance to nursing staff regarding the protocols or resources that should be used when making care decisions. (p. 30)
- Over time, DOC should seek facility improvements that help to ensure patient privacy during encounters with health services staff. (p. 31)
- DOC should develop a system-wide policy for addressing the emergency needs of offenders 24 hours a day. (p. 34)
- DOC should:
  - Require documentation of offenders' chronic conditions in its main offender information system;
  - Require transferring facilities to notify receiving facilities when moving offenders with chronic conditions; and
  - Implement a comprehensive chronic care program across all facilities that is consistent with professional standards. (p. 40)
- DOC should:
  - Consider ways to maximize the therapeutic potential of its existing Mental Health Unit, which may require exploring other options for addressing mentally ill offenders with difficult behaviors; and
  - Work with the courts to help ensure that court hearings related to involuntary administration of medication occur in a timely manner. (p. 46)

- DOC should (1) monitor the extent to which segregation is used for offenders with mental illness and (2) consider ways to reduce the disproportionate use of segregation for such offenders, where appropriate. (p. 49)
- DOC should explore ways to improve access to mental health care for mentally ill offenders in segregation. (p. 51)
- The Legislature should amend state law to:
  - Require the Department of Human Services (DHS) to periodically determine the compliance of DOC’s Mental Health Unit with applicable DHS rules; and
  - Require the Department of Health to periodically determine whether the Oak Park Heights correctional facility’s Transitional Care Unit and the Faribault correctional facility’s Linden Unit comply with applicable Department of Health rules. (p. 57)
- DOC should ensure that (1) its facilities collect sufficient data on health services processes and outcomes and (2) staff prepare plans that outline ways to achieve improvements in performance. (p. 62)
- DOC should amend its policy and practice so that clinical mortality reviews are completed within 30 days of offender deaths. (p. 64)
- DOC should amend its policy to ensure that staff who were involved with the care of an individual who died are informed of key conclusions and recommendations of the mortality review. (p. 64)
- DOC should retain a list of all mortality review recommendations and systematically collect information that documents implementation of these recommendations. (p. 65)
- If the Legislature does not create a corrections ombudsman, it should consider whether the reports of the DOC health services Peer Review Committee should be classified in law as public documents. (p. 67)
- DOC should ensure that each of its correctional facilities provides inmates with information on the grievance process at the time they enter the facility. (p. 68)
- The Legislature should improve oversight of DOC health services by (1) requiring DOC to license its state-run correctional facilities, (2) requiring DOC to seek accreditation of entire facilities or those facilities’ health services activities, or (3) establishing a state ombudsman for corrections. (p. 74)
- The Legislature should clarify in *Minnesota Statutes* 243.212 DOC’s authority to adopt exemptions to the statute’s general copayment requirement of \$5 per visit. (p. 83)



- DOC should ensure that:
  - Copayment policies are well understood by facility staff and consistently applied; and
  - Orientation materials given to offenders at each facility contain a complete and accurate overview of DOC's copayment policy. (p. 86)
- DOC should periodically solicit information from the Minnesota Multistate Contracting Alliance for Pharmacy to determine the competitiveness of pharmacy prices paid by the department's contractor. (p. 90)
- DOC should develop and annually update a health services staffing plan.(p. 93)
- DOC should develop a health services strategic plan with goals and measurable objectives, and annually measure progress toward these goals and objectives. (p. 94)
- DOC should (1) amend health services policies as appropriate to conform more fully to professional standards and (2) ensure that each health services policy is reviewed annually. (p. 95)
- DOC should periodically collect information on the actual expenditures of its health services contractor, including the contractor's operating profits and various types of administrative expenses. (p. 100)
- DOC should improve recordkeeping for decisions related to off-site appointments, both to facilitate timely scheduling and ensure accountability for contract requirements. (p. 102)
- As part of licensing and inspection reviews, DOC should ensure that local correctional facilities are complying with state requirements for those facilities to transmit offenders' health records at the time of transfer to a new facility. (p. 103)





## Office of the Commissioner

1450 Energy Park Drive Suite 200 ▪ St. Paul MN, 55108  
PH 651-361-7200 ▪ Fax 651-642-0223 ▪ TTY 800-627-3529  
[www.doc.state.mn.us](http://www.doc.state.mn.us)

February 7, 2014

Mr. James R. Nobles, Legislative Auditor  
Office of the Legislative Auditor  
Room 140 Centennial Building  
658 Cedar Street  
St. Paul, MN 55155-1603

Dear Mr. Nobles:

Thank you for the opportunity to review and respond to the findings and recommendations made by your office after its recent evaluation of health services in state correctional facilities. The Department of Corrections (department) appreciates this external review and the resulting recommendations.

An important major finding confirms that offenders in the state correctional system have considerable access to health care. This finding is a confirmation that the health of offenders in the state system is a high priority of the department, particularly in light of the following facts noted in the report:

- Minnesota's prison mortality rate is the **lowest** of the 49 states reporting; 155 deaths per 100,000 over a ten-year period.
- Minnesota's prison population served is significantly less healthy than the general population.
- Minnesota spends considerable financial resources, 20% of facility expenditures are attributable to health care, including recidivism-reducing chemical dependency and sex offender treatment.

The department believes many of the recommendations will improve the delivery of offender health care and the department is committed to implementing them within the financial and physical plant constraints with which we are faced. The department is working hard at its commitment to a continuous improvement approach in all of the work that it does. The department is well into a process of establishing, documenting and implementing internal controls for all department operations, and the delivery of health care is among them.

The department agrees with your assessment that many of the concerns identified in your review would be addressed by seeking and maintaining accreditation by the

James R. Nobles  
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American Correctional Association (ACA). At your recommendation, the department will seek accreditation of all its facilities and operations including health care services. This is a substantial undertaking that requires significant financial and staff resources. The ACA has long been the standard-setting and accrediting body for prison operations including the delivery of health care. In 2011, the ACA began evaluating the compliance of health care against benchmarks that focus on performance-based standards which are based on outcome measures.

All of the department's activities are focused on our mission, which is "reduce recidivism by promoting offender change through proven strategies during safe and secure incarceration and effective community supervision."

Thank you again for the opportunity to respond and for your recommendations. The department values your evaluation and the improvements it will generate in our health care delivery system.

Sincerely,

/s/ Tom Roy

Tom Roy  
Commissioner

Enclosure

Department of Corrections  
Response to the Legislative Audit Report titled  
*Health Services in State Correctional Facilities*

**Report Recommendations**

**1. *The Department of Corrections should:***

- ***Establish a fifth day of sick call per week at the Shakopee and Moose Lake prisons;***
- ***Adopt policies that limit the instances in which non-health care staff may transmit inmate requests to health care staff; and***
- ***Adopt a policy that requires DOC facilities to maintain documentation of sick call requests for at least 90 days.***

**Partially agree with recommendations**

The department will amend its practice at the Minnesota Correctional Facility (MCF) -Shakopee and MCF- Moose Lake and establish a fifth day of formal sick call.

Persons Responsible – John Agrimson, Director of Nursing; Margaret Gemmell, Director of Nursing

Estimated Completion Date - 3/2014

With respect to the second bullet, we certainly understand the concerns raised by this report. However, the report also indicates that there is no evidence “that security staff have failed to pass along inmate requests to health services staff.”

The department will formalize a requirement that sick call lists be retained for a minimum of 90 days.

Persons Responsible – John Agrimson, Director of Nursing; Margaret Gemmell, Director of Nursing

Estimated Completion Date -3/2014

**2. *DOC’s tracking log for off-site appointments should indicate when and why DOC has authorized exceptions to contractual requirements.***

**Agree with recommendation**

The internal tracking log will be updated to include “when” and “why” the DOC has authorized exceptions to contractual requirements.

Person Responsible – Mike Hermerding, Program Manager

Estimated Completion Date -3/2014

**3. *DOC should centrally track the dates of psychiatric appointments and monitor their frequency.***

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**Response to the Legislative Audit Report titled**  
***Health Services in State Correctional Facilities***

**Agree with recommendation**

The department will utilize one of its existing systems and add dates of psychiatric appointments in order to monitor frequency. The department will also require monthly reporting by each facility.

Person Responsible – Steve Huot, Behavioral Health Director  
Estimated Completion Date – 5/2014

**4. *DOC policy should provide guidance to nursing staff regarding the protocols or resources that should be used when making care decisions.***

**Agree with recommendation**

The department does provide guidance to nursing staff through an online nursing resource center. This includes information for use when making care decisions.

The department has received nursing protocols from our new health care vendor. The protocols will be reviewed at the next Pharmacy and Therapeutics Committee meeting for adoption and implementation for inclusion in the nursing resource center. In the interim, nursing staff are directed to professional on-line clinical resources.

Person Responsible – Cheri Mayer, Associate Director of Nursing  
Estimated Completion Date –3/2014

**5. *Over time, DOC should seek facility improvements that help to ensure patient privacy during encounters with health services staff.***

**Agree with recommendation**

The department agrees and has a number of initiatives already in process, such as a bonding request for a new Health Services Unit at the MCF-St. Cloud.

Person Responsible – Nanette Larson, Director of Health Services  
Estimated Completion Date - Ongoing

**6. *DOC should develop a system-wide policy for addressing the emergency needs of offenders 24 hours a day.***

Department of Corrections  
Response to the Legislative Audit Report titled  
*Health Services in State Correctional Facilities*

**Agree with recommendation**

The department agrees and will develop one policy addressing emergency health care that is currently articulated in numerous policies. When nursing is not available, non-clinical staff has support through an on-call physician, nurse and mental health professional. Staff can call an ambulance, or transport an offender to an emergency room with or without the concurrence of the on-call physician.

The department will explore what role telemedicine can play in addressing medical emergencies.

Person Responsible - Margaret Gemmell, Director of Nursing  
Estimated Completion Date – 6/2014

**7. DOC should:**

- a. Require documentation of offenders' chronic conditions in its main offender information system;**
- b. Require transferring facilities to notify receiving facilities when moving offenders with chronic conditions; and**
- c. Implement a comprehensive chronic care program across all facilities that is consistent with professional standards.**

**Agree with recommendation**

Chronic care is provided at every facility. The new contract vendor uses a consistent comprehensive chronic care program that will be implemented across all facilities. A consistent system of tracking and notification upon offender transfer will be included.

Persons Responsible – John Agrimson, Director of Nursing; Margaret Gemmell, Director of Nursing  
Estimated Completion Date –7/2014

**8. DOC should:**

- Consider ways to maximize the therapeutic potential of its existing Mental Health Unit which may require exploring other options for addressing mentally ill offenders with difficult behaviors; and**
- Work with the courts to help ensure that court hearings related to involuntary administration of medication occur in a timely manner.**

**Agree with recommendation**

The department does consider ways to maximize the therapeutic potential of its existing Mental Health Unit (MHU). Due to changes in offender population over the years, the department has made many adjustments in the types of services

**Department of Corrections**  
**Response to the Legislative Audit Report titled**  
***Health Services in State Correctional Facilities***

and delivery to maximize therapeutic potential given the physical plant limitations in the MHU. The department will continually explore options to keep mentally ill offenders out of segregation.

Considerable time and effort is spent working with courts on mental health issues. Examples of these efforts include obtaining interim court orders while the judge is drafting the final order, making psychiatrists available for medication-specific questions, and trying to problem solve the issue of lack of court-appointed examiners. The department will review whether a legislative remedy should be pursued.

Persons Responsible – Steve Huot, Behavioral Health Director; Diane Medchill, Behavioral Health Associate Director; Nanette Larson, Director of Health Services

Estimated Completion Date - Ongoing

- 9. *DOC should: 1) monitor the extent to which segregation is used for offenders with mental illness; and 2) consider ways to reduce the disproportionate use of segregation for such offenders where appropriate.***

**Agree with recommendation**

The department does this. The department has taken numerous steps to ensure that offenders who are mentally ill are placed in appropriate living units. Currently, if behavioral health professionals determine an offender is not responsible for their behavior, segregation is not used. Also, mentally ill offenders can serve their segregation time in the MHU. Staff in many facilities have received Crisis Intervention Training which focuses on deescalating situations before the offender's behavior gets out of control and results in discipline, leading to segregation.

Person Responsible – Steve Huot, Behavioral Health Director

Estimated Completion Date - Ongoing

- 10. *DOC should explore ways to improve access to mental health care for mentally ill offenders in segregation.***

**Agree with recommendation**

The department does this. Offenders who are on the mental health caseload are regularly seen in segregation. Providing more programming or services to mentally ill offenders who are housed in segregation would require additional staffing and modifications to physical plant space.



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*Health Services in State Correctional Facilities***

Person Responsible – Steve Huot, Behavioral Health Director  
Estimated Completion Date – Pending additional funding

**11. *The Legislature should amend state law to:***

- ***Require the Department of Human Services (DHS) to periodically determine the compliance of DOC's Mental Health Unit with applicable Department of Human Services' rules; and***
- ***Require the Department of Health to periodically determine whether the Oak Park Heights correctional facility's Transitional Care Unit and the Faribault correctional facility's Linden Unit comply with applicable Department of Health rules.***

Any change in law would require careful consideration of the differences among department units and those regulated by the Department of Human Services and Department of Health. The Transitional Care Unit (TCU) is not a hospital and the Linden Unit is not a nursing home. The TCU and Linden Unit are living units dealing with specialized populations in correctional facilities. The above agencies would need to develop rules and standards separate from existing regulations to ensure compliance.

Our previously stated intent to seek external review through the ACA would provide independent external oversight.

**12. *DOC should ensure that 1) its facilities collect sufficient data on health services processes and outcomes and 2) staff prepares plans that outline ways to achieve improvements in performance.***

**Agree with recommendation**

The department agrees that expanding our data collection, particularly outcome data, would be of value to the system. The associate director of nursing position is primarily responsible for developing a comprehensive quality assurance plan for medical, dental and nursing. Significant progress on the plan has been made, which includes an active Continuous Quality Improvement committee.

Person Responsible – Cheri Mayer, Associate Director of Nursing  
Estimated Completion Date – 6/2014

**13. *DOC should amend its policy and practice so that clinical mortality reviews are completed within 30 days of offender deaths.***

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**Agree with recommendation**

In order to quickly address any system problems or failures, policy will be amended to require a preliminary review within 30 days, with the final reviews completed within 90 days to ensure information from autopsy and toxicology reports are included.

Person Responsible – David Paulson, M.D., Medical Director  
Estimated Completion Date - Immediate

***14. DOC should amend its policy to ensure that staff members who were involved with the care of an individual who died are informed of key conclusions and recommendations of the mortality review.***

**Disagree with recommendation**

Amending policy to permit the release of information developed during the review process would violate Minnesota Statute 145.64.

However, the department continues to share knowledge gained from mortality reviews with staff and to make procedure and policy changes as needed. These reviews also guide the development and delivery of training curricula while complying with the confidentiality requirements of Minnesota Statute 145.64.

In addition, any staff member who is determined to have violated policy is subject to appropriate corrective or disciplinary measures. Investigations of staff misconduct are not subject to the confidentiality provisions of Minnesota Statute 145.64.

***15. The DOC should retain a list of all mortality review recommendations and systematically collect information that documents implementation of these recommendations.***

**Agree with recommendation**

The department will consolidate the recommendations and strengthen internal controls regarding the documentation of improvements.

Person Responsible – Nanette Larson, Director of Health Services  
Estimated Completion Date – 4/2014

***16. DOC should ensure that each of its correctional facilities provide inmates with information on the grievance process at the time they enter the facility.***

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**Agree with recommendation**

Orientation materials are provided to all offenders through the Adult Facilities Offender Handbook upon intake. This handbook becomes the property of the offender and references policies specific to grievances.

Person Responsible – John King, Assistant Commissioner  
Estimated Completion Date – 3/2014

***17. The Legislature should improve oversight of DOC health services by 1) requiring DOC to license its state-run correctional facilities, 2) requiring DOC to seek accreditation of entire facilities or those facilities' health services activities, or 3) establishing a state ombudsman for corrections.***

Our already stated intent to seek external review through the ACA would provide independent external oversight.

***18. If the Legislature does not create a corrections ombudsman, it should consider whether the reports of the DOC health services Peer Review Committee should be classified in law as public documents.***

The department has great concern about this recommendation. It is well established in Minnesota law that information about and documentation of such review functions shall not be disclosed to anyone (except as necessary to carry out the purposes of the review body) nor is such information subject to subpoena or discovery. The purpose of such reviews is to candidly and thoroughly review situations to determine whether improvements can be made to the delivery of care. The current confidentiality law is designed to encourage such review bodies to maintain focus on public health without concern for exposing an entity to liability by its review. For these reasons, the department disagrees that such reports should be classified in law as public documents.

***19. The Legislature should clarify in Minnesota Statutes 243.212 DOC's authority to adopt exemptions to the statutes general copayment requirement of \$5.00 per visit.***

The department supports clarification of the statute and agrees with the report that best practice is to exempt mental health visits from the copayments.

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*Health Services in State Correctional Facilities*

**20. DOC should ensure that:**

- ***Copayment policies are well understood by facility staff and consistently applied; and***
- ***Orientation materials given to offenders at each facility contain a complete and accurate overview of DOC's copayment policy.***

**Agree with recommendation**

The copayment policy was recently revised for clarity and consistency and issued on 8/6/2013. Training will be provided for nursing and medical records staff.

Person Responsible – Cheri Mayer, Associate Director of Nursing  
Estimated Completion Date – 4/2014

Orientation materials will be reviewed at every facility to ensure complete and accurate information is provided.

Person Responsible – John King, Assistant Commissioner  
Estimated Completion Date – 3/2014

**21. DOC should periodically solicit information from the Minnesota Multistate Contracting Alliance for Pharmacy to determine the competitiveness of pharmacy prices paid by the department's contractor.**

**Agree with recommendation**

The department will work with its new health care vendor and Multistate Contracting Alliance for Pharmacy on a comparative analysis. The department has made a preliminary inquiry on a number of medications.

Person Responsible – Nanette Larson, Director of Health Services  
Estimated Completion Date – 7/2014

**22. DOC should develop and annually update a health services staffing plan.**

**Agree with recommendation**

A staffing plan will be developed and additional comparative data will be used to determine staffing levels across the system.

Persons Responsible – John Agrimson, Director of Nursing; Margaret Gemmill, Director of Nursing; Steve Huot, Behavioral Health Director  
Estimated Completion Date – 2/2015

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*Health Services in State Correctional Facilities*

***23. DOC should develop a health services strategic plan with goals and measureable objectives and annually measure progress towards these goals and objectives.***

**Agree with recommendation**

The Health Services Unit will work with department administration to develop a strategic plan that aligns with the department's strategic plan.

Person Responsible – Nanette Larson, Director of Health Services  
Estimated Completion Date – 10/2014

***24. DOC should 1) amend health services policies as appropriate to conform more fully to professional standards and 2) ensure that each health services policy is reviewed annually.***

**Agree with recommendation**

Health Services' policies will be reviewed annually. During that review, ACA standards will be reviewed to ensure department policies comply and reflect any recent changes in the ACA standards.

Person Responsible – Margaret Gemmell, Director of Nursing; Steve Huot, Behavioral Health Director  
Estimated Completion Date – Calendar year 2014

***25. DOC should periodically collect information on the actual expenditures of its health services contractor, including the contractor's operating profits and various types of administrative expenses.***

**Agree with recommendation**

The department's contract with its past and current health care vendors already permits a review of these expenditures.

***26. DOC should improve record keeping for decisions related to off-site appointments both to facilitate timely scheduling and ensure accountability for contract requirements.***

**Agree with recommendation**

The department will incorporate these elements into the off-site tracking log.

Person Responsible – Mike Hermerding, Program Manager  
Estimated Completion Date – 3/2014

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Response to the Legislative Audit Report titled  
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***27. As part of licensing and inspection reviews, DOC should ensure that local correctional facilities are complying with state requirements for those facilities to transmit offenders' health records at the time of transfer to a new facility.***

**Agree with recommendation**

As part of the inspection process, the department will provide notice to the local correctional facilities of this requirement.

Persons Responsible – Inspection and Enforcement; Ron Solheid, Deputy  
Commissioner

Estimated Completion Date – Ongoing

## **Forthcoming OLA Evaluations**

*Agricultural Commodity Councils*, 2014  
*Councils on Asian-Pacific Minnesotans, Black Minnesotans, Chicano/Latino People, and Indian Affairs*, 2014  
*DNR Forest Management*, 2014  
*Managed Care Organizations' Administrative Expenses*, 2014  
*MnDOT Selection of Pavement Surface for Road Rehabilitation*, 2014

## **Recent OLA Evaluations**

### Agriculture

*"Green Acres" and Agricultural Land Preservation Programs*, February 2008  
*Pesticide Regulation*, March 2006

### Criminal Justice

*Health Services in State Correctional Facilities*, February 2014  
*Law Enforcement's Use of State Databases*, February 2013  
*Public Defender System*, February 2010  
*MINNCOR Industries*, February 2009  
*Substance Abuse Treatment*, February 2006  
*Community Supervision of Sex Offenders*, January 2005

### Education, K-12, and Preschool

*Special Education*, February 2013  
*K-12 Online Learning*, September 2011  
*Alternative Education Programs*, February 2010  
*Q Comp: Quality Compensation for Teachers*, February 2009  
*Charter Schools*, June 2008

### Education, Postsecondary

*Preventive Maintenance for University of Minnesota Buildings*, June 2012  
*MnSCU System Office*, February 2010  
*MnSCU Occupational Programs*, March 2009  
*Compensation at the University of Minnesota*, February 2004

### Energy

*Renewable Energy Development Fund*, October 2010  
*Biofuel Policies and Programs*, April 2009  
*Energy Conservation Improvement Program*, January 2005

### Environment and Natural Resources

*Sustainable Forest Incentive Program*, November 2013  
*Conservation Easements*, February 2013  
*Environmental Review and Permitting*, March 2011  
*Natural Resource Land*, March 2010  
*Watershed Management*, January 2007

### Government Operations

*Helping Communities Recover from Natural Disasters*, March 2012  
*Fiscal Notes*, February 2012  
*Capitol Complex Security*, May 2009  
*County Veterans Service Offices*, January 2008  
*Pensions for Volunteer Firefighters*, January 2007  
*Postemployment Benefits for Public Employees*, January 2007

### Health

*Financial Management of Health Care Programs*, February 2008  
*Nursing Home Inspections*, February 2005

### Human Services

*Medical Assistance Payment Rates for Dental Services*, March 2013  
*State-Operated Human Services*, February 2013  
*Child Protection Screening*, February 2012  
*Civil Commitment of Sex Offenders*, March 2011  
*Medical Nonemergency Transportation*, February 2011  
*Personal Care Assistance*, January 2009

### Housing and Local Government

*Consolidation of Local Governments*, April 2012

### Jobs, Training, and Labor

*State Employee Union Fair Share Fee Calculations*, July 2013  
*Workforce Programs*, February 2010  
*E-Verify*, June 2009  
*Oversight of Workers' Compensation*, February 2009  
*JOBZ Program*, February 2008  
*Misclassification of Employees as Independent Contractors*, November 2007  
*Prevailing Wages*, February 2007

### Miscellaneous

*The Legacy Amendment*, November 2011  
*Public Libraries*, March 2010  
*Economic Impact of Immigrants*, May 2006  
*Liquor Regulation*, March 2006  
*Gambling Regulation and Oversight*, January 2005  
*Minnesota State Lottery*, February 2004

### Transportation

*MnDOT Noise Barriers*, October 2013  
*Governance of Transit in the Twin Cities Region*, January 2011  
*State Highways and Bridges*, February 2008