

# **The Michigan Prisoner Health Care Improvement Project**

## **STRATEGIC PLAN**

*A Collaborative Venture of the  
Michigan Department of Corrections  
and the  
Michigan Public Health Institute*

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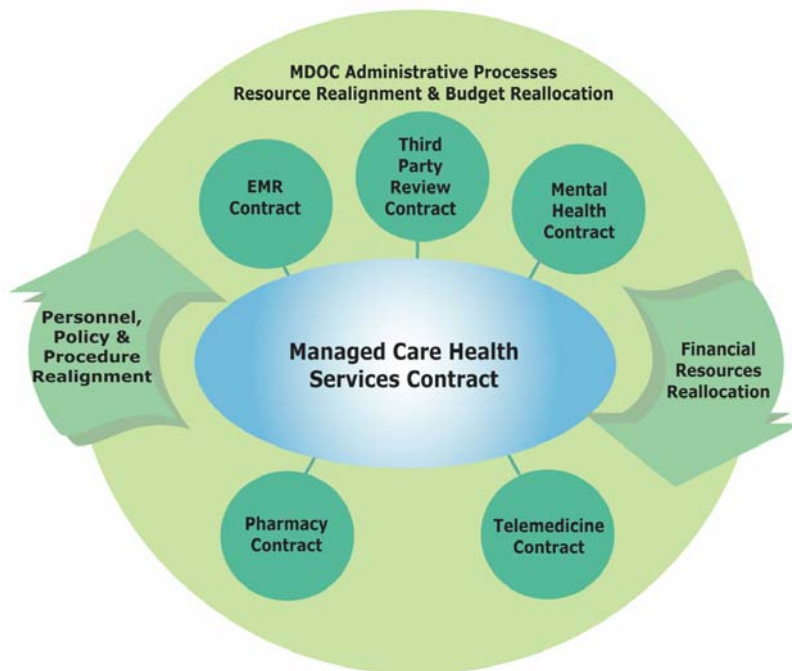
## *The MDOC Strategic Plan: A Blueprint for Transforming Prisoner Health Care*

The efforts of the department's Health Care Improvement Team (HCIT) over the preceding months have marked a successful partnership between the Michigan Department of Corrections (MDOC) and Michigan Public Health Institute (MPHI) with the assistance of consultants from Community Health Ventures (CHV) and RBJ Enterprises (RBJ) whose expertise has helped to fill the gaps in core competencies and health care knowledge. In addition, the HCIT process has included other state government agencies working in a unique collaborative manner to expedite the challenging contract procedures necessary to the redesign of critical health service contracts. These government agencies, at the direction of the Governor, have been at the table throughout the process and include: the Department of Management and Budget (DMB), the Department of Community Health (MDCH), and the Department of Information Technology (DIT). This collaborative process has been made possible by the generous support of the JEHT Foundation.

The MDOC strategic plan consists of three integral parts:

1. The redesign of the engine of health care, the Managed Care health services contract;
2. The redesign of the ancillary health services in support of the core Managed Care contract; and
3. Based on these redesigns, the complete restructuring of the MDOC's administrative resources responsible for the management of the new contracts and its new and improved health care system.

The following diagram illustrates the concept of the strategic plan that integrates the contract redesigns and the administrative changes to personnel resources and budget reallocations.



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## ***THE REDESIGN OF THE MDOC HEALTH CARE SYSTEM***

### **1. Strategic Objective # 1: Redesign of the Managed Care Contract**

The Managed Care contract is a redesign of the core contract that drives the operations of all the ancillary health service contracts. It is redesigned from a cost-plus, fee-for-service contract to become a true Managed Care contract that is risk-based with a capitated payment structure. Costs of specialty care and inpatient hospitalization rose 26% in Fiscal Year 2006 and are projected to rise 30% in Fiscal Year 2007 under the current contract for those services. Cost increases to health services have been the main reason for supplemental appropriations by the legislature during the past two budget years. Efforts to reduce departmental costs have been overwhelmed by cost increases related to health services through the existing contract. The new contract is markedly different from the current one. Key changes include:

- Requiring MDOC health service contractors be licensed Managed Care plans with a Certificate of Authority to operate in Michigan. Correctional health services contractors do not typically operate as licensed Managed Care plans and are not required to meet the same level of performance standards.
- Changing from one statewide contract to several regional contracts, similar to the state's Medicaid contracts. HMOs will be able to bid on one or more regions, but each must be operated as a separate entity.
- An independent third-party review contract to assess the cost and health quality between the seven health contract regions.
- Holding providers "at-risk" or accountable for costs and quality, including a penalty for failure to meet rigorous performance criteria.
- Requiring the use of telemedicine, which will expand the pool of specialists, reduce the cost of consults, improve the timeliness and quality of specialty care and reduce transportation costs.

**All other health service operations depend on the successful redesign of the Managed Care contract.**

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## ***THE REDESIGN OF THE MDOC HEALTH CARE SYSTEM***

### **2. Strategic Objective #2: Redesign of the Ancillary Health Services Contracts**

Our initial work has identified several critical health service contracts that require development, redesign or upgrading to accommodate the operations of the changes envisioned for the core Managed Care contract. This group is referred to collectively as the Ancillary Health Services Contracts and consists of:

1. The Electronic Medical Records contract (EMR): The current EMR has been sharply criticized in the preliminary reports from NCCHC and others as being unwieldy. The HCIT is in the process of developing an RFP that will upgrade the current EMR to a fully integrated system that includes an electronic medical record, a practice management application and a claims reporting application.

The new EMR will also incorporate the pharmaceutical software for acquisition of drugs, a mental health medical record, and dental health record. All components will provide reports to MDOC to enable the managers to monitor compliance with the “Service Level Agreements” of the Managed Care contract. These agreements include performance standards based on Health Care Effectiveness Data and Information Set (HEDIS) requirements and those of the NCCHC.

2. The Pharmacy Contract: In the past, the Pharmacy contract was bid as a separate contract to the current health services contract (Managed Care) held by Corrections Medical Services (CMS). The contract was awarded, however, to PharmaCorr, a subsidiary of CMS. Under this arrangement, the management of pharmacy utilization has been complicated by the less-than-independent relationship between the two vendors.

The redesign of the Managed Care contract requires another stand-alone contract for the purchase of drugs by the new Managed Care contractors who are responsible for the utilization of these products within the capitated payment structure of their contracts. It is anticipated that the new stand-alone contractor will not be a subsidiary of any of the Managed Care contractors. Claims data from the pharmacy vendor will be provided to both the Managed Care contractors and the MDOC, to improve contract management and enhance the annual negotiations for the capitated payment limit to providers.

3. The Telemedicine Contract: The inadequate use of telemedicine in the current prison health system has been identified as a significant contributor to the problem of specialty care delays. The ability of health service contractors to get specialty care diagnosis for prisoners inside the prison facilities frequently means that this care must be provided on an outpatient basis. This frequently results in scheduling delays and compromises the health of the ill prisoners, which leads to more sick prisoners in need of hospitalization and additional stress to the system in the form of increased demand for sub-acute care beds.

Upgrading the existing telemedicine system through the state's existing telemedicine contract is critical to the overall improvement of health quality and the improved use of scarce resources. Improved health care will, in turn, enable health services contractors to meet the health quality performance standards prescribed in their contracts.

4. The Mental Health Contract: The redesign of the mental health services contract is unique from the other ancillary health services contracts. Until very recently, Michigan law required that MDOC only contract with the MDCH for mental health services. Under this statutory provision, the MDOC contracted with DCH for mental health services, while retaining responsibility for psychiatric program operations. The result was a much-criticized bifurcated delivery system with vague systemic reporting requirements. As a result, operations for the delivery of critical mental health services to prisoners have been on an *ad hoc* basis. With the recent change in law, MDOC will explore in partnership with MDCH more effective arrangements for the delivery of mental health services to prisoners. The MDOC estimates that 16% of all prisoners in its system are diagnosed with mental health problems.

Apart from the contracts related to the operations of the core Managed Care contract, there are two additional on-going areas of work in which the MDOC and its partners are engaged. Both are integral to achieving stated objectives of the Governor to improve the quality of health care in the MDOC. These areas are:

5. Third Party Review Contract: In the process of redesigning the Managed Care contract, the MDOC determined that a separate, independent third-party review would greatly enhance its ability to manage the contracts for health quality performance. The MDOC currently lacks the core competencies to properly evaluate the performance of its health service providers. A contract with an independent third-party will remedy that weakness in the system, as well as provide credibility in reports to all stakeholders. This contract is viewed to be critical to the mission of providing accountability to the total redesign of health services.

In work group discussions it has been recommended that the best course of action to meet this strategic objective is to assess the potential of entering into a contract with an existing third-party reviewer through the MDCH where the state's Medicaid contracts are managed. Known as a "piggy-back" arrangement, the MDOC can contract with the third-party review vendor through an addendum to the MDCH contract. These arrangements are allowed by the rules of the DMB and can expedite the contract process by eliminating the normal bid process.

6. The Community Placement of the Medically Fragile: This initiative is a stated goal of the Governor in response to her concerns for the humane treatment of prisoners with serious health conditions. There is a complex history surrounding the problems of medically fragile prisoners in Michigan, in large part due to: 1) the long-standing Federal Consent Decree that precludes the transfer of prisoners to facilities outside of the Court's jurisdiction; 2) the limited number of paroles granted due to concerns about the care of these prisoners once they are released; and, 3) the lack of community partnerships that might provide the medical attention needed by this group once they have been paroled.

In this context, the Governor charged the MDOC with the task of developing community partnerships that would increase the number of paroles to the medically fragile population, while satisfying the concerns of the Parole Board. A pilot program was developed in conjunction with the Muskegon, Michigan MPRI health contract. The pilot program was developed by MDOC with community partners to test the processes that might later be incorporated into a statewide community placement RFP. The program is envisioned to work in a manner similar to that of the MPRI mental health initiative, wherein the MDOC provides additional funding to support the transitional needs of the parolee, in partnership with community mental health providers.

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## ***REDESIGN OF THE MDOC HEALTH CARE ADMINISTRATION***

### **Strategic Objective #3: Redesigning a New Administrative Structure in the MDOC to Improve Health Care Contract Management**

The systemic redesign and integration of the health services contract define the business processes vendors must follow in order to be in compliance with the expectations of the MDOC. The management of these multiple contracts is the administrative responsibility of the MDOC.

The next step in the process is the retooling of the administrative resources. This effort will require the development of appropriate management policies and procedures and training of administrative personnel within the MDOC Bureau of Health Care Services who are responsible for the management of all health service contracts and the supervision of the state's health service employees within the MDOC. The MDOC will work in collaboration with MPHI, CHV and RBJ to create the framework for improving management tools and capabilities. The framework for doing this includes the following activities:

1. *Implementation of the NCCHC review recommendations*, to be integrated into all new contracts and administrative operations. The contract for an independent review of the prison health system was directed by the Governor and subsequently put out to bid by the state. The contract was awarded to the National Commission on Correctional Health Care (NCCHC) and is scheduled for completion by November 2007. It is the stated intention of the MDOC to incorporate the recommendations of the NCCHC into the new contract for Managed Care.

The expertise required by the MDOC to complete this objective involves an analysis of the recommendations and guidance through the negotiations with prospective vendors to incorporate the NCCHC recommendations into the deliverables of the contract. Generally, it is anticipated that this will involve the design of administrative procedures to collect data through the EMR and the third-party review processes that will serve to generate performance based reports in addition to those reports generated through the Service Level Agreements of the Managed Care contracts.

2. *MDOC restructuring* will be necessary once the RFPs become the new reality. The MDOC will need an executive structure significantly different than the one currently used and help designing a management system to interface with licensed HMOs. Areas such as quality management, multiple contract oversight, HMO conflict resolution, and external reporting will be some of the new tasks facing MDOC leadership.

**MDOC will need help with designing a management system that will interface well with licensed HMOs – an entity it has not worked with before, in a multi-contract, and therefore, competitive environment that it has not had to work previously.**

3. *Development of a Continuous Quality Improvement program* with a training component for front-line managers. The Continuous Quality Improvement (CQI) program was requested by the Medical Officers of the MDOC in recognition of the need for systemic quality monitoring and improvement of the MDOC health services personnel. There is currently no CQI program in place. The objective of the CQI initiative is two-fold: to improve health quality and reduce the risk exposure resulting from deficiencies in the health service operations.

The CQI program is being designed to extend from the senior management team to the front line staff, system wide. The completion of this project is expected to take three years. The startup of this initiative will engage MPHI during the process of systems evaluation and general program design. It is expected that the MDOC Medical Officers and Regional Health Administrators will be able to continue the development of the program once the initial construct is completed.

4. *Development of a dynamic health system demographic and clinical profile* that includes clinical, financial, and utilization data to provide quarterly snapshots of the health system performance, and to assist in the development of data-driven budget requests to the legislature. The new Managed Care contract is divided into eight regions, with potentially different providers in each region. The capitated payment structure is adjusted for acuity in each of the eight regions.

The MDOC intends to contract for actuary services annually to assist in the negotiations to reset the capitated payment rate annually. This will provide the MDOC a financial picture on a regional basis and by each facility within the regions. To complete the profile for health services, the MDOC will need a clinical, demographic, financial and utilization profile that complements the financial data. The demographic and clinical profile will improve the level of data-driven decision making in the process of resource allocation and budget negotiations with the legislature.

5. *An Evaluation of the Reception and Guidance Center* as the gateway to the prison system and entry point into the health services system for both medical and mental health needs. The Reception and Guidance Center (RGC) is the entry point for approximately 1,000 prisoners per month from all counties throughout the state. The arriving prisoners are processed through 4-5 sections at RGC. These sections include custody; health care; psychology for prisoners with known mental health problems; and, vocational assessment and classification. This processing is designed to identify, assess and classify custodial levels and placement location.

MDOC has asked for analysis of the productivity of the intake process and recommendations as to how it can shorten the average time from arrival to medical clearance for transfer to the prisoner's destination facility. This analysis is intended to review the timeframes, impact and planning capabilities at RGC in order to focus on: Improved workflow efficiency of the department; Improved quality of care by ensuring the initial health care assessment appropriately establishes the prisoner medical health care needs; and Improved diagnostics process for the mental health needs of prisoners



6. *An evaluation and recommendations on the need for sub-acute care beds* throughout the system, based on the need to reduce the number of inpatient days at hospital facilities. A lack of sub-acute care beds within the system has contributed in large part to the dramatic increases in the number of inpatient days. Inpatient days have increased 30% from Fiscal Year 2004 to Fiscal Year 2006. The HCIT identified this as a priority objective in order to improve the quality of health care and reduce costs.

The process in place will evaluate the data related to “opportunity days,” the number of days a prisoner remains in a hospital setting for care due to the lack of sub-acute care beds within the system. The evaluation will address the problem by facility and make a recommendation as to the appropriate number of sub-acute care beds a facility should have. The evaluation will also take into account the staffing needs required to support the additional number of sub-acute care beds.

7. *Development and management of an integrated reporting system* at all levels of the system based on: the new EMR medical data; the Managed Care contract service level agreements for health quality outcomes, performance measurements and timeliness of service; and financial reporting based on annual actuarial audits. The result of the redesigned Managed Care contract and several of the ancillary contracts will be the addition of multiple new reports. In addition, there will likely be many old reports that continue to be generated even though there is no longer a defined need for the data.

The resources required to manage the old reports can be better utilized elsewhere. The retooling of administrative resources includes the systemic review of all the reports, new and old, to determine which reports are necessary, which can be discontinued, who best to generate the reports, who needs to review the reports, and how the reports impact the decision-making processes for budget and personnel.

8. *An evaluation and recommendation on the role of the D. L. Waters Health Center* in the context of the likely closure of the Southern Michigan Correctional Facility through the Consent Decree and the need for increases in sub-acute beds throughout the system. Currently the MDOC has one hospital within its system, D. L. Waters Health Center (DWH). This is primarily used as an acute care facility for those prisoners with serious health conditions. There are several issues that need to be evaluated in the context of determining the appropriate role for DWH. These include the potential impact on DWH in the event the Court decides to end the Hadix Consent Decree; the capacity of local providers to support the current demand for acute care at DWH; the needs identified from the sub-acute care evaluation for more beds; and, the impact of an accelerated effort through MPRI to parole the most medically fragile prisoners, many of whom are at DWH.

9. *Recommendations to MDOC on the organization and team building* activities that could enhance the executive level health care services management team. The current management organization has been greatly improved by the removal of silo barriers through the department reorganization that placed the Bureau of Health Care Services within the Correctional Facilities Administration. This opened the opportunity to further strengthen the “team” approach to the development of policy, budget development, and collaborative management. The intent of this task will be to recommend a management

process that can build and sustain the team approach to management of the Bureau of Health Care Services.

10. *Assistance in the development of an appropriate staffing model for nurses and medical support personnel at each facility.* The current national shortage of nurses has had a direct impact on the ability of the MDOC to provide the required support to contract providers in the delivery of health services. This impact varies by facilities for several reasons, including those pertaining to Civil Service requirements, as MDOC nurses are Civil Service employees. The HCIT recommendation for an assessment of the nurse staffing model will focus on ways to maximize the nurse capacity in the context of a national shortage.
11. *Development of a contract compliance department within MDOC* specifically designed to manage the multiple complex health services contracts. As the MDOC changes from one statewide contract responsible for numerous services to a system utilizing multiple contracts, the need for additional personnel to manage these contracts arises. Management of these contracts also intensifies as the contracts themselves are based on performance measurements and compliance. Current staffing levels and expertise in the area of health services contract management is less than will be required with the implementation of all the new contracts. The HCIT recommendation for an increase to the compliance management operations will address this need.
12. *Development of communications processes* that provide opportunities to have meaningful dialogue with prisoners, prisoners' families, and advocacy groups on behalf of prisoners. Virtually all stakeholders have suggested that there needs to be an improvement in the communications between the MDOC and prisoners and their families. In media reports, the recommendation is to recreate an Ombudsman position. Some in the legislature have support this approach as well. Others have suggested regularly-scheduled forums or focus groups with prisoners. The common ground in all of these suggestions is to improve the communications.