Program Evaluation

Prepared for the Budgetary Responsibility Oversight Committee

Inmate Health Care
Georgia Department of Corrections

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Background

Purpose of Inmate Health Care

Inmates[1] in the custody of state, federal, or local correctional systems are entitled to a constitutionally required level of health care. In Georgia, providing inmate health care is the responsibility of the Office of Health Services (OHS) within the Georgia Department of Corrections (GDC). OHS's purpose is to ensure adequate health care is provided to the more than 54,000 inmates in Georgia's state correctional system in the most efficient, cost-effective, and humane manner possible, while protecting the public health and safety interests of the rest of the state's citizens. Providing inmates with adequate health care also protects the welfare of local communities that receive released inmates. Inmates in the custody of GDC are provided physical, mental, and dental health services.

Health Care Rights and Standards

Inmates' Right to Health Care

Generally, courts have held that inmates have a right to reasonable health care designed to meet their routine and emergency medical needs, including diagnosis, preventive care, treatment, and rehabilitation. Courts have cited the Eighth Amendment of the United States Constitution, which protects a person against cruel and unusual punishment, as the basis for an inmate's health care right. Most notably, in *Estelle v. Gamble* (1976), the U.S. Supreme Court found that an inmate has a right to be free of "deliberate indifference to their serious health care needs" and that an indifference is a violation of the Eighth Amendment.

Historically, inmates have filed large numbers of claims against correctional health care systems. In addition, other

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[1] The term "inmate" used in this report denotes any incarcerated person for whom GDC is responsible. The terms "probationer" or "detainee" may be used in cases where they alone are affected.

organizations such as the U.S. Department of Justice and the American Civil Liberties Union make legal challenges influencing state correctional health care programs. Through court rulings, three basic rights have emerged:

- Inmates have the right to access health care services;
- Inmates have the right to a professional medical judgment; and,
- Inmates have the right to care that is ordered by a health care professional.

In addition, court rulings have resulted in modifications to prison health care delivery systems. For example, following the 1984 U.S. District Court case *Cason v. Seckinger*, psychiatric hours and educational requirements for mental health counselors in Georgia prisons were mandated.

Standards of Health Care

While inmates are not guaranteed the right to the best health care available, an accepted policy in correctional health care programs is to provide inmates with a community standard of care. Essentially, this is the level of health care recognized and accepted by the medical community. This level of care is based on published recommendations by expert panels or organizations, such as the Centers for Disease Control and Prevention, the American Heart Association, or the American Diabetes Association. Also, community standard of care may be defined as the level of health care provided by Medicaid.

Correctional health care programs also may use standards developed by organizations such as the National Commission on Correctional Health Care (NCCHC) and the American Correctional Association (ACA). These two organizations have established guidelines on operating health care programs within a correctional setting.

GDC has defined its standard of care through Standard Operating Procedures, which are based on a combination of community standards and guidelines issued by NCCHC, ACA, and

professional medical organizations.

Health Characteristics of Inmates

Inmates are proportionately sicker than the general population and are more likely to suffer from serious chronic and communicable diseases. For example, inmates represent nearly one in five of all HIV infections in the United States and suffer in high numbers from sexually transmitted diseases and drug and alcohol addiction. It is estimated that more than 80% of inmates had a substance abuse addiction prior to their offense. In addition, as more inmates serve longer sentences, the population is aging. The over-50 inmate population faces geriatric-related ailments and diseases. As a result, they are 20 times more likely to be assigned a special-needs bed than a younger inmate. See **Exhibit 1** for additional information on the prevalence of several medical conditions.

Exhibit 1
Prevalence of Infectious, Chronic, and Mental Disorders in Inmate Populations

Category	Condition	Prevalence Compared to U.S. Population
Infectious Disease	Active Tuberculosis	4 times greater
	Hepatitis C	9-10 times greater
	AIDS	5 times greater
	HIV Infection	8-9 times greater
Chronic Diseases	Asthma	Higher
	Diabetes/Hypertension	Lower
Mental Illness	Schizophrenia or Other Psychotic Disorders	3-5 times greater
	Bipolar Disorder	1.5-3 times greater
	Major Depression	Roughly equivalent

Source: National Commission on Correctional Health Care Report, "The Health Status of Soon-to-be-Released Inmates." May 2003.

Inmate Health Care in Georgia

Georgia has one of the largest state inmate populations in the United States. Its approximately 54,000 inmates are housed in 117 facilities across the state, as depicted in **Exhibits 2 and 4** on pages 5 and 8 respectively. GDC operates 90 facilities and contracts to house approximately 9,500 of the state's inmates in 24 county correctional institutions and three private prisons. As of June 30, 2004, 82.3% of Georgia's state inmates were housed in a GDC-operated facility, 9.3% were housed in a county correctional

institution (CCI), and 8.4% were housed in a private prison.

Inmates in Georgia
June 30, 2004

Facility Type	# of Facilities	# of State Inmates
GDC Facilities	90	44,471
County Correctional Institutions	24	5,054
Private Prisons	3	4,517
Totals	117	54,042

Source: GDC records

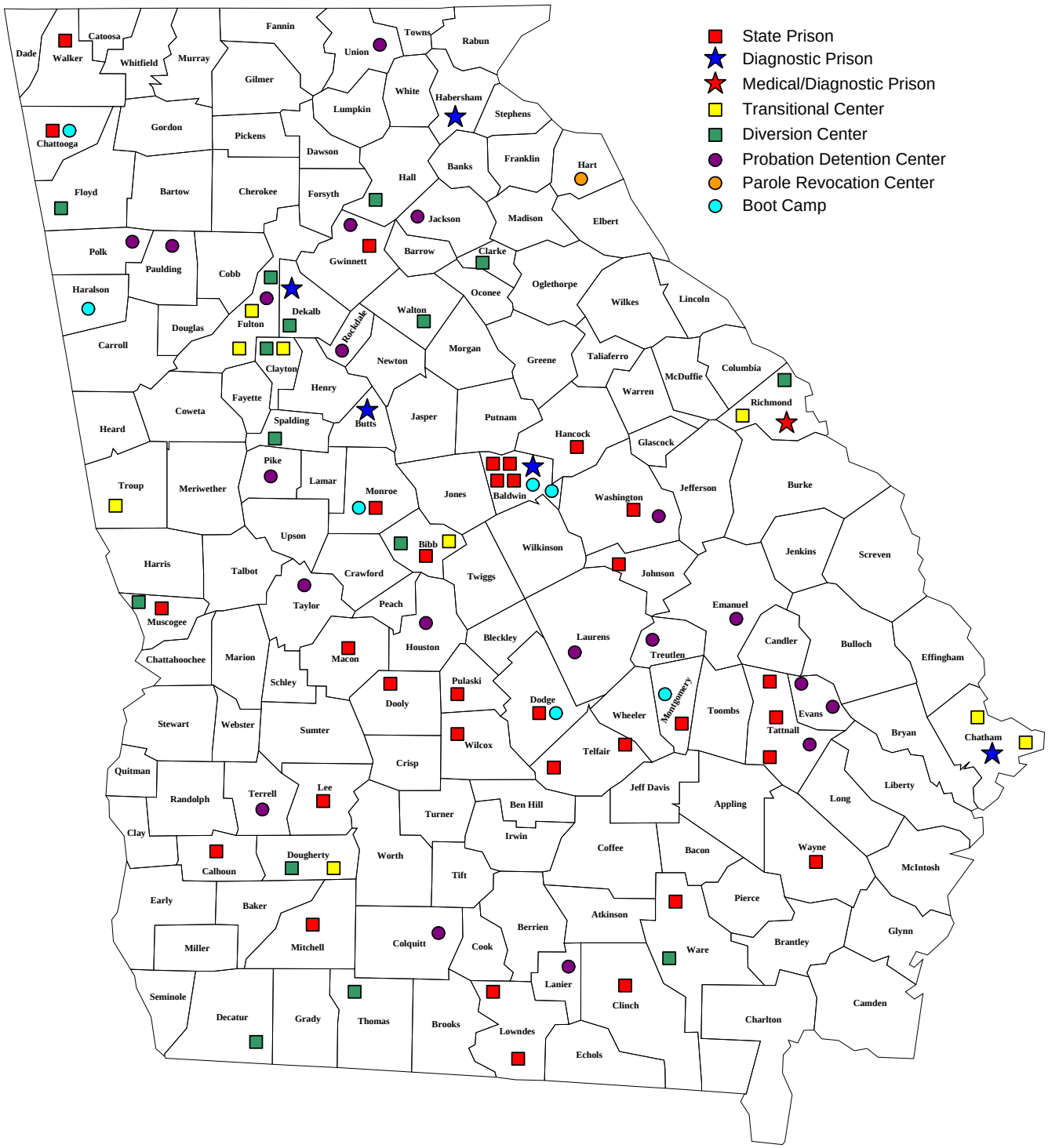
Inmates are provided physical, mental, and dental health services primarily through on-site clinics at their facilities. Inmates are housed in facilities that meet the inmates' security requirements, as well as their physical and mental health care needs. If inmates require services not available at their facilities, such as 24-hour nursing, they can be transferred to other state correctional facilities that have those services or be seen by a private health care provider. Access to emergency services is provided to all inmates.

Upon entrance into the GDC correctional system, an inmate is housed in one of GDC's six diagnostic state prisons. Personnel administer a battery of tests to diagnose medical problems, establish treatment needs, and determine an inmate's physical capabilities. These assessments are a consideration in determining the inmate's assignment to a GDC facility, private prison, or county correctional institution.

Health Care in GDC Facilities

As shown in **Appendix A** on page 81, most of GDC's physical, mental, and dental health care capabilities are located in the 38 state prisons. Augusta State Medical Prison provides a broad range of hospital-level care services for inmates, including medical specialists and surgery. The health care services provided in the other 52 GDC-operated facilities vary based on the purposes and functions of the facilities. Inmates in GDC diversion centers, which do not have on-site health care staff, are typically responsible for obtaining their own health care services in the community.

Exhibit 2
Georgia Department of Corrections Facility Locations



Source: GDC Records

Physical Health Care – Most inmates' primary physical health care needs are addressed through clinics conducted at all state prisons, as well as other GDC-operated facilities. For inmates requesting care, sick call clinics are conducted each weekday. Inmates with chronic care issues, such as diabetes, are seen in specialty clinics scheduled periodically. For some services, inmates are charged a co-pay of $5. Primary care clinics are staffed by licensed nurses, clinical practitioners, and/or physicians. Some facilities have x-ray and vision services in the prison site clinic.

In addition to the clinics, 12 state prisons have infirmaries that provide 24-hour nursing care. These infirmaries house inmates with various medical needs, including short-term treatment for an illness or injury, observation or continued treatment after returning from a stay in the hospital, or long-term care.

Treatment provided by specialists generally occurs outside of an inmate's facility. For most male inmates, these services occur at Augusta State Medical Prison (ASMP). Services at ASMP include acute inpatient and outpatient care, surgeries, and diagnostic procedures. In addition, specialty services are delivered through telemedicine, at clinics held in certain state prisons, and by contracted local providers. Specialty care provided to female inmates generally occurs in the state prisons, while more advanced care is provided at a private health care facility, the Atlanta Medical Center. If inmates require hospital-level care not available within a GDC facility, community hospitals are utilized.

Appointments with specialists and hospitalizations must be approved by GDC's Utilization Management program. The inmate's facility physician submits a request to Utilization Management, whose clinical personnel determine if the requested care is necessary and appropriate. Emergency hospitalizations are reviewed after care is delivered.

Mental Health Care – Inmates with mental health care needs are housed primarily in GDC state prisons (see **Appendix A)**. Inmates' mental health care needs may be identified through initial intake diagnostic assessment, self-reporting of mental problems by

Health Care Definitions

Primary Care – Provided by clinicians who are accountable for a broad range of personal health care needs.

Secondary Care – Provided by specialists to whom patients are referred by primary care providers.

Tertiary Care – Given in a health care center that includes highly trained specialists and often advanced technology.

Chronic Care – Provided over an extended period of time, usually for a persistent condition such as asthma.

Long-Term Care – Provided over a long period of time, such as rehabilitation or care for disabilities.

Acute Care – Provided during the very initial stages following an injury. Treatment may include surgery or intensive care. The focus is on stabilizing the patient.

Skilled Nursing Care – Given or supervised by a Registered Nurse. Examples include intravenous injections, tube feeding, and changing sterile dressings on a wound.

inmates, or referral to mental health care staff by prison personnel. All inmates are assigned a mental health classification based on initial mental health assessments and/or subsequent consultations with mental health care personnel. An inmate's mental health classification determines the type of unit in which the inmate may be housed. **Exhibit 3** describes each level of GDC's mental health classification along with the mental health care provided and the housing status of inmates at each level.

Exhibit 3
GDC Mental Health Classifications

Classification Levels	Description and Care Provided	Housing
Level I	• No mental health care needed	General Population – GDC facilities, private prisons, or county correctional institutions
Level II	• May show mild impairment in mental function • May need monitoring due to discontinuation of psychotropic medication or recent history of self-injury • Treatment usually provided on an outpatient basis to include various forms of counseling, therapy, and psychotropic medications	May live in General Population – GDC facilities or private prisons
Level III	• Shows moderate impairment of mental functioning such as impulsive behavior, delusional thinking, or a deterioration of emotional controls • At risk if left in the general population • Structured treatment program includes counseling, therapy, and psychotropic medication	Supportive Living Unit (SLU) – GDC facilities
Level IV	• Shows severe impairment of mental functioning • Has no activity in the general population • Limited ability to attend treatment and recreational groups • Ancillary services such as special education and psychotropic medications are provided in the residential living units. • May require an escort when moving through a facility	Supportive Living Unit (SLU) – GDC facilities
Level V	• Shows severe impairment of mental functioning that may include the need for more intensive psychopharmacological interventions • Infirmary-level care is needed	Crisis Stabilization Unit (CSU) – GDC facilities
Level VI	• Has severely debilitating symptoms that cannot be safely and adequately treated in a CSU or other unit	Hospital Services, such as Central State Hospital

Source: GDC Standard Operating Procedures

Mental health care is provided by mental health counselors, mental health nurses, psychologists, and psychiatrists staffed at facilities throughout the GDC system. In addition to counseling, psychiatrists may write prescriptions for inmates in need of psychotropic medication.

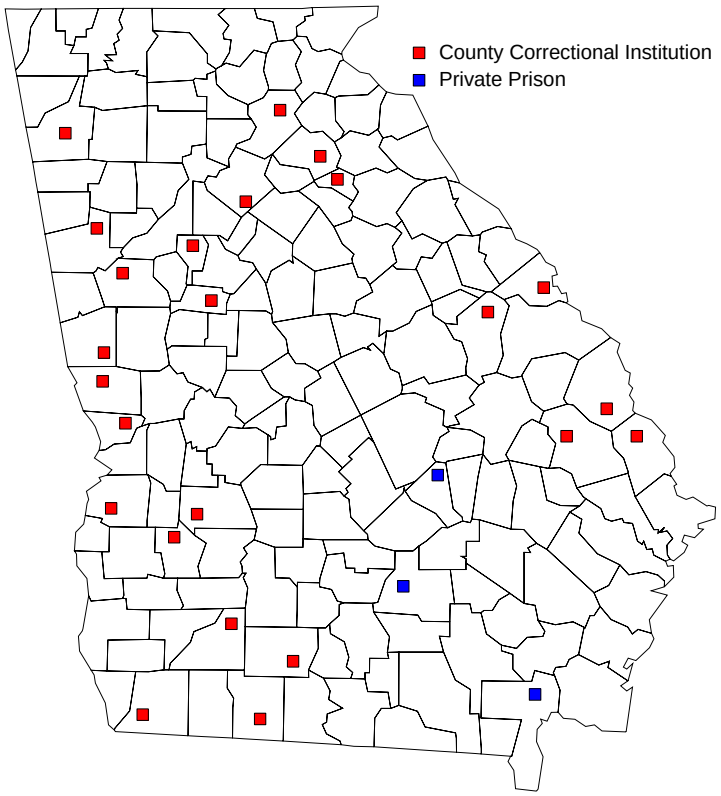
Dental Health Care – Although routine dental examinations are not performed, inmates may request dental services through physical health care sick-call procedures. In general, routine services such as extractions and fillings are provided. Crowns, bridges, dentures, root canals, orthodontics, and implants are provided only on an exception basis and as authorized by the Statewide Dental Supervisor. Services are provided by dentists, dental assistants, and dental hygienists staffed at GDC facilities.

Pharmacy Services – Prescriptions for physical, mental, or dental health care needs are processed through a network of 15 regional pharmacies located on state prison grounds. These pharmacies dispense and package prescriptions for distribution to GDC facilities.

Health Care in Private Prisons and County Correctional Institutions

The standards of care for inmates housed in private prisons and county correctional institutions are the same as those for inmates in GDC-operated facilities. The private prison operators and counties are responsible for the health care provided to state inmates housed in their facilities. Inmates whose medical care needs significantly increase may be transferred to a GDC-operated facility.

Exhibit 4
Private Prisons and County Correctional Institutions



Source: GDC Records

Private Prisons – The primary health care provided in the three private prisons is similar to that offered in many of the GDC-operated state prisons. Two of the private prisons also operate infirmaries. In addition, inmates have access to specialist care, outside hospitalizations, emergency

care, and dental care. The private prisons house inmates requiring up to Level II mental health services.

Cost-Sharing with Private Prisons

Total Cost	GDC Share
$0 to $24,999	0%
$25,000 to $49,999	50%
$50,000 to $99,999	75%
$100,000 or More	100%

Source: GDC records

The per diem paid to the private prison operators by GDC is intended to cover all costs, including health care. However, GDC shares additional responsibility in cases of high-cost hospitalizations. For each hospitalization in which the private prison operator's cost is $25,000 or more, GDC pays a portion of the cost on a sliding scale.

County Correctional Institutions – All county correctional institutions (CCIs) are required to maintain space, equipment, and medical supplies to meet the basic medical needs of inmates. The institutions are also required to provide a physician on at least a part-time basis. According to GDC personnel, most CCIs have full-time nurses and provide on-site physicians for a limited number of hours each week.

It should be noted that inmates housed in county correctional institutions are generally healthier than the overall inmate population and are not expected to need substantial health care. Inmates requiring mental health services are not housed in the county facilities.

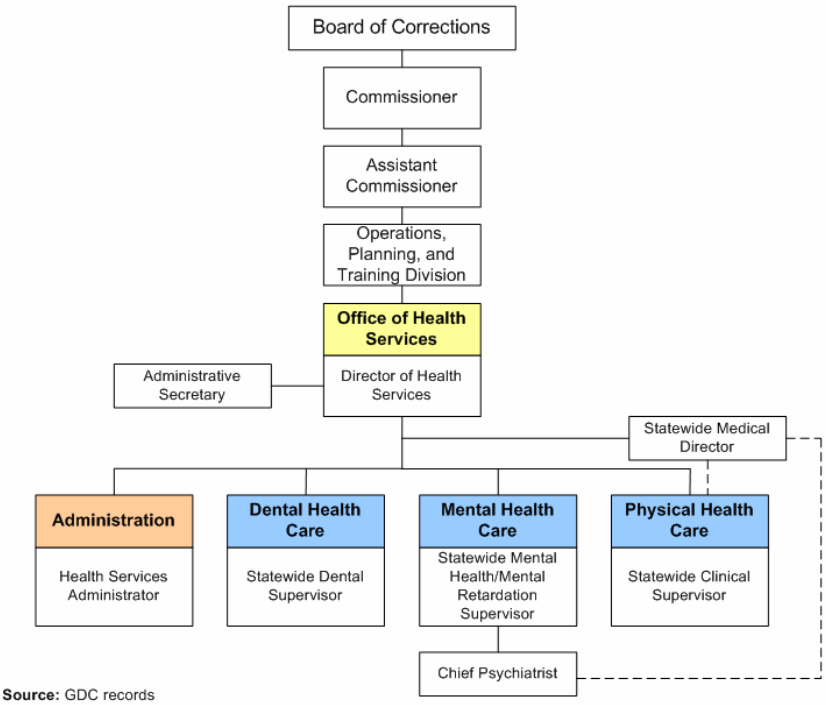
The per diem paid to the counties by GDC is intended to cover all costs, including health care. However, GDC pays all costs above $1,000 incurred for an inmate in a single occasion.

Management of Inmate Health Care

The Office of Health Services (OHS) in GDC is responsible for ensuring that all state inmates are provided adequate physical, mental, and dental health care. OHS provides clinical oversight and administrative oversight of care. Responsibilities include the establishment of standards of care and clinical protocols, monitoring the care provided to all state inmates, adjudication of appealed inmate grievances, management of the health care budget, determination of staffing levels, and the monitoring of vendors.

As shown in **Exhibit 5**, OHS is managed by a Director of Health Services who oversees all administrative policy and decision-making. The Statewide Medical Director oversees the provision of physical health care and makes the final medical decision on appealed cases. Assistance is provided by the Statewide Clinical Supervisor. Mental health care is primarily overseen by the Statewide Mental Health/Mental Retardation Supervisor, but the Statewide Medical Director supervises certain clinical decisions made by psychiatrists. Dental health care is overseen by the Statewide Dental Supervisor. The Health Services Administrator is responsible for day-to-day management of all administrative tasks of the program, including contracts, budgeting, and staffing issues.

Exhibit 5
Georgia Department of Corrections
Office of Health Services
Fiscal Year 2005



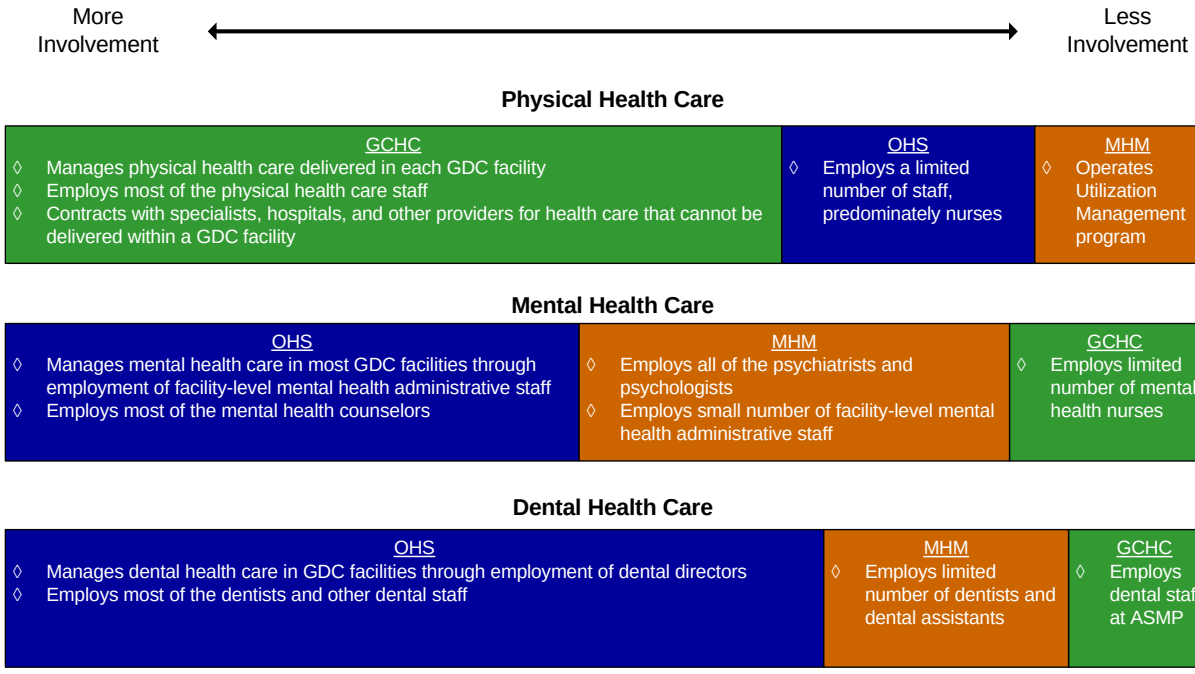
Source: GDC records

Delivery of Inmate Health Care

Health care is provided by a combination of GDC employees and contracted entities. As previously stated, the delivery of health care in private prisons and county correctional institutions is the responsibility of those entities; they can employ staff directly or

contract for this care. In order to provide health care in GDC facilities, OHS has contracted with two vendors, Georgia Correctional HealthCare (GCHC), a division of the Medical College of Georgia, and MHM Services, Inc. (MHM), a health care staffing agency. OHS and these two vendors have approximately 1,450 health care-related positions in GDC facilities. **Exhibit 6** depicts each of these entity's roles and relative degree of participation in the delivery of health care to inmates. The entities are discussed more fully in the following sections.

Exhibit 6
Roles and Relative Involvement in Delivery of Health Care within GDC Facilities



Source: GDC, GCHC, and MHM records

Office of Health Services

In addition to the management responsibilities previously discussed, OHS has significant responsibilities for the delivery of mental and dental health care and a limited role in the delivery of physical health care. As shown in **Exhibit 7** on page 13, OHS is budgeted nearly 54% of the mental health staff and 80% of dental staff. OHS staff comprises less than 6% of physical health care staff. OHS's facility-level physical health care positions are those

not transferred to GCHC when GCHC became the entity primarily responsible for the delivery of physical health care. The positions are transferred to GCHC when vacated.

Georgia Correctional HealthCare (GCHC)

In July 1997, GDC entered into an agreement with the Medical College of Georgia (MCG) to provide physical health care services to inmates in GDC facilities. As a result of this agreement, Georgia Correctional HealthCare (GCHC) was created as a functional unit within MCG. Among GCHC's responsibilities under the fiscal year 2005 agreement are:

- To manage physical health care operations in GDC facilities;
- To provide intake services at GDC's diagnostic facilities;
- To conduct physical health care clinics addressing urgent illnesses and injuries, non-urgent illnesses and injuries, and chronic illnesses; and
- To negotiate and manage contracts with health care service providers throughout Georgia (e.g., hospitals, specialty clinics, ambulance services, etc.) for health care services that cannot be provided by resources within GDC facilities.

As presented in **Exhibit 7**, GCHC personnel account for approximately 70% of all budgeted staff for correctional health care in GDC facilities. Of these GCHC personnel, most provide physical health care services.

MHM Services, Inc. (MHM)

In fiscal year 1998, GDC contracted with MHM Services, Inc. (MHM) for the provision of psychiatrists and psychologists. Since that time, the contract has been expanded to include additional mental health and dental staff. In addition, during fiscal year 2003 MHM was contracted to provide the Utilization Management program that oversees specialist and hospital usage to ensure that the most appropriate and cost-effective services are provided.

Exhibit 7
Budgeted Inmate Health Care Staffing for GDC Facilities
Fiscal Year 2005

	OHS	GCHC	MHM	Totals
Physical				
Central Office Staff	15.50	41.00	7.00 (1)	63.50
Field Administrative Staff	0.00	36.00	0.00	36.00
Physicians	0.50	51.20	0.00	51.70
Clinical Practitioners (2)	0.00	52.15	0.00	52.15
Nurses (3)	36.00	659.25	0.00	695.25
Pharmacy Staff (4)	6.00	63.80	0.00	69.80
Other Physical Health Staff	5.00	34.50	0.00	39.50
Support Staff	1.00	85.70	0.00	86.70
Total Physical Health Care Staff	64.00 (5.8%)	1,023.60 (93.5%)	7.00 (0.6%)	1,094.60
Mental				
Central Office Staff	11.00 (5)	0.00	0.00	11.00
Field Administrative Staff	16.00	0.00	3.00	19.00
Psychiatrists	0.00	0.00	21.25 (6)	21.25
Psychologists	0.00	0.00	20.50 (6)	20.50
Counselors	134.50	0.00	37.00	171.50
Nurses (3)	0.00	72.70	2.00 (6)	74.70
Other Mental Health Staff	36.50	7.00	4.00	47.50
Support Staff	0.00	2.00	0.00	2.00
Total Mental Health Care Staff	198.00 (53.9%)	81.70 (22.2%)	87.75 (23.9%)	367.45
Dental				
Central Office Staff	1.00	0.00	0.00	1.00
Dental Assistant	23.75	1.00	2.00	26.75
Dental Hygienist	6.00	0.50	0.00	6.50
Dental Director (7)	3.00	0.00	0.00	3.00
Dentist	12.75	1.00	7.00	20.75
Total Dental Health Care Staff	46.50 (80.2%)	2.50 (4.3%)	9.00 (15.5%)	58.00
Other Program Staff				
OHS Director and Secretary	2.00	0.00	0.00	2.00
Clerk	17.00	0.00	3.00	20.00
GCHC Fiscal Manager	0.00	1.00	0.00	1.00
Secretary	28.50	13.00	0.00	41.50
Total Other Program Staff	47.50 (73.6%)	14.00 (21.7%)	3.00 (4.7%)	64.50
Overall Total	**356.00 (22.5%)**	**1,121.80 (70.8%)**	**106.75 (6.7%)**	**1,584.55**

Notes:

(1) As of April 15, 2004, there were seven full time MHM employees budgeted to operate Utilization Management.

(2) Clinical Practitioners include Physician Assistants and Nurse Practitioners.

(3) Nurses include Registered Nurses, Licensed Practical Nurses, and Certified Nurse Assistants.

(4) Although pharmacy staff are involved in both physical and mental care needs, they are presented as physical health care staff since approximately two-thirds of pharmacy purchases are for physical care medications.

(5) Only three of these positions have statewide responsibilities. The remaining eight have full-time field assignments.

(6) MHM budgeted staff positions are current as of April 15, 2004.

(7) Dental Directors are dentists working in GDC facilities who are assigned additional management responsibilities.

Source: GDC Records

Financial Information

As shown in **Exhibit 8**, OHS expended approximately $150.5 million in fiscal year 2004 to provide health care to inmates. This does not include the per diem paid by GDC to private prisons and county correctional institutions, a portion of which is spent on inmate health care. The private prisons reported total health care expenditures of $11,304,131 in calendar year 2003.

Of the $150.5 million expended by OHS, approximately $143.1 million (95.1%) was state funds and $7.4 million was "telephone commissions" collected from telephone companies for calls made by inmates. OHS spent approximately $134.6 million (89.3%) on "health services purchases," which includes the contracts with GCHC for approximately $113 million and MHM for $18.4 million. **Appendix B** on page 85 provides additional detail on GCHC's expenditures for fiscal year 2003.

OHS's contract with GCHC specifies that OHS is responsible for physical health care expenditures above the contract amount of $113 million. This contract stipulation ensures that if expenditures exceed $113 million, either GCHC or MCG will not be directly responsible for paying any portion of inmate health care. While GCHC is not directly responsible for paying for inmate health care, GCHC's operations directly impact the expenditures for inmate health care. As an incentive to control costs, the GCHC contract includes a $500,000 incentive to be paid to GCHC for spending at least $500,000 less then the amount specified in the contract with GDC.

Exhibit 8
GDC Office of Health Services
Fund Sources and Expenditures[1]

	Fiscal Year 2003				Fiscal Year 2004			
	Physical Health	Mental Health	Dental Health	Total	Physical Health	Mental Health	Dental Health	Total
Fund Source:								
State Appropriations	$113,726,891	$19,338,871	$3,420,310	$136,486,072	$119,694,156	$20,025,699	$3,424,995	$143,144,850
Telephone Commissions	0	9,705,465	0	9,705,465	0	7,369,287	0	7,369,287
Total	$113,726,891	$29,044,336	$3,420,310	$146,191,537	$119,694,156	$27,394,986	$3,424,995	$150,514,137
Expenditures:								
Personal Services[2]	$4,645,513	$7,555,333	$2,809,169	$15,010,015	$4,339,236	$8,356,054	$2,711,323	$15,406,613
Regular Operating Expenses	113,514	39,359	357	153,230	31,207	47,084	6,241	84,532
Travel	11,714	39,623	11,170	62,507	16,173	37,658	6,155	59,986
Equipment	4,700	0	0	4,700	379,927	0	0	379,927
Telecommunications	21,899	3,781	0	25,680	10,341	11,491	1,149	22,981
Contracts	95,000	168,750	0	263,750	0	0	0	0
Health Services Purchases[3]	108,834,551	21,237,490	599,614	130,671,655	114,917,272	18,942,699	700,127	134,560,098
Total	$113,726,891	$29,044,336	$3,420,310	$146,191,537	$119,694,156	$27,394,986	$3,424,995	$150,514,137

(1) Revenues and Expenditures were adjusted for encumbrances. Funds are included during the fiscal year in which they were expended for goods or services, not during the year in which they were encumbered.

(2) In fiscal year 2003, $1.96 million of the Personal Services (13.1%) was for OHS Central Office staff, with the remainder representing staff in GDC facilities. In fiscal year 2004, $2 million was for OHS Central Office staff.

(3) Health Services Purchases primarily consists of the GCHC contract for $108 million in FY 2003 and $113 million in FY 2004. The GCHC contract includes a $500,000 incentive fee to be paid to GCHC for spending at least $500,000 less than the amount specified in the contract with the GDC.

Source: GDC Expenditure Records

Objectives, Scope, and Methodology

This evaluation was conducted in accordance with O.C.G.A. 45-12-178 and generally accepted government auditing standards for performance audits. The evaluation was conducted at the request of the Budgetary Responsibility Oversight Committee (BROC) of the Georgia General Assembly. In its request for the evaluation, BROC indicated that, at a minimum, the evaluation should address the following questions:

- How does Georgia compare to other states in cost per inmate, types of services provided, and other relevant factors?
- To what extent have health care costs for inmates changed compared to health care costs for others?
- To what extent are the health care costs affected by the aging inmate population?
- To what extent does the state use the Medical College of Georgia?

The request from BROC indicated the evaluation should include physical health care, mental health care, and dental health care provided to Georgia inmates. In addition, BROC requested that the report comment on and evaluate the validity and reliability of GDC's Priority Based Budgeting data regarding health care for inmates and the extent to which the data had been used to inform resource allocation decisions.

In addition to the preceding questions, the evaluation also considered:

- Does GDC provide inmates with the appropriate access to the required quality of care?
- What is the total cost of providing inmate health care and the cost of providing care to specialty groups such as aging inmates, AIDS/HIV-positive inmates, diabetic inmates, etc.?
- Has GDC implemented adequate cost containment measures to address increasing health care costs, especially in the areas of staffing, pharmaceuticals, and contracted providers?

Additionally, although some aspects of health care provided to state inmates housed in private prisons and county correctional institutions are discussed, this evaluation focused primarily on the health care operations of GDC-operated facilities. Also, the term "inmate" used in this report denotes any incarcerated person for whom GDC is responsible. The terms "probationer" or "detainee" may be used in cases where they alone are affected.

The evaluation methodology included conducting interviews with and reviewing records obtained from GDC, GCHC, MCG, and MHM. Visits were made to 13 GDC facilities and one private prison to observe the provision of health care. A survey of health care personnel in GDC facilities was conducted. Information also was collected from correctional health care officials in other states and non-profit organizations in Georgia.

This report has been discussed with the appropriate personnel representing GDC and GCHC. A draft copy was provided for GDC review and it was invited to provide a written response, including any areas in which it plans to take corrective action. Agency responses have been added in *italics* as appropriate.

Responses to BROC Questions/Issues

Evaluate the physical health care, mental health care, and dental care provided to Georgia inmates.

OHS has developed an extensive management control system to effectively manage all aspects of physical, mental, and dental health care. Administrative tasks, such as budgeting and planning, are well operated, as are many of the quality control functions.

OHS has numerous operational controls to ensure that inmates receive a standard quality of health care. Among these controls are standardized procedures, audits of facility operations, accreditation of health care operations, and the use of outside experts. (See Recommendation 12 on page 46 for more detailed information on OHS's quality control measures.)

As with any system as complex as health care for more than 40,000 individuals, problems do exist. For example, inmates are often not seen by physical health care specialists in the timeframe required by GDC policy, and dental care is inconsistent between facilities. (See Recommendations 18 and 21 on pages 59 and 65, respectively.)

In addition to these specific problems, the quality of the inmate health care system is threatened by decreased staffing levels that are a result of budget constraints. According to a report[2] prepared by the Georgia Department of Community Health, "a growing body of evidence indicates that staffing has a profound impact on the outcomes of care." The report further states, "Shortages in staffing, for health care professionals in general, will result in negative consequences for health care quality."

Budget constraints have led to artificially low spending increases. From fiscal year 2001 to 2004, the amount spent by GDC per inmate increased 10.6% (from $8.45 to $9.35). For the same time period, the Centers for Medicare and Medicaid Services reports that national health care expenditures per person increased 22.8%.

[2] Health Care Workforce Policy Advisory Committee FY 2003 Annual Report

Since staffing comprises a majority of inmate health care costs, much of the cost savings have been the result of reducing staff or not increasing staff when the inmate population increased.

- In fiscal years 2003 and 2004, GDC's reduced contract funding for staffing required GCHC to maintain vacancy rates of 22% and 18%, respectively, among its facility-level physical health care positions.

- From August 2001 to August 2003, while the mental health population increased nearly 22%, the psychiatry and psychology hours decreased 31% and 17%, respectively. During this time, the ratio of counselors to mental health inmates increased from 1:34 to 1:40.

- From fiscal year 2001 to 2005 the ratio of dentists to inmates in GDC facilities increased from 1:1,537 to 1:1,770.

Since GDC is legally obligated to deliver an adequate level of health care to inmates, a continuing weakening of the system would make the department more susceptible to lawsuits filed by inmates or other groups, such as prisoner rights advocacy groups or the U.S. Department of Justice. Correctional health care experts have concluded it is less expensive, in the long term, to deliver a higher level of care initially and avoid expensive litigation and court-mandated levels of care. GDC is aware that the temporary measures imposed to control costs cannot be maintained for an extended period of time and when these measures are removed that inmate health care expenditures could increase significantly.

GDC Response: *The Department acknowledges and agrees with this finding. Although GDC has made great strides in instituting managed care, continuing budgetary constraints will indeed bring increasing pressure to bear on the correctional health care system. With this added pressure comes increased risk.*

Staffing of health services within correctional institutions is becoming increasingly difficult to maintain. The vacancy rate of the last 2-3 years has been well documented. The current vacancy rate is 14%, a level that cannot be sustained over the long run.

Further, with the continuing nursing shortage, the replacement costs of having to rely upon agency nurses for critical vacancies invariably come at increased expense. In short, expenditures for maintaining an adequate health care workforce within GDC will increase over the coming years, but will be necessary to deliver the required level of care.

Compare Georgia to other states in cost per inmate, types of services provided, and other relevant factors.

Georgia's inmate health care costs compare favorably to four other states with inmate populations similar in size, though Georgia does spend a higher portion of its corrections budget on health care.

To identify a standard of comparison for Georgia's correctional health care costs, Michigan, Pennsylvania, Ohio, and Virginia were surveyed. **Exhibit 9** provides the percentage of each state's correctional budget spent on inmate health care, health care expenditure per inmate, and inmate population in fiscal year 2003.

Exhibit 9
Comparison of Inmate Health Care Costs
Fiscal Year 2003

	% of Corrections Budget Expended on Health Care	FY2003 Health Care Expenditure Per Inmate	FY2003 Inmate Population (1)
Georgia	14.98%	$3,349 (2)	43,301
Michigan	15.97%	5,426	50,761
Ohio	12.36%	4,281	45,338
Pennsylvania	12.20%	3,917	40,809
Virginia	11.44%	3,037	30,000

Notes:
(1) Georgia's population is the average daily population in GDC-operated facilities. An additional 9,437 Georgia inmates were housed in private prisons or county correctional institutions. Michigan's inmate population is as of January 2, 2004; other states' inmate populations are as of June 30, 2003.
(2) Georgia's health care expenditure per inmate does not include payments to private prisons or county correctional institutions.

Source: GDC Records; Comparable State Survey

According to a survey published by the American Correctional Association (ACA) in October and November of 2003, the average annual health care expenditure per inmate for 34 responding U.S. states was $3,131. While GDC's annual expenditure of $3,502 for

state fiscal year 2002 is slightly higher, it should be noted that direct comparisons between state correctional systems may be tenuous because of differences between the states' number and size of facilities, security issues, types and levels of health care services provided, and the use of private vendors. The varying impacts of these factors are evident in the range of per inmate annual health care expenditures compiled in the ACA survey – a high of $6,614 (Wyoming) to a low of $1,398 (Alabama).

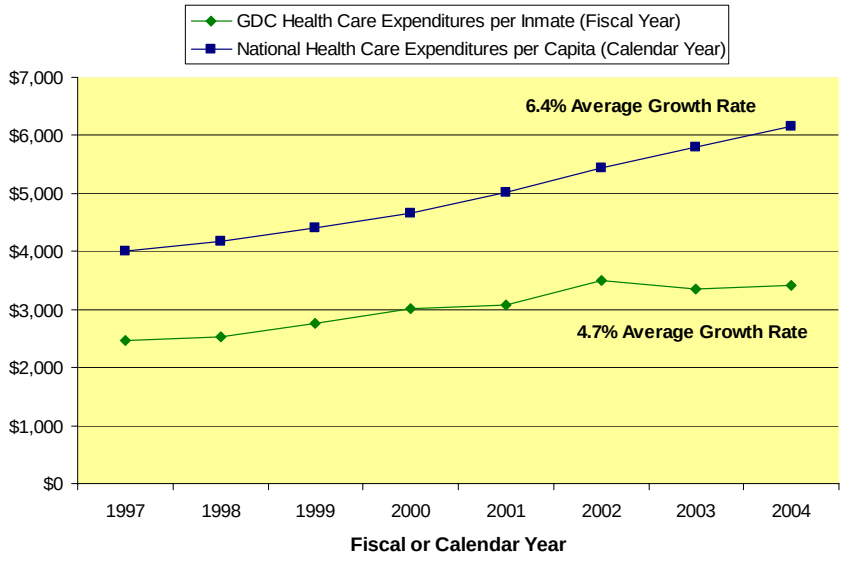
The ACA survey also compiled the percentage of each state's total corrections budget that is spent on inmate health care. While Georgia spent 15.3% in fiscal year 2002, ranking third highest among all respondents, the average for responding states was 11.6%. Responses ranged from a high of 21% (South Dakota) to a low of 3.98% (Wisconsin).

GDC Response: *The Department agrees with this finding. The reported health care cost comparisons are consistent with a number of surveys conducted by OHS in the past. The proportion of agency spending that is devoted to health care is likely the reflection of socio-economic demographics within the population of Georgia as a whole.*

To what extent have health care costs for inmates changed compared to health care costs for others?

Georgia's health care costs per inmate have increased at a slower annual rate than comparable national health care expenditures. As shown in **Exhibit 10** on the following page, from fiscal year 1997 to 2004, Georgia's expenditures per inmate increased by an average of 4.7% annually, while national health care expenditures per capita increased 6.4%.

Exhibit 10
GDC vs. National Health Care Expenditures



Source: GCHC records; Centers for Medicare & Medicaid Services

OHS's success in controlling inmate health care costs has been the result of the implementation of several permanent cost containment measures common in health care systems, as well as temporary cost containments measures implemented in fiscal years 2003 and 2004. Those permanent cost containment measures that have become part of the daily operations of the inmate health care system include the following, which are discussed in further detail in later findings:

- Pharmacy Operations (Recommendation 4 on page 33); and,
- Third-Party Provider Contracts (Recommendation 5 on page 35).
- Telemedicine (Recommendation 6 on page 35);
- Inmate Co-payments (Recommendation 7 on page 37);
- Utilization Management (Recommendations 19 and 20 on pages 63 and 64);

As shown in **Exhibit 10**, GDC's cost containment success was greatest in fiscal years 2003 and 2004. This is partly attributable to

temporary cost containment measures that cannot be sustained in the long term without negatively impacting the quality of health care. These measures include targeted vacancy rates of at least 18% for GCHC physical health care staff in fiscal years 2003 and 2004 and a delay in adding additional medical and mental health beds despite an increase in the inmate population. However, even without the physical health care staffing reductions in the last two years, GDC's annual growth rate would have been 5.2%, significantly lower than the national average.

GDC Response: *The Department agrees with this finding. Rigorous financial controls have been employed over the last 2-3 years, with good results. As stated in the report, however, these controls cannot be sustained long term without negatively impacting the quality of care.*

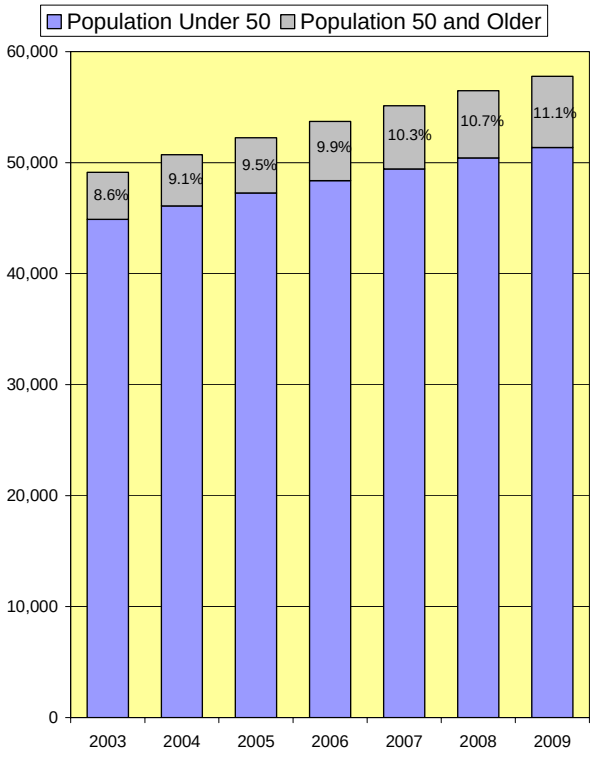
To what extent are the health care costs affected by the aging inmate population?

Since GDC does not allocate health care costs to individual inmates, it is not possible to determine the total cost of providing health care to an inmate or a group of inmates. However, the limited available cost information and numerous studies indicate that aged inmates are more costly than other inmates and more likely to require a medical bed. Due to the prevalence of substance abuse and the history of poor health care, inmates age 50 and above are typically classified as aged inmates.

A review of medical claims paid by GCHC indicated that aged inmates are more likely to require services from an outside provider and those services cost more than they do for inmates under age 50. Aged inmates comprised 9.7% of the population delivered health care by GCHC in fiscal year 2003 but accounted for 28.6% of all claims submitted. Additionally, the aged inmates' claims were an average of 10% higher ($324 vs. $356) than claims for other inmates.

In addition to needing more outside services, aged inmates are more likely to require a medical bed while inside the correctional facility. According to a study conducted for GDC by Barrell and Associates (a consulting firm) in 1998, inmates age 50 and older were 20 times more likely to be assigned to a special medical bed than younger inmates. A review of infirmary bed usage in May 2004 showed that 32% of the occupied beds were filled within inmates age 50 and above. Also, ASMP's Assisted Living Level 2 Unit, which essentially serves as a 20-bed nursing home, is always fully occupied, primarily with aged inmates. For additional information about GDC's bed space shortage, see Recommendation 22 on page 67.

Exhibit 11
Projected Inmate Population



Source: GDC inmate projections

The aged inmate population's impact on health care costs will likely be greater in the future. While GDC's March 2004 inmate projections show the inmate population increasing 14% from 2004 to 2009, the number of aged inmates is expected to increase by 39%. As shown in **Exhibit 11**, this will result in aged inmates comprising more than 11% of the inmate population.

It should be noted that there are other special population groups that significantly contribute to the total cost of inmate health care. For information about the cost of providing health care to selected special population groups, see Recommendation 2 on page 30.

GDC Response: *The Department agrees with this finding. Indeed, certain population groups within the correctional system do consume a disproportionate share of resources. This reflects comparable phenomena that are occurring in the free world. As the demographic profile of public offenders changes in the future, correctional health care demands will change as well. Along with these changes will come increasing health care costs.*

To what extent does the state use the Medical College of Georgia?

As stated on page 12, GDC has contracted with the Medical College of Georgia (MCG) since fiscal year 1998 for the provision of physical health care services to inmates in GDC facilities. Georgia Correctional HealthCare, a division of MCG, provides day-to-day management of physical health care services and employs more than 90% of the staff providing direct services within the facilities. GCHC is also responsible for negotiating contracts with health care providers (i.e., hospitals, specialists, medical transport companies) throughout the state in those instances in which an inmate's medical needs exceed the capability of the correctional facility and for paying the related claims with its contract funds.

MCG is part of the MCG Health System, which includes two other entities – MCG Health, Inc. (MCGHI) and Physicians Practice Group (PPG). MCGHI is responsible for managing the Medical Center, including hospitals, and is frequently the provider of hospital bed space for male inmates. PPG, whose physicians are faculty members of MCG, provides much of the specialist care delivered in the Augusta area, including that delivered at ASMP. In fiscal year 2003, MCGHI and PPG were paid approximately $6.7 million (27.8%) of the $24.2 million in claims paid by GCHC. MCGHI rates were comparable or favorable to similar hospitals.

GDC Response: *The Department agrees with this finding. The partnership between GDC and MCG has served the state well over the last seven years and is recognized nationally as a model for correctional health care in the public sector.*

Comment on and evaluate the validity and reliability of the Results-Based Budgeting data for the programs, goals, and desired results that include the topic of health care for inmates.

Although the results measures reported in the Fiscal Year 2005 Governor's Budget Report are valid measures of a correctional

health care program, the data reported is incomplete and incorrect. For GDC's fiscal year 2005 Prioritized Program Budget, 12 programs were identified and prioritized. GDC prioritized the Health Program as third. Of the Health Program's results measures, two were reported in the Fiscal Year 2005 Governor's Budget Report: 1) Cost per Inmate for Health Care, and 2) Inmate Mortality Rate.

Prioritized Program Budget

Under PPB, an agency's resources are identified based on its program-level activity as opposed to its organizational structure.

Cost Per Inmate for Health Care

Daily health care expenditure per inmate is commonly used by state correctional health care programs as a performance measure.

OHS reports daily health care costs per inmate as a results measure to the Governor's Office of Planning and Budget (OPB). According to the Fiscal Year 2005 Governor's Budget Report, GDC's daily health care expenditures per inmate for fiscal year 2003 was $7.51. However, fiscal year 2003 program expenditure records, excluding inmates housed in county correctional institutions and private prisons, indicate daily costs per inmate as $9.18, approximately 22% higher than reported in the fiscal year 2005 budget report. GDC confirmed the data in the budget report is not correct and that mental health care costs appear to have been omitted.

Inmate Mortality Rate

Inmate mortality rates may indicate performance of health care services. In its fiscal year 2005 PPB submission to OPB, GDC used the inmate mortality rate compared to the general population of the state of Georgia and comparable correctional systems.

Although the PPB documentation submitted to OPB, and subsequently reported in the Fiscal Year 2005 Governor's Budget Report, provides the GDC inmate mortality rate (per 100,000 inmates) for fiscal years 2001 through 2005 (fiscal years 2004 and 2005 were projected), it does not provide comparisons to the mortality rate for Georgia's population except in fiscal year 2001. Furthermore, the PPB submission did not provide inmate mortality rates for the comparable states GDC had selected – North Carolina, Pennsylvania, Ohio, and Michigan.

GDC Response: *The Department agrees with these findings. Health care costs were reported separately for physical and mental health in the referenced FY05 Budget Report. Apparently the physical health care cost was taken to be all-inclusive, although that was not the intent.*

With regard to mortality rates, this is one, among many, agreed upon outcome measures. For reasons that are understandable, however, most states are reluctant to release this information. National surveys are available on occasion, but these studies are invariably several years old at the time of reporting. Nonetheless, GDC will retain this measure as a quality of care indicator and will continue to seek corresponding information from other states.

Recommendations and Agency Responses

Financial Recommendations

Recommendation No. 1

While OHS successfully controlled inmate health care costs in fiscal years 2003 and 2004, costs will likely increase to more than $180 million by fiscal year 2007 due to a growing and aging inmate population, health care cost inflation, and additional resources needed to address recent shortfalls.

OHS is likely to experience a significant increase in the cost of inmate health care in the near future. Costs will climb due to the need to address staffing shortfalls, necessary expansion of medical and mental health bed space, growth and aging of the inmate population, and health care cost inflation.

Despite the changing characteristics of the inmate population and rising national health care costs, from fiscal year 2002 to 2004, total inmate health care costs rose at an annual rate of just 0.25% and the daily cost per inmate dropped from $9.59 to $9.35.

OHS's recent cost containment success was achieved partly through cost controls than cannot be sustained in the long term. In fiscal years 2003 and 2004, OHS reduced contract funding for GCHC staff, resulting in annual physical health care vacancy rates of approximately 22% and 18%, respectively. Additionally, OHS avoided an expansion of medical and mental health bed space, despite a rise in the population requiring those services.

When these cost containment measures are removed, OHS will experience a significant increase in health care costs. For instance, in fiscal year 2005, the targeted vacancy rate for GCHC personnel has been lowered from 18% to 14%. Combined with market adjustments for many GCHC personnel and state-mandated pay raises of 2%, staffing costs alone will rise much faster in fiscal year 2005 than they have over the last few years. Also, since August 2002, the mental health caseload has increased by approximately 900 inmates, but capacity in the form of additional counselors and SLU beds has not increased.

In addition to the immediate adjustments, spending will likely continue to increase as a result of the changing characteristics of the inmate population. As noted on page 3, inmates typically have higher rates of health problems than individuals not in prison. Longer prison sentences, a decline in early releases, and the overall aging of the U.S. population have led to larger numbers of inmates age 50 and older. These aged inmates accounted for 5% of Georgia's prison population in 1989 but 8.9% (4,025 inmates) by 2002. GDC expects aged inmates to number nearly 7,000 by 2010. Finally, the number and percentage of inmates with a mental illness continues to rise. GDC's mental health caseload was 5,255 (12.2% of the inmate population) at the end of fiscal year 2000 compared to 7,054 (15.1%) in May 2004. Special population groups such as these significantly increase the cost of health care.

Inmate health care expenditures are difficult to accurately project and are subject to change. The total projected annual cost is based on estimates of future inmate populations and future costs per inmate. GDC officials project future inmate populations, but changes in sentencing or early release practices could change the number. And while the future cost per inmate is based on a three-year average of the Medical Consumer Price Index (CPI) for the South (4.04% for 2000-2003), GDC costs per inmate were likely artificially low in fiscal year 2004, the baseline year of the analysis. As shown in **Exhibit 12**, inmate health care costs would rise considerably if GDC's cost per inmate increased at the CPI rate and its inmate population increased as expected.

Exhibit 12
Projected Inmate Health Care Costs
Through Fiscal Year 2007

	FY04 Actual	FY05 Projection	FY06 Projection	FY07 Projection
Cost Per Inmate	$9.35	$9.73	$10.12	$10.53
Inmate Population	43,727	45,048	46,318	47,541
Annual Cost Per Inmate	$3,412.75	$3,550.63	$3,694.07	$3,843.31
Health care Expenditures[1]	$149,229,319.25	$159,946,980.90[2]	$171,101,568.18	$182,713,643.03

(1) Expenditures do not include GDC's supplement for catastrophic cases at private prisons or county correctional institutions, nor does it include the per diem these institutions receive for services, including health care.
(2) The OHS budget for fiscal year 2005 is currently $151.1 million; however, OHS expects to submit a fiscal year 2005 supplemental funding request.

Source: Actual numbers from GDC records; projected population based on GDC figures; projected cost per inmate based on Medical Consumer Price Index – South (4.04%).

GDC Response: *The Department agrees with this finding and has no further comment.*

Recommendation No. 2

Special population groups, such as inmates with HIV, mental health conditions, and those aged 50 and above, significantly increase the total cost of inmate health care.

While the average health care cost per inmate was approximately $3,350 ($9.18 daily) in fiscal year 2003, inmates with serious health problems have significantly higher annual costs. Inmates with chronic illnesses, mental health conditions, and those aged 50 and above are a few of the special population groups that increase the average health care cost per inmate.

We were unable to determine the exact cost of special population groups' health care since GDC does not allocate costs to each inmate (i.e., no bill is generated for inmates seen in sick call, served by a mental health counselor, provided a prescription medication, or housed in an infirmary). However, we were able to identify some of the expenditures associated with certain special population groups. It should be noted that there are other inmates whose health care costs may be significant but not as identifiable, including those with chronic illnesses such as diabetes, hypertension, and kidney disease.

HIV-Positive Population

A review of medical claim and pharmaceutical expenditures shows that the HIV-positive population accounts for a disproportionate share of each type of expenditure. As shown in **Exhibit 13**, during fiscal year 2003, HIV-positive inmates comprised 2.1% of the inmates who received health care by GCHC but accounted for nearly 4.5% of the medical claim expenses. Their average claim was significantly higher than the average for inmates without HIV. In addition, costs for HIV drugs accounted for 32% of all GCHC expenditures for pharmaceuticals, despite the small size of the HIV-positive population. This resulted in the average daily cost of HIV medications for HIV-positive inmates to be 15 times greater than the daily cost of medication for the average inmate.

Exhibit 13
Health Care Costs of HIV-Positive Inmates
Fiscal Year 2003

Medical Claims				Pharmaceuticals	
% of Inmate Population - HIV-Positive	% of Claim Expenses for HIV-Positive Inmates	Average Claim - Non-HIV	Average Claim - HIV	Average Inmate Cost/Day	HIV Inmate Cost/Day
2.1%	4.5%	$328	$436	$1.36	$20.70

Source: GDC and GCHC records

Mental Health Caseload

Inmates on the mental health caseload consume a disproportionate share of health care expenses. (OHS maintains a separate budget for the mental health expenditures.) During fiscal year 2003, OHS expended an additional $4,747 for each inmate in the mental health population, making these inmates' total health care costs significantly higher than inmates not receiving mental health care (see **Exhibit 14**).

A portion of the mental health expenditures go toward prescription medications. Not only are inmates on the mental health caseload more likely to be on prescription medication, the cost per inmate for the medication is significantly higher than for the average inmate. Nearly 80% of inmates on the mental health caseload are taking a prescription drug, compared to about 60% of all inmates. The cost of those psychotropic drugs was $2.84 per mental health inmate per day, compared to only $1.36 per inmate per day for all medications.

Exhibit 14
Health Care Costs of Mental Health Population
Fiscal Year 2003

OHS Expenditures Per Inmate(1)		Pharmaceuticals	
Average Cost - Non-MH Inmate	Average Cost - MH Inmate	Average Inmate Cost/Day	Average MH Inmate Cost/Day
$2,679	$7,426	$1.36	$2.84

(1) The cost for non-mental health inmate includes average physical and dental cost, while the mental health inmate cost includes an additional $4,747 for mental health services.
Source: GDC and GCHC records

Inmates Age 50 and Above

As stated on page 23, aged inmates are less healthy than younger inmates and their health care costs are greater. A review of claims

shows that they are more likely to require care outside of a GDC facility and that care is more expensive.

GDC Response: *The Department agrees with this finding and has no further comment.*

Recommendation No. 3

Daily health care costs per inmate at GDC-operated facilities are higher than those of private prisons due to the higher proportion of the most ill inmates in GDC facilities and GDC sharing the costs of catastrophic cases at the privately operated facilities.

While the private prison operators spend less per inmate on health care than GDC, their inmate populations are younger, have a lower incidence of chronic illness, and fewer mental health problems. In addition, GDC pays a share of the cost for catastrophic cases at private prisons.

As shown in **Exhibit 15**, the private prisons' health care expenditures per inmate are less than GDC's, but their populations are healthier on average. As the proportion of aged, mentally ill, and chronically ill increases, health care costs increase. For example, the privately operated prison D. Ray James maintains a lower percentage of mentally and chronically ill patients, and

Exhibit 15
Private and GDC Facility Health Care Costs
Fiscal Year 2003

Category	Private Prisons			Private Prison Average	GDC Facility Average
	D. Ray James	Coffee	Wheeler		
Average health care cost per inmate per day	$5.99	$6.76	$7.76	$6.84 (calendar year 2003)	$9.18
Percentage of the population mental health Level II	9.47%	9.99%	10.25%	9.90%	10.39%
Percentage of the population mental health Levels III, IV, and V	0.00%	0.00%	0.00%	0.00%	4.25%
Percentage of inmates aged 50 and above (1)	8.2%	7.9%	9.6%	8.6%	11.4%
Percentage of the population HIV-positive	N/A	N/A	N/A	2.06%	2.07%
Percentage of the population chronically ill (2)	28.08%	29.74%	32.32%	30.05%	35.63%

Notes:
(1) Elderly inmate population as of March 18, 2004
(2) Based on six month average, August 2003 - January 2004

Source: Corrections Corporation of America, Cornell Companies, and GDC records

reports a correspondingly lower cost per inmate per day than does the privately operated Wheeler correctional facility.

As discussed in the prior recommendation, special population groups, such as inmates with HIV, mental health conditions, and those aged 50 and above, significantly increase the total cost of inmate health care. In addition, GDC's contracts with private prison operators have a stop-loss contingency that mitigates private prisons' health care costs. If the cost of a single inmate, or the hospitalization of several inmates for a single incident, is $25,000 or above, GDC will pay a portion of the cost. GDC also has the option to transfer the most expensive inmates to a GDC facility, in order to access Augusta State Medical Prison and/or contracted hospitals at lower costs. In fiscal year 2003, GDC paid a total of $213,081 directly to private prisons to mitigate their health care costs.

The stop-loss provision in the private prison contracts as well as GDC's maintenance of a higher proportion of inmates age 50 and over, chronically ill, and mentally ill inmates in GDC-operated facilities result in GDC having higher health care costs than the privately operated prisons.

GDC Response: *The Department agrees with this finding and has no further comment.*

Recommendation No. 4

GCHC has effectively controlled pharmaceutical costs by bulk purchasing and managing pharmaceutical use through a drug formulary.

While national drug expenditures per capita increased 42.1% from 2001 to 2004, GCHC's pharmaceutical expenditures per inmate dropped 3.4% during a similar time period (see **Exhibit 16** on the following page). GCHC's decrease in spending was not a result of a reduction in prescriptions per inmate but rather a decrease in the cost per prescription. Containing drug costs is at least partially a result of GCHC's efforts to purchase pharmaceuticals through a primary vendor and maintain a drug formulary.

Exhibit 16
GCHC and National Pharmaceutical Expenditures[1]
2001 – 2004

	GCHC Pharmacy				National Drug Expenditures	
Year	Total Expenditures Fiscal Year	Expenditures Per Inmate Fiscal Year	Average Prescription Cost Fiscal Year	Prescriptions per Inmate Fiscal Year	Total (in Billions) Calendar Year	Per Capita Calendar Year
2001	$21,396,888	$521.28	$24.89	20.9	$140.6	$497
2002	$22,173,665	$522.89	$21.53	24.3	$160.7 [3]	$563
2003	$21,419,543	$494.67	$21.26	23.3	$182.1 [3]	$633
2004	$22,007,979 [2]	$503.30	$19.39	26.0	$204.7 [3]	$706
% Change, 2001 - 2004	**2.9%**	**-3.4%**	**-22.1%**	**23.9%**	**45.6%**	**42.1%**

Notes
(1) GCHC expenditures do not include drug costs incurred by county jails, county correctional institutions, or private prisons.
(2) GCHC fiscal year 2004 pharmaceutical costs included all 12 months but were not official as of the time the data was acquired.
(3) National drug expenditures for 2002-2004 are projections from the Centers for Medicare & Medicaid Services developed in 2002.

Source: GCHC Pharmacy Records; Centers for Medicare & Medicaid Services

In fiscal year 2003, GCHC made 98.9% of its pharmacy purchases in fiscal year 2003 through Cardinal Health, its primary pharmaceutical provider. GCHC staff state that purchasing drugs in large volumes allows GCHC to take advantage of favorable pricing and to track the overall usage of medications system-wide. Additionally, GCHC maintains a drug formulary in order to make sure the most cost effective pharmaceuticals are being used.

Although drugs not on the formulary may still be prescribed, this is done on an exception basis and requires approval from a pharmacist, who relies on guidance from the GCHC medical director. For example, according to GCHC records, from June 2003 through May 2004, 83% of the top 100 drugs purchased during the period were drugs on the formulary. GCHC staff noted that approximately 40% of the non-formulary drugs used during the 12-month period had previously been on the formulary but were removed during 2004 to better control their use. The drug formulary is adjusted as necessary through the GDC Pharmacy and Therapeutics Committee.

GDC Response: *The Department agrees with this finding.*

Recommendation No. 5

GCHC has negotiated favorable rates with medical service providers throughout Georgia.

GCHC has negotiated over 300 contracts with third-party medical service providers throughout Georgia including hospitals, medical staffing services, medical specialists, and other direct medical care providers. A 2003 review of GCHC's discount rates with providers conducted by PricewaterhouseCoopers L.L.P. (PwC) found that GCHC has achieved favorable rates. The January 2003 report stated that "the average discounts achieved by the GCHC are relatively strong in comparison to the discounts given to PPO, POS [point of service], and HMO plans in the commercial/employer market in the state of Georgia." In particular, PwC noted the very favorable discount for professional services (see **Exhibit 17).**

Exhibit 17
GCHC and Commercial Discounts
Fiscal Year 2002

Type of Service	GCHC Discounts	Typical Commercial/Employer Discounts		
		Aggressive	Moderate	Low
Hospital Inpatient and Outpatient	44.7%	45.0%	39.0%	33.0%
Professional	58.3%	43.0%	33.5%	24.0%
Total	**48.0%**	**44.1%**	**37.2%**	**30.4%**

Notes:
Aggressive = Typical for HMO/POS plans with a large percentage of employees located in Atlanta
Moderate = Typical for PPO plans with national carriers that have a moderate concentration of employees in Atlanta
Low = Typical for PPO plans with regional networks that have a high concentration of employees outside Atlanta

Source: PricewaterhouseCoopers January 2003 Report *"Georgia Department of Corrections: Review of Payment Rates for Health Care Services of Freeworld Providers"*

GDC Response: *The Department agrees with this finding and has no further comment.*

Recommendation No. 6

In order to control costs, GDC should continue to work to maximize the use of telemedicine.

Telemedicine allows a medical consultation to occur between a physician and a patient who are at different physical locations. The consultation may consist of a static image, such as an x-ray transmitted to a physician, or a video-conference where a physician

consults directly with the patient using video monitors and microphones. Telemedicine is commonly used in correctional health care in a wide variety of treatment areas including cardiology, orthopedics, physical therapy, pulmonary medicine, renal medicine, and urology.

Although the use of telemedicine has benefits, its use in GDC facilities has declined over the past two years. The number of telemedicine appointments decreased by 29.7% from fiscal year 2002 to fiscal year 2004. A decline in the functionality of the current telemedicine technology, a decrease in treatment areas from 10 to four over the last two years, and the elimination of telemedicine sites at all three female state prisons are reasons for the decrease in usage. In addition, GDC staff stated that the resistance of some GCHC-contracted specialists to the technology has contributed to the decline.

The financial and security benefits of using telemedicine in correctional settings are well documented. In fiscal year 2001, GDC estimated it was saving $210,000 per year in transportation costs by using telemedicine. Telemedicine also lowers the risk of inmates escaping by reducing transportation outside of correctional facilities.

Although GDC intends for telemedicine to be maximized, the use of telemedicine is decreasing. OHS and GCHC should continue to work together to maximize the use of telemedicine.

GDC Response: *The GDC Office of Health Services (OHS) has worked aggressively in recent months to increase the utilization of telemedicine. This has included meeting with consultants one-on-one, resulting in six (6) additional specialty clinics to come on line via telemedicine in January 2005. In the meanwhile, OHS is in process of replacing all telemedicine equipment with newer technology. This will result in services that are more attractive to consultants while reducing telecommunications costs. To date, 5 of 11 sites have been upgraded. Telemedicine has the full support of Dr. Daniel Rahn, President of MCG, and OHS will continue to work with GCHC and MCG to increase the use of this technology.*

Medical Co-Pay

- GDC collected an average of approximately $400,000 annually in co-payments from fiscal year 2001 through fiscal year 2003.

Recommendation No. 7

GDC should ensure that all facilities follow co-pay procedures in order to maximize collections and deter inmates from requesting unnecessary health care services.

According to GDC policy, all facilities are to charge co-payments for most inmate-initiated health care requests.[3] Health care personnel determine if the co-pay is to be assessed for the service and administrative personnel charge the inmate's account. However, during visits to eight state prisons, we identified three facilities that were not properly charging inmate accounts. Specifically, one prison did not charge 27% of the sampled inmates a co-payment as required, another did not charge 45% of those sampled, and the third did not charge any co-payments for an entire day of service.

Co-payments are charged to defray the cost of providing health care services to inmates and to serve as a deterrent to inmates requesting unnecessary health care services. For example, inmates may request an appointment in order to avoid work detail.

OHS should ensure that personnel at GDC prison facilities are following the applicable procedures for collecting co-payments for health care services provided. Improved compliance with established standard operating procedures for co-payments may increase co-payment collections and serve as a consistent deterrent to inmates making unnecessary medical requests.

GDC Response: *OHS will take steps to ensure that medical co-pay is consistently applied in accordance with GDC standard operating procedures. This will include data collection from the field to assess current practices, additional training to health care personnel and, if necessary, auditing medical co-pay as part of the standard OHS facility audit.*

[3] Health care services are not withheld if the inmate is unable to pay out of their inmate account. Co-pays are also not assessed for services such as emergency care, chronic care, and physicals.

Recommendation No. 8

GDC agrees that various services now procured through MHM should be put out for bid.

GDC should re-bid the services currently provided by MHM. While GDC officials expressed general satisfaction with MHM, it is prudent to periodically put services out for bid to determine if better values are available.

In fiscal year 1998, MHM was awarded a contract to provide mental health services to inmates in GDC custody. The contract was renewable for four one-year terms (ending June 30, 2002) and required the company to provide psychiatrists, psychologists, and a limited number of counselors. The original RFP acknowledged this point in stating that the contract would only be renewed through fiscal year 2002.

Since the initial award, GDC has added services to the MHM contract without competitive bidding. These additional services include providing a limited number of dentists, dental assistants, dental hygienists, mental health counselors, mental health nurses, behavioral specialists, activity therapists, mental health clerks, and mental health directors. Since the initial contract, GDC has also made MHM responsible for a program managing CSU bed space and the Utilization Management program for physical health care.

Given that the original contract was intended to extend only through June 2002 and services have been added to the contract, GDC should place the services for bid. Additionally, with such disparate services, GDC officials should consider multiple procurements for mental health staffing, dental staffing, and physical health utilization management.

GDC Response: *OHS has drafted three (3) Requests for Quotes (RFQs), separating the current MHM contract into three bids: mental health, dental services and utilization management. The goal is to have these RFQs finalized and issued through the Department of Administrative Services (DOAS) by December 1, 2004. These procurements will each be for a service commencement date of July 1, 2005.*

Staffing Recommendations

Recommendation No. 9

GDC does not have sufficient budgeted mental and dental health care staff to comply with its own policies or studies.

Although the inmate population requiring mental and dental health care services in the last few years has increased, there has not been a comparable increase in staffing levels. In order to comply with GDC Standard Operating Procedures, GDC would need to budget for more than 50 new mental health counselors, mental health nurses, dentists, and dental hygienists. In addition, a joint GDC-MHM study of psychiatry hours indicated that additional hours are needed to address the growing mental health population.

Mental Health

The inmate population requiring mental health services has grown by over 1,300 (23.7%) since August 2001; simultaneously, mental health counselors' case loads have increased, and psychiatry and psychology hours per inmate have decreased. These changes have coincided with an apparent weakening of GDC mental health care system. In the last year, the mental health population has shown increases in the number of self-injuries and assaults per 100,000 inmates, as well as increases in the number of mental health-related grievances filed and appealed.

Exhibit 18
Mental Health Required Ratios

Mental Health Level	MH Counselors		MH Nurses			
	Counselor to Inmates		RNs to Inmates		LPNs to Inmates	
	Male	Female	Male	Female	Male	Female
Level II	1:50	1:40	1:200	1:150	n/a	n/a
Level III	1:30	1:20	1:150	1:100	n/a	n/a
Level IV	1:20	1:15	1:150	1:100	n/a	n/a
Level V	1 per Crisis Stabilization Unit		4 per Crisis Stabilization Unit		2 per Crisis Stabilization Unit	

Source: GDC Standard Operating Procedures

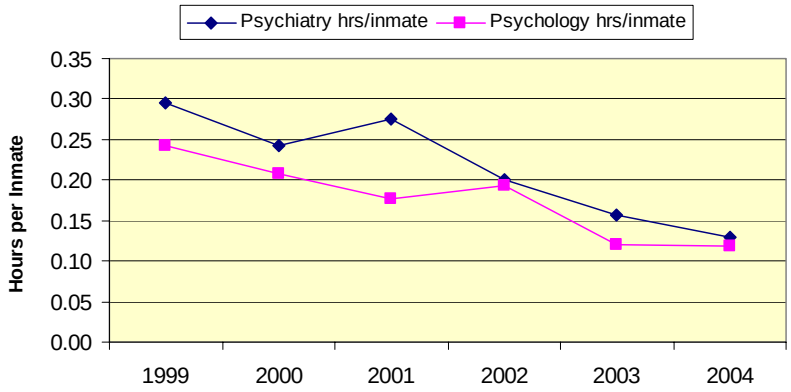
Mental Health Counselors – As of May 2004, an additional 8.43 budgeted counselors were needed to meet GDC's mandated staffing ratios (see **Exhibit 18**). The monthly mental health reports

indicated that 14 (64%) of 22 GDC prisons providing mental health services had fewer counselors budgeted than were required to service their populations.

Mental Health Nurses – As of May 2004, GDC was out of compliance with SOP mental health nurse requirements by more than 18 budgeted RN positions.

Psychiatry and Psychology – Between August 1999 and April 2004, psychiatry hours per inmate decreased 56%, and psychology hours per inmate decreased 51% (see **Exhibit 19**). No required ratios for psychiatrists and psychologists have existed since 2002; however, a joint 2004 GDC and MHM review of psychiatry hours indicates the need for additional psychiatric staff.

Exhibit 19
Psychiatry and Psychology Hours per Inmate
1999 - 2004



Source: GDC records

Dental Health

GDC has budgeted fewer dental positions than are required to meet its own "rule of thumb" for optimal staffing. In recent years, GDC has increased its "rule of thumb" for the number of inmates served by a dentist from 1,200 to 1,500.

Dentists – In fiscal year 2005, GDC has only 23.75 dentist positions budgeted to serve approximately 42,000 inmates, resulting in a ratio of 1,770 inmates for each dentist position. As indicated in **Exhibit 20**, GDC would need an additional 4.25

dentists (an increase of 18%) to meet its current standard.

Dental Hygienists – GDC has a shortage of 7.51 hygienists. With only 6.50 budgeted positions in fiscal year 2005, a 116% increase would be necessary to meet GDC's optimum ratio.

Exhibit 20
Dentist and Hygienist Staffing

	GDC's Optimum - Inmates Per Staff	Actual Inmates to Budgeted Staff (1)	Current Budgeted Staff (2)	Needed Budgeted Staff to Meet Optimum Ratio	Difference in Needed and Current Budgeted Staff
Dentists	1,500	1,770	23.75	28.0	4.25
Hygienists	3,000	6,467	6.50	14.0	7.51

Source: GDC staffing and inmate count data
(1) Inmate population as of June 30, 2004.
(2) Budgeted staff as of fiscal year 2005.

GDC Response: *The Department does not disagree with this finding. In order to address staffing shortages, OHS has prepared and submitted budget requests for FY06 to increase mental health and dental services staffing. These requests seek to retrofit the system with staffing to meet current standard operating procedures as well as for expansion to meet future growth.*

With regard to psychiatric hours specifically, both GDC and MHM have had discussions that have led to the increase of psychiatry hours at diagnostic facilities. No final recommendations have been presented. GDC will continue to monitor mental health staffing patterns and make adjustments as needed and as permitted by appropriations.

Recommendation No. 10

In addition to a shortage of budgeted positions, GDC and its vendors have high vacancy rates that can negatively impact their ability to deliver the required level of physical, mental, and dental heath care.

Analysis of GDC's physical, mental, and dental health care operations shows that each area has high vacancy rates. Near the end of fiscal year 2004 there were at least 160 vacancies, the majority of which were physical or mental health nurses. The

vacancy rates are attributable to mandated staffing reductions because of budget constraints, low salaries, the correctional environment, and national shortages in health care staff. Additionally, these factors likely contribute to the high turnover rates present in the physical and mental health care operations.

Physical Health

Due to budget constraints, GDC funding required GCHC to maintain vacancy rates of approximately 22% and 18%, respectively, in fiscal years 2003 and 2004. In fiscal year 2005, the targeted vacancy rate is 14%. In addition to these required vacancies, GCHC has had difficulty filling positions for which it has contract funds. During May and June 2004, GCHC officials were actively recruiting for more than 100 nurses, approximately 15% of all GCHC nursing positions.

In the last three fiscal years, GCHC has experienced turnover rates between 35% and 42%.

Once positions are filled, GCHC has had difficulty retaining employees. In the last three fiscal years, GCHC has experienced turnover rates between 35% and 42%. According to GCHC personnel, a significant portion of the turnover has occurred within nursing positions.

Mental Health

GDC does not have a mandated vacancy rate for mental health care personnel, but significant vacancies exist for mental health counselors and mental health nurses. Twenty-four (14%) of 171.5 counselor positions were vacant in April 2004. The following month, the mental health nurse vacancy rate was 34.6% (27.2 of 78.7 positions) in the state prisons. Fourteen (64%) of the 22 GDC prisons that provide mental health care were affected by the nursing vacancies.

Turnover has also plagued several mental health care positions and most facilities providing mental health care. From January 2003 to May 2004, the turnover rates for psychiatrists and psychologists were 91% and 56%, respectively. The mental health counselor position had a turnover rate of 44%. Only 3 of 28 facilities had no turnover in these positions during the 17-month period.

Dental Health

As of July 2004, OHS reported that 8 (33.7%) of 23.75 positions were vacant due to illness, military leave, or an inability to hire a dentist into a position. In calendar year 2003, at least three facilities went through periods with no permanent dental coverage. In these situations, OHS may hire short-term substitute staff and/or ask other dentists in the system to provide minimal care; primary coverage for pain management and emergency services is provided by the facilities' medical staff.

The vacancies not mandated by GDC and high turnover rates have similar causes. Low salaries and the correctional environment were both noted during interviews with GCHC health care personnel, and GDC personnel noted that mental health counselors, who are required to have a Master's degree, receive the same starting salary as general population counselors who do not need a Master's. Additionally, Georgia, as well as the rest of the nation, have a documented shortage of health care personnel, especially within the nursing profession.

As noted in the response to the BROC question on page 18, staffing shortages have a negative effect on health care quality. In our survey of GDC facility health care staff (**Appendix C** on page 86), 65 of 98 respondents (66%) said that their work unit does not have enough staff to complete required duties. Like high vacancy rates, high turnover is likely to have a negative effect on quality. In the survey, 50 of 98 (51%) stated that the turnover rate in their work unit negatively affects the health care delivered.

Higher cost is a secondary effect of high vacancy and turnover rates. Because of the difficulty in hiring nurses, GCHC often has used high-cost temporary nurses employed by staffing agencies. For a six-month period during fiscal year 2004, approximately 17% of GCHC's nursing hours were covered by staffing agency nurses, whose cost may be more than 100% higher than a GCHC nurse.

GDC Response: *The Department acknowledges this finding, recognizing health care staffing shortages that are impacting both*

public and private health care delivery throughout the state. Accordingly, OHS has worked to on multiple fronts to recruit and retain health care professionals. This includes, but is not limited to, increasing salaries for nursing and other clinical personnel. OHS will continue to pursue all options within available funding to address staffing shortages that are attributable to excessively high vacancy rates.

Recommendation No. 11

GDC should review its physical and dental health care staffing plans in order to address a current misallocation of positions among correctional facilities.

Physical and dental health care staff are currently misallocated among facilities. This can result in excess staff in some facilities, in relation to others, as well as inconsistent care among facilities due to the staffing differences.

Physical Health

The staffing levels currently utilized by GCHC in the state prisons have little correlation to GDC's staffing plan that allocates positions to the facilities. Few facilities can follow GDC's staffing plan exactly, since GCHC was required to operate with an 18% vacancy rate in fiscal year 2004. However, GCHC vacancy rates varied significantly among state prisons during a six-month period in fiscal year 2004, though GCHC contends that the quality of care provided at these facilities was comparable. Some sites operated with a 5% vacancy rate while others had vacancy rates of 25% to 34%. If facilities are providing comparable quality of care with significantly different vacancy rates, it indicates that budgeted positions are not properly allocated.

Dental Health Care

Fiscal year 2005 data show that budgeted dental staff-to-inmate ratios varied considerably across facilities.

- Dentist-to-inmate ratios ranged from 1:994 to 1:2,616;
- dental assistant-to-inmate ratios ranged from 1:608 to 1:2,963;

- hygienist-to-inmate ratios ranged from 1:994 to 1:4,719; and,
- dentist with one assistant-to-inmate ratios ranged from 1:994 to 1:2,297.

Although some differences in staffing levels are reasonable due to variances in the security level and physical structure of facilities, over half of all facilities (51 of 71, or 72%) were operating with dentist staffing ratios greater than the 1:1,500 optimum ratio in fiscal year 2005. The average ratio for these 51 facilities, which house 73% of the serviced population, was 1:2,106 inmates.

GDC should review the allocation of physical and dental health care staff to ensure the most efficient use of resources. A more consistent allocation of work would assist health care staff in the delivery of a consistent level of services to those inmates in the facilities to which the employees are assigned.

GDC Response: *Authorized staffing patterns vary from one facility to another based upon a myriad of factors. These include facility size, mission, security level, gender, physical plant layout, proximity to other facilities and inmate profile, e.g. age of offenders. As a result, these variables quite often dictate differing staffing patterns at facilities that otherwise appear to be similar. These things being stated, the Department will continue to work to ensure appropriate staffing of all facilities, while addressing both real and perceived inconsistencies.*

A joint task force comprised of OHS and GCHC managers met in May 2004 to review facility staffing patterns, particularly among like institutions, with a goal of correcting inconsistencies in the distribution of personnel. This resulted in a number of recommendations that were adopted and implemented in July 2004.

With regard to facility vacancy rates, the geographic location of GDC institutions along with the disproportionate distribution of the health care work force within the state often results in staffing disparities. The Department has taken steps to address this as

funding has allowed, by increasing salary levels at targeted sites, e.g. sites with pending litigation. This has not been possible at all sites, however, for budgetary reasons.

The GDC Office of Health Services will continue to work with GCHC and the Medical College of Georgia to ensure appropriate and efficient staffing of all facilities.

With regard to dental staffing patterns, these vary, based upon many of the same factors as delineated above. In addition, given the circuit rider system currently employed (for reasons of efficiency), along with the geographic locations of GDC sites, an ideal distribution of dental professionals is not always possible. These things being stated, however, OHS will conduct a review of dental catchment areas and make adjustments where possible to address any misallocation of positions.

As a further measure to address dental staffing, a budget request was prepared and submitted for FY06 to provide additional staffing in select areas of the state. If funded, this request will help address the concerns of how dental personnel are distributed within the correctional system.

Quality Recommendations

Recommendation No. 12

OHS has instituted a number of operational controls to ensure that all inmates have access to a standard quality of health care.

OHS has made a significant effort to ensure that all inmates have access to a standard quality of health care. This effort includes assessing the care delivered by facilities as well as care delivery by individual clinicians. Descriptions of quality control efforts are summarized below. For some of these efforts, additional detail and recommendations for improvements are provided in separate findings to follow.

Standard Operating Procedures (SOPs): OHS has developed

standardized health care policies and procedures to ensure that all facilities provide inmates with a consistent level of access to and quality of care.

Central office OHS physical, dental, and mental health care clinical audits: Periodic clinical audits of facility operations assess the facilities' compliance with SOPs, evaluate the quality of care delivered, and monitor inmates' access to care. Written reports are produced, and facilities are required to submit corrective action plans addressing negative audit findings. (See Recommendations 13, 14, and 16 on pages 49, 51, and 55.)

Self-audits of facility operations: During self-audits, facility staff use central office clinical audit tools to evaluate their own operations and identify areas of needed improvement. Mental health self-audits are to occur at least once a year. The physical health self-audits were instituted in April 2004, and are projected to occur on a monthly basis.

County correctional institution (CCI) reviews: Annually, OHS conducts an administrative review of the health care operations conducted by each of the CCIs. Additional clinical review is conducted when deemed necessary by the administrative reviewers. A written report of findings is provided to the CCI. (See Recommendation 15 on page 52.)

Medical Association of Georgia accreditation: The Medical Association of Georgia (MAG) has a team of reviewers that evaluate state and private prison operations using National Commission on Correctional Health Care standards. An on-site review is conducted once every three years and a paper review is conducted in the intervening years. Once a facility meets all requirements, it receives MAG accreditation.

Review by nationally-recognized experts in correctional health care: GDC annually contracts with nationally-recognized experts to evaluate indicators of the quality of care provided to state inmates and to make recommendations on improvements to the clinical audit tools. (See Recommendation 17 on page 58.)

Continuous Quality Improvement studies: GDC has established Continuous Quality Improvement (CQI) processes for both physical and mental health care. Using topics and tools for evaluation identified at the state level, facilities are to monitor and evaluate the quality and appropriateness of the care they provide on a monthly basis. CQI studies are then reviewed at the state level.

Mortality Review: Following the death of an inmate, OHS conducts a review to ascertain the housing facilities' compliance with OHS standards of care. This process is also used to educate health care staff about trends in and causes of inmate deaths, and to correct any identified deficiencies that may have contributed to the death.

Inmate grievance process: Inmates have access to a grievance/appeals process whereby health care decisions and/or actions can be reviewed and addressed by upper-level OHS staff. If the grievance cannot be resolved to the inmate's satisfaction at the facility level, grievances may be appealed to the Statewide Medical Director, Statewide Dental Supervisor or Statewide Mental Health/Mental Retardation Supervisor, depending on the complaint.

In addition to the controls undertaken by OHS, other GDC offices collaborate in controlling the quality of inmate health.

Private prison contract monitors: Private prison contract monitors are stationed within each of the three private prisons to review all activities on an ongoing basis. Among the areas reviewed are health care operations. The monitors conduct their reviews by interviewing inmates, reviewing paper files, and monitoring the daily work of health care staff.

GDC Facilities Division audits: In conjunction with OHS physical health care clinical audits, the GDC Facilities Division evaluates the interface between security and health care at each audited facility. This review includes such things as: evaluation of inmates' access to health care, the speed of emergency transports, and the

processes used by officers to monitor inmates' use of medication.

As shown in **Exhibit 21**, the quality control measures vary by type of correctional facility. State and private prisons are subject to most of the controls, while county correctional institutions are subject to the least.

Exhibit 21
GDC's Use of Quality Assurance Mechanisms

	Facilities			
Quality Assurance Mechanism	State Prisons	Private Prisons	Probation Detention Centers, Transition Centers, Substance Abuse Treatment Center	County Correctional Institutions
Standard Operating Procedures	●	●	●	●
OHS physical, dental, and mental health care clinical audits	●	●	●	
Self-audits of facility operations	●	●	●	
County correctional institution (CCI) reviews	n/a	n/a	n/a	●
Medical Association of Georgia accreditation	●	●		
Continuous Quality Improvement studies	●	●	●	
Mortality review	●	●	●	●
Inmate grievances permitted	●	●	●	●
Private prison monitors	n/a	●	n/a	n/a
GDC Facilities Division audits	●	●	●	

Source: GDC records and staff interviews

GDC Response: *The Department agrees with this finding and has no further comment.*

Recommendation No. 13

In order to ensure that problems with a correctional facility's provision of health care are identified and corrected in a timely manner, OHS should continue with efforts to increase the frequency of physical health care clinical audits.

Currently, correctional facilities may not receive a physical health care clinical audit for more than two years. As a result, significant problems with the provision of health care at these facilities can occur without detection for extended periods of time. For example, one state prison did not receive an audit from February 2002 to December 2003, a span of 22 months. During that period, the facility developed significant problems, dropping from an overall

passing audit score of 75% to a failing score of around 50%. All areas reviewed showed diminishing performance, including a decline from 77% to 27% in the quality of patient tracking for follow-up treatment/testing and professional consultations.

As of June 2004, 11 facilities had not been audited in at least two years, including four which had not been audited in over three years.

Although OHS's audit schedule for 2004 is more comprehensive than the preceding years', our review found that as of June 2004, 11 facilities had not been audited in at least two years. Of these, four facilities had not been audited in over three years. In addition, 17 probation detention centers and transitional centers, housing approximately 2,744 (5.1%) of the state's 54,042 inmates, have never received a physical health care clinical audit.

When the physical health care clinical audit process was initiated, the goal was to review each facility on an annual basis. OHS personnel attribute the lengthening timeframe to staffing and budget constraints. These factors are consistent with the findings of an OHS external reviewer's concerning the clinical audit process. In June 2002, the reviewer "strongly recommend[ed]… identify[ing] a strategy to expand audit team membership" to address the timeframe, reiterating the same point also made in June 2001, when the lag time between audits was only a year and a half.

It should be noted that in preceding years OHS has requested that GCHC staff conduct separate reviews to evaluate the care provided at facilities OHS did not have the time or staff to audit. In addition, OHS recently began a new facility-level self-auditing process. Although this process is intended to enhance OHS oversight of facility operations, it will not substitute for the more objective OHS physical health care clinical audits. In order to ensure that the GDC standard of care is maintained, and problems with the provision of health care at correctional facilities are identified in a timely manner, OHS should continue its efforts to increase the frequency of physical health care clinical audits.

GDC Response: *The Department agrees with this recommendation and will take steps to acquire the necessary resources to return to annual auditing of all facilities. An option that has been considered is to reduce the scope and resulting time required to*

conduct an audit. This option is not advisable, however, inasmuch as the OHS audit methodology was born out of past litigation. Neither the OHS leadership nor the outside correctional health experts recommend a course that would lower the bar of audits for facilities. Accordingly, OHS will continue to work to obtain personnel to carry out annual audits of all facilities, using the current audit mechanism. With this in mind, a plan will be developed by January 1, 2005, with an implementation date contingent upon the availability of necessary resources.

Recommendation No. 14

OHS should institute a procedure to monitor facilities' implementation of the corrective action plans established following clinical audits.

OHS has no formal procedures for ensuring that facilities initiate corrective action to address negative findings in their physical and mental health care clinical audits. Although each facility is required to submit a corrective action plan addressing the audit findings, there is no mechanism in place to ensure that the plans are implemented. As a result, problems identified during the audit may go uncorrected for extended periods of time.

Our review of a random sample of physical health care clinical audits found that facilities generally maintain or improve their audit scores over time. In some instances, however, significant problems have developed during the intervening time, with audit scores declining. OHS central office staff members overseeing this clinical audit process have agreed that, ideally, OHS would follow up with facilities during implementation of the corrective action plans, but noted that a lack of central office staff hinders implementation of such a process. A recent review of the mental health care corrective action plans by an outside expert also noted that "the effectiveness of the audit process is significantly reduced by the central office being unable to provide regular follow-up on submitted corrective action plans … [due to the] diversion of central office staff to various prisons … to fill vacant [positions]."

Instituting a formal follow-up procedure would ensure that

adequate corrective action plans are both developed and implemented. Formal follow-up also could provide OHS with early indications of further problems with the provision of health care at the facilities. OHS could then provide facilities with systematic direction and insight on how to improve operations. Such direction could help prevent the development of further problems and aid in the development and implementation of effective solutions to issues identified in the audits.

GDC Response: *The Department agrees with this recommendation and will develop a plan to address this finding. This plan will encompass placing greater emphasis on CAPs during monthly Audit Team meetings and further follow-up as may be required in individual cases. Additional resources will be requested as deemed necessary to fully implement this process. Follow-up to mental health audits and resulting CAPs will be handled similarly.*

Recommendation No. 15

The review process used to evaluate physical health care services provided to state inmates in county correctional institutions (CCIs) should be expanded to include clinical reviews and a requirement that corrective action plans be submitted by the CCIs. In addition, the review process and reporting structure should be standardized to ensure consistent review.

Since January 2002, OHS has conducted annual on-site reviews of medical services provided by each of the 24 CCIs. However, unlike the physical health care clinical audits conducted by OHS for state and private facilities, the CCI reviews do not contain a clinical component and do not require facilities to submit written corrective action plans. As a result, OHS does not have assurance that these facilities are meeting OHS standards of care or that necessary improvements in the administration of health care are made. In addition, the CCI review tool provides only general guidance, leaving each reviewer to determine the best evaluation method. The specificity of reporting also varies by reviewer and is significantly less descriptive than OHS audit reports. Consequently, the CCI review reports are much less useful for the

facilities and are insufficient for OHS to trend and monitor the quality of operations. These points are discussed in more detail below.

Lack of Clinical Reviews

CCI reviews are largely limited to administrative activities and non-clinical operating procedures. This is because the reviews are conducted separately by the OHS Health Services Administrator and the Statewide Dental Supervisor who, because of their qualifications, cannot review clinical activity.[4] If the reviewers suspect that there may be problems with the clinical quality of health care provided, they can request that the physical health care clinical audit team evaluate the facility as well. However, because the CCI reviewers lack the expertise to evaluate clinical care, this method of detecting potential problems with the quality of care is questionable.

It should be noted that when the CCI reviewers have requested that a clinical audit be conducted, the clinical auditors have detected problems. For example, one CCI had a clinical review conducted in May 2003. This review found physicians omitting key clinical data from inmate progress notes and neglecting the charting of follow-up care. If evaluation of clinical quality had been a regular part of the CCI review, these problems could have been detected and addressed earlier. Without regular clinical review of the CCIs, OHS has little assurance that they are meeting GDC standards for health care.

Lack of Corrective Action Plans

While OHS requires each facility that undergoes a clinical audit to submit a corrective action plan addressing audit findings and recommendations, current OHS practices do not require the CCIs to provide a similar response or plan of corrective action following health care reviews. As a result, OHS has no assurance that the CCIs take corrective action.

[4] The Statewide Dental Supervisor is qualified through his doctorate of dentistry to review a limited degree of the clinical activity, but does not routinely do so during the CCI reviews.

Lack of Evaluation and Reporting Standards

The CCI review tool contains no clear standards for evaluation, only general descriptions of the areas to be reviewed. For example, the review tool indicates the following regarding inmate orientation and intra-system transfer:

1) *Orientation procedure in place*
2) *Intra-system Transfer Form is used for initial screening and documentation of continuity of health care*

There is no indication of which files or logs, or how many of them, should be reviewed to conduct the evaluation. As a result, each reviewer must decide how he will evaluate the subject matter. This difference is reflected in the audit reports. For example, one reviewer reported that "of 9 charts reviewed, 9 (or 100%) contained documentation of the intra-system transfer." Another reported stated that "the Intra System [Transfer] Form is being used." There is no indication of how the latter reviewer conducted his evaluation.

In addition, through a review of the 48 audit reports from 2002 and 2003, it was determined that there are significant differences in reporting. Some review reports contain details on all areas listed in the review tool, while others contain limited information, without mention of whether or not other review areas were evaluated. Standardized reporting criteria would provide documentation that audit objectives were followed, and would provide for greater efficiency in conducting follow-up reviews and data trending and analysis.

In order to ensure that state inmates held in county correctional institutions are receiving health care that meets GDC standards, and that problems are detected and addressed as early as possible, OHS should adopt a process whereby CCIs undergo regular clinical review and standard criteria are used for evaluation. CCIs should then be required to submit to OHS corrective action plans, which OHS can use to evaluate improvements and negotiate improvement plans. Finally, action should be taken to improve the quality and consistency of the review reports in order to provide

the facilities with more complete information and to provide OHS with a standard for trending performance data.

GDC Response: *The Department does not disagree with this finding and will reassess the approach to CCI audits in order to introduce a clinical component to the process. Audits of CCIs were begun in 2001 in the manner described by DOAA in an attempt to provide some OHS oversight of CCI operations whereas previously there had been none. While progress has been made in the last 3 years, it is recognized that additional steps are necessary to bring CCI audits in line with the audit process for GDC sites. Accordingly, OHS will develop a plan for auditing CCIs to include the clinical component, requesting additional resources if necessary, to carry this out. This plan will be developed by January 1, 2005 for an implementation date contingent upon available resources. Further, this plan will incorporate a standard audit methodology, along with requiring corrective action plans.*

Recommendation No. 16

In order to more effectively review and manage the delivery of health care, OHS should consider analyzing additional existing data such as health care-related grievances, lawsuits, physical health clinical audit scores, and dental treatment data.

Although OHS has instituted a number of controls to monitor the quality of health care provided to inmates, OHS has additional sources of quality-indicator data that could be used to identify both potential problems and possible efficiencies in the delivery of health care. Health care-related grievances, lawsuits, physical health clinical audit scores, and dental treatment data should all be analyzed to improve the health care system.

Health-Care Related Grievances

OHS should analyze all health care-related grievances filed by inmates in order to identify potential problems with correctional facilities' provision of care. Currently, there is no process in place for GDC to trend this data, and OHS management only reviews grievances appealed to the state level. The volume of inmate grievances regarding health care – and particularly changes in the

volume of grievances at certain facilities – can indicate weaknesses in the quality of care provided, even if the grievances are adequately addressed at the facility level. In addition, trends in the subject of grievances may provide indicators of specific problems within a facility or developing problems across all facilities.

Only appealed grievances receive any central office staff review, leaving more than 3,500 grievances (or 65% of the total) to be addressed at the facility level without additional OHS oversight or analysis.

Our review found that the number of grievances filed increased from 90 per 1,000 inmates in 2001 to 116 per 1,000 inmates in 2003, a 29% increase. Significant increases were noted at certain facilities. For example, from 2002 to 2003, Autry State Prison mental health services grievances increased 633% (from 3 to 22 per 1,000 inmates) and Valdosta State Prison grievances increased 310% (from 10 to 41 per 1,000 inmates). Both facilities failed their fiscal year 2003 and fiscal year 2004 clinical audits, indicating that grievances may serve as an indicator of weaknesses in the health care system.

Lawsuits

In order to identify potential problems indicated by the filing or notification of intent to file a lawsuit by an inmate or other party, OHS should establish a formal notification process with the Department of Administrative Services and the Office of the Attorney General. Currently, there is no formal process whereby OHS will be notified that a health care-related lawsuit will be or has been filed. Unless OHS receives a request for information from attorneys working on the case, or the outcome of the case requires corrective action on the part of OHS, the case may be settled or adjudicated without OHS receiving formal notification. Inmates' filing of or notice of intent to file a lawsuit regarding his/her health care may indicate problems with the quality of care provided at his or her facility. Although these claims are often unsubstantiated, they can be indicators of real problems in the system of care.

The Department of Administrative Services (DOAS) may receive notice from an inmate that he/she intends to file a lawsuit related to the provision of health care and settle the case with the inmate without OHS ever knowing the complaint existed.

Physical Health Care Clinical Audit Scores

In order to better identify persistent problems within a facility and developing problems across all facilities, OHS should trend and analyze facilities' physical health care clinical audit scores. Physical and mental health care clinical audits provide numerical scores for many evaluation criteria. Although the mental health

care program trends much of the mental health clinical audit data, the physical health care audit scores currently are not trended or analyzed. By evaluating changes in audit scores over time and across facilities, management could identify problem facilities, problem areas within a facility, and problem areas across all facilities. This data also could help OHS to provide facilities with benchmarks for performance. OHS management overseeing the physical health care clinical audit process has agreed that trending this data could be beneficial for managerial oversight.

Dental Treatment Data

In order to better evaluate dental care provided across all facilities, OHS should improve data collection and monitoring. Although OHS has developed a reporting mechanism whereby dental providers submit information on the procedures performed and the number of patients seen, this information is not consistently submitted by facilities, or consistently collated for comparison. For example, when 2003 activity data was requested by the audit team in April 2004, OHS management reported that it had not been retained. In addition, data for January to March 2004 was incomplete, with activity data from numerous facilities missing.

As noted in previous recommendations, OHS has instituted a number of controls to monitor the quality of health care provided at facilities and to regulate the manners in which that care is provided. However, by also implementing additional performance monitoring activities, OHS could better identify potential strengths and weaknesses in the quality of health care provided to inmates.

GDC Response: *The Department agrees with this finding except for the recommendation to review <u>all</u> grievances, including the more than 3,500 grievances currently addressed at the facility level. Inmates whose grievances are not handled to their satisfaction at the facility level, have the opportunity to appeal. These appeals are all reviewed by staff of the Office of Health Services. Further, inmates have multiple other opportunities to express their concerns and complaints, as evidenced by the more than 1,500 such contacts that OHS responds to each year.*

Reviewing an additional 3,500 grievances each year (most of which were presumably successfully resolved) would be neither efficient nor productive. OHS personnel would be much better advised to spend such time in other risk management activities.

The above notwithstanding, the Office of Health Services initiated a statewide CQI study of inmate grievances at the facility level in the second quarter of FY04. Results were tabulated by GCHC Regional Managers. A more focused follow-up study will be conducted in FY05.

With regard to the other recommendations growing out of this finding, OHS will pursue the development of a plan to track and report all risk management indicators to appropriate personnel in the interest of strengthening OHS oversight of inmate health care delivery. At present, the audit database contains several years of facility scores. Trending and analysis can be initiated through queries, reports and graphs. OHS will continue such initiatives in the interest of addressing this recommendation.

Recommendation No. 17

OHS should be commended for its efforts to regularly review the effectiveness and operations of its quality control measures.

Since 1999, OHS annually has contracted with nationally recognized experts in both mental and physical correctional health care to review its clinical audit tools and evaluate indicators of the quality of care provided to state inmates. Both expert reviewers regularly compliment the work of GDC in managing the provision of health care. Our review of their reports and OHS's formal responses to them also indicate that these experts' recommendations are given serious consideration by OHS and are actively addressed. For example, one reviewer recently recommended that OHS expand its review of patient treatment outcomes. In response, OHS developed a new review process that will expand this portion of the physical health care clinical audit. OHS should be commended for its continued efforts to improve the clinical auditing processes and to evaluate its effectiveness and quality assurance procedures.

GDC Response: *The Department acknowledges this finding and has no further comment.*

Recommendation No. 18

A significant percentage of inmates' appointments with medical specialists occur outside OHS's required timeframe. This includes approximately 30% of appointments designated as "urgent" by a facility physician.

Inmates' appointments with specialists are frequently outside GDC's required timeframes of 10 days after UM approval for urgent cases and 60 days for routine cases. Delays in appointments can result in an inmate's health condition deteriorating, which may lead to more costly care and increased liability to the state.

GDC analysis of specialty appointments requested between December 2003 and May 2004 shows that significant percentages of urgent and routine requests had corresponding appointments that were not in compliance with the agency's established timeframes (see **Exhibit 22**). This was the case with both initial and follow-up appointments.

Exhibit 22
Specialty Appointments Out of Compliance

	May 2003	May 2004
Routine Initial	24.3%	22.4%
Routine Follow-up (1)	32.9%	30.0%
Urgent Initial	45.6%	30.8%
Urgent Follow-up	52.6%	33.4%

(1) The percentage of routine follow-up appointments out of compliance is inflated. If a specialist requests a follow-up appointment in six months and the inmate's home facility enters the request immediately after the initial appointment, an appointment scheduled at the correct interval would appear out of compliance. This is because more than 60 days elapse between the request and appointment dates.

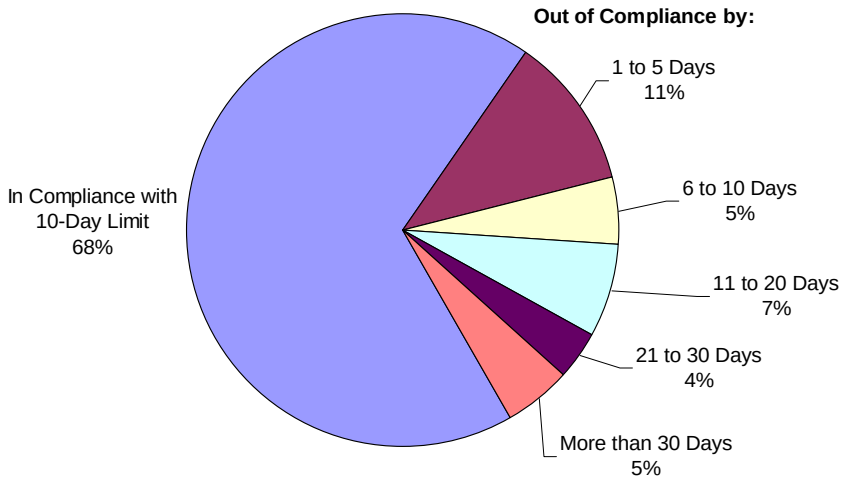
Source: GDC Analysis

Our review of GDC data showed that 21% of urgent appointments occurred more than five days after the required 10-day timeframe. As shown in **Exhibit 23** on the following page, approximately 5% of urgent appointments occurred more than 30 days out of compliance. Among the longest delays between UM approval of

the urgent appointment and the actual appointment date include:

- 132 days for a cardiology appointment
- 103 days for an infectious disease appointment
- 92 days for a neurology appointment
- 77 days for a liver biopsy appointment
- 50 days for an oncology appointment

Exhibit 23
Timeframe for Urgent Appointments



Source: GDC records

The delays are the result of numerous factors, such as the volume and growth in specialty appointment requests, cancelled clinics, and clinics in which all contracted slots are not used.

Volume – In fiscal year 2004, an average of 2,700 requests were approved by UM each month, with approximately 1,700 approved for services at ASMP. GCHC officials indicated that the number of specialist appointments has recently increased 10% to 15% annually, resulting in a strain on the limited clinical space at ASMP, an increase in the number of approved appointments with local providers, and an increase in the number of specialty clinics offered in GDC facilities other than ASMP.

Cancelled Clinics – Since numerous inmates see specialists during one clinic, a scheduled clinic cancelled for any reason (e.g.,

Specialty Clinics

GCHC contracts with specialists to provide a certain number of clinics per month, during which an agreed-upon number of inmates will be seen. For example, during FY03 a urologist contracted to provide four clinics a month with 22 inmates per clinic. The physician was paid a flat rate of $1,250 per clinic, which results in a cost of $56.82 per inmate.

provider unavailability due to medical emergency) results in a significant number of inmates needing to be rescheduled. The rescheduled appointment is nearly always outside GDC's timeframe. A review of a sample of inmates scheduled for clinics cancelled between October 2003 and March 2004 showed that 64 of 70 (91%) had appointments out of compliance with GDC policy. In three cases, the delay was increased because the inmate's home facility was unaware that the clinic had been cancelled and did not immediately request a rescheduled appointment. In these cases, the home facility "closed out" the appointment request, mistakenly thinking the inmate had been seen.

Use of Clinic Slots – The number of inmates seen during a specialty clinic is sometimes less than the number of appointment slots contracted for by GCHC. This can be the result of GCHC not scheduling all of the slots or inmates refusing to go to an appointment. A targeted review of February 2004 appointments at ASMP in four specialties showed that for two of the specialties, a significant percentage of the contracted slots were not utilized.

- Two endocrinology clinics with a total capacity of 28 inmates were held during the month. Only 17 inmates were scheduled (61% of capacity) and 15 actually seen (54% of capacity). GDC's study of noncompliance showed that 22% of endocrinology appointments were scheduled outside the required timeframe.

- Sixteen infectious disease clinics with a total capacity of 220 were held during the month. Only 96 inmates were scheduled (44% of capacity) and 85 actually seen (39% of capacity). GDC data indicates that 25% of infectious disease appointments were scheduled outside the required timeframe.

In addition to delaying appointments, when contracted slots are not fully utilized, the cost per inmate is higher than the expected rate. During the month reviewed, the actual cost per inmate seeing the endocrinologist was $106.67 versus the contracted rate of $57.14. For infectious disease, the actual cost was nearly $132 versus the average contracted rate of $51.

While GCHC officials have reduced the percentage of

appointments out of compliance, OHS and GCHC should continue to work to ensure that specialty appointments occur within GDC's required timeframe. Several steps that could be taken include:

- OHS determination of whether appointments for all specialties should be subject to the same 10-day and 60-day timeframes;

- OHS evaluation of whether GCHC is effectively using contracted slots;

- Periodic comparison of contracted slots to appointments needed for each specialty to ensure that GCHC is contracting for and scheduling enough slots per specialty; and,

- Review of procedures for an inmate's home facility to close out an appointment request and request a new appointment after a cancelled clinic.

GDC Response: *The Department recognizes this finding, having worked for a number of months on a plan to address this problem. This is evidenced by the reduction in the number of appointments that are outside the established timeframes. Even so, OHS will continue to work aggressively to address this issue. A joint OHS/GCHC committee is currently working on a plan to address the current pending cases that are outside the timeframes of the Scope of Services. OHS will continue to take steps as necessary to achieve full compliance with established clinical guidelines.*

With regard to specialty clinic utilization, in August 2004, GDC contracted with Barrell and Associates, Inc., an outside correctional health care consulting firm, to study the efficiency of clinic operations at ASMP. The goal is to determine current clinic capacity by specialty and to identify barriers to optimal clinic productivity. Study results are expected in November 2004. With this outside assessment of ASMP operations, OHS will work with GCHC to achieve maximum efficiency from existing services while expanding clinic capacity as necessary to meet demand.

Utilization Management (UM)

UM is a common cost-containment method used by public and private insurance plans. GDC's UM Office:

- Evaluates necessity and appropriateness of various health services
- Approves or denies hospital stays and requests for specialist appointments made by GCHC physicians
- Determines if inmate will be seen in-person during a GCHC specialty clinic, through telemedicine, or by a local provider
- Manages infirmary bed space
- Consists of a UM medical director and five nurses
- Is operated by MHM

Recommendation No. 19

OHS should strengthen the Utilization Management program by eliminating unauthorized medical consultations and clarifying Utilization Management's role in selecting the service delivery location.

While Utilization Management (UM) is intended to ensure that requests for specialty appointments are appropriate and necessary, this control is being bypassed by facility health care staff and the GCHC Scheduling Office. Facility health care staff send inmates to local specialists without UM approval, while GCHC Scheduling Office personnel change the location where the service will be provided without consulting UM.

Unauthorized Specialist Appointments

Facility personnel are sending inmates to local specialists without UM approval. After the appointment, UM is asked for an approval number that allows payment of the provider's claim. Ordinarily, approval numbers are assigned before the appointment, when UM issues its approval. Although the number of these occurrences could not be determined, UM personnel stated that it was a frequent occurrence.

Unauthorized Service Delivery Location

The GCHC Scheduling Office changes the service delivery location (i.e., Augusta State Medical Prison, telemedicine, local provider) without notifying UM. According to UM staff, the decision to approve a consultation request and service delivery location is based on a review of the urgency of the medical condition, ASMP availability, and the cost of security and transportation. GCHC scheduling personnel stated changes are made since UM may not have all relevant information when selecting a service delivery location. For example, UM may specify a delivery location of telemedicine, but telemedicine is not available for the specialty requested or within GDC's required timeframe.

OHS and UM should work to eliminate unapproved local specialist appointments. In order to prevent GCHC's unauthorized changes to the service delivery location, OHS should either ensure that UM

has all of the relevant information to make the proper decision or transfer responsibility for selecting the service delivery location to GCHC.

GDC Response: *The Department agrees with this finding and resulting recommendation. As stated previously under Recommendation 8, OHS is currently in process of rebidding a number of services, including Utilization Management. As currently drafted, this Request for Quote (RFQ) will tighten up the UM approval and scheduling process. Appointment scheduling itself will become an integral part of UM, unlike the current model that has scheduling as an independent function. As recommended, OHS will continue to work with UM to eliminate both unauthorized specialty appointments and unauthorized service locations.*

Recommendation No. 20

OHS should institute an oversight process to ensure that Utilization Management is operating as intended.

Although UM plays a critical role in granting or denying inmates access to specialist care, OHS has not developed a comprehensive review process to determine if approvals and denials of consultation requests are appropriate. A review process of UM would assist OHS in monitoring the performance of the vendor operating the program, ensure that UM decisions are clinically appropriate, and help identify any facility staff training needs.

Since UM reviewed more than 33,000 requests for specialist appointments in fiscal year 2004, the potential medical and financial impact of improper decisions is significant. Necessary services can be improperly denied or unnecessary services approved. In fact, GCHC officials and their contracted specialist physicians have stated that UM has approved inmates for specialty services that should have been denied. The risk involved with UM, as well as the fact that its operation is contracted to MHM, makes it necessary for OHS to provide clinical and contract oversight.

A review of UM would allow OHS to assess the performance of facility medical personnel as well. UM officials stated that the

information provided by facility physicians is frequently insufficient in order to make an informed decision, requiring UM to request additional information from facility medical personnel. Results of the review would assist OHS in developing training for facility medical personnel on the information necessary for an appointment request and in assessing whether facility medical personnel have attempted all clinically appropriate treatments before making a specialist appointment request.

Since GDC is ultimately responsible for the medical care delivered to inmates, OHS should implement a review process to ensure that the UM contractor is properly approving and denying specialty appointment requests.

GDC Response: *The Department acknowledges this recommendation and will take steps to determine what level of review is considered to be the industry standard. At present, the Department is not aware of such a standard. Once determined, however, the Department will develop a plan to be consistent with this standard.*

Recommendation No. 21

Action should be taken by OHS to ensure that a consistent level of dental care is provided to all inmates.

The level of dental care provided by individual practitioners can vary greatly across facilities. GDC Standard Operating Procedures provide for both *routine restorative procedures* (i.e., fillings) and *routine dental extractions*. However, dental activity data[5] indicates that from January to March 2004, the ratio of fillings to extractions conducted by each dental provider ranged from 1:1 to 1:31. Program management largely attributes these differences to "professional judgment." However, a medical expert who consults with OHS stated that reviewing the ratio of fillings to extractions is a useful method for identifying problems at individual facilities, indicating that less variation in the ratios across facilities is desirable.

[5] Activity data was not uniformly available for all providers or facilities.

In addition, Program policy states that dental cleanings "may be made available on a schedule deemed appropriate by the [facility] dentist." According to OHS management, inmates must request a dental cleaning and be placed on a waiting list to receive the service. The waiting time can vary from six to 18 months, depending on staff availability.[6] Cleanings are rarely offered to inmates at the 44 facilities served by a dentist without a hygienist. These facilities house 25,396 inmates, or 61% of the inmates in GDC facilities.

Finally, a medical expert who consults with OHS recently stated that the conservative nature of GDC's dental program is of concern. Advocacy groups also have expressed concern regarding the level of dental health care GDC provides, citing the growing number of inmate grievances regarding their care. Our analysis also found that the number of dental health care-related grievances filed per inmate increased by 100% between 2001 and 2003 (from 3 to 6 per 1,000 inmates).

These factors point to current and potentially growing disparities among the level of care provided to inmates at different facilities. In order to ensure that a consistent level of quality health care is provided to inmates, OHS should closely monitor the work of the dental staff and the level of care inmates are receiving.

GDC Response: *The Department will address this finding, recognizing that staffing shortages do pose a major obstacle to service delivery. Even so, the Department will conduct a comprehensive study of dental services with a goal to eliminate disparities or inconsistencies in the levels of care offered. This review will consist of an analysis of the current dental catchment areas, working towards a plan that will distribute dental staffing resources more equitably throughout the correctional system.*

It should be noted that during dental audits throughout the year, all the services provided were found to be clinically indicated.

[6] Waiting lists maintained at the facilities were not reviewed during the audit and no centralized data on waiting lists is maintained.

Further, inmates with urgent dental problems may be transferred to a neighboring facility to access care when needed. OHS is not convinced that the ratio of restorations to extractions is a valid indicator of the level of dental services. This being stated, the Dental Director for the Department will explore productivity indicators that might serve the intended purpose.

Health Care Infrastructure Recommendations

Recommendation No. 22

GDC will require additional medical beds for male inmates in order to accommodate an increasing and aging population.

GDC's current medical bed space is nearing capacity. ASMP's unit for long-term care is consistently full, which contributes to higher occupancy rates in the infirmaries. As the inmate population continues to grow and age, there is likely to be an increase in the number of days that no infirmary beds are available, which could lead to the unnecessary use and expense of hospitals.

Medical Beds

- As of April 2004, GDC had 391 medical beds of various types.
- Beds are located at the Augusta State Medical Prison and in infirmaries at other state prisons.
- See **Appendix D** on page 87 for a description of each type of medical bed.

Our review of medical bed space indicated a shortage of beds in ASMP's Assisted Living Level 2 Unit and a future shortage of beds in male state prison infirmaries. There does not appear to be a shortage of medical beds for female inmates.

ASMP's Assisted Living Level 2 Unit

ASMP has a 20-bed Assisted Living Level 2 unit for inmates needing long-term care similar to that provided in a nursing home setting. During February through April 2004, the unit was consistently full, with a 98% occupancy rate. All 20 beds were occupied for 47 of 63 weekdays (75%) and were at least 85% every weekday. Since the unit is operating at capacity, long-term care inmates also are being housed in state prison infirmaries.

Long-Term Care Inmates

- Often have a serious, irreversible illness and require constant medical care.
- Require care similar to that provided in a nursing home setting.

Infirmaries in GDC Facilities

While infirmaries are capable of providing care to inmates with various health care needs, they are commonly used to provide short-term care to inmates with an illness or injury from which the inmate should recover. Inmates are also discharged from local

hospitals and housed in infirmaries for continued recovery.

Our review of male infirmaries indicated that a significant number of beds are occupied by inmates who are not being treated for short-term problems. These include long-term care and wheelchair-bound inmates. As the population continues to grow, housing these inmates in infirmaries will make it increasingly difficult to find beds for inmates with short-term illnesses or inmates needing to be discharged from the hospital.

Of the 95 infirmary beds, 41 (43%) were occupied by long-term care inmates and wheelchair-bound inmates in May 2004. Ideally, less than one-third of infirmary beds should be occupied by these types of inmates, according to personnel responsible for managing infirmary bed space.

While the overall occupancy rate from February to April 2004 was 83%, several infirmaries have limited remaining capacity. As shown in **Exhibit 24**, seven of 10 facilities were more than 85% occupied and some infirmaries had a significant number of days with no available beds. For example, Macon State Prison had no available beds for 66.7% of the 63 days reviewed and Georgia State Prison had no available beds 55.6% of the time.

Wheelchair-Bound Inmates

- Not in need of 24-hour nursing care but may need limited assistance with basic living needs.
- May be housed in infirmaries due to assignment to a non-wheelchair accessible facility.

Exhibit 24
Occupancy of Male State Prison Infirmaries
February – April 2004

State Prison	Number of Beds	Occupancy Rate	Number of Days (63 Total)	
			100% Occupied	At Least 80% Occupied
Lee Arrendale SP	12	94.8%	31 (49.2%)	63 (100%)
Georgia SP	11	93.8%	35 (55.6%)	60 (95.2%)
Macon SP	8	92.1%	42 (66.7%)	53 (84.1%)
Phillips SP	7	89.1%	30 (47.6%)	54 (85.7%)
GDCP	13	88.6%	23 (36.5%)	46 (73.0%)
Ware SP	12	86.6%	22 (34.9%)	47 (74.6%)
Valdosta SP	7	85.9%	22 (34.9%)	44 (69.8%)
Hays SP	9	68.7%	6 (9.5%)	16 (25.4%)
Baldwin SP	12	60.7%	4 (6.3%)	15 (23.8%)
Calhoun SP	4	50.0%	12 (19.0%)	12 (19.0%)
TOTAL	**95**	**83.0%**	**0 (0%)**	**46 (73%)**

Source: MHM Utilization Management Records

Growing and Aging Population

Any remaining medical bed capacity is likely to be eliminated by the growth and aging of the inmate population. From 2004 to 2009, GDC projects the inmate population to increase 14% and the number of inmates age 50 and older to increase 39%. As expected, the older inmates are much more likely to need a medical bed.

If medical bed space is not increased to account for the changing population, it is likely that additional hospital days will eventually result because inmates currently admitted to infirmaries for monitoring would be sent to local hospitals instead. Additionally, inmates now discharged from a local hospital and temporarily housed in an infirmary would likely stay in the hospital for additional days.

GDC should consider a number of options for expanding medical bed space. In doing so, consideration should be given to the impact that increasing one type of medical bed space would have on another type. For example, the creation of a long-term care facility would impact both ASMP and the infirmaries. ASMP's Assisted Living Level 2 Unit could be eliminated and that bed space used for another purpose. The occupancy rate of the infirmaries would also be reduced, delaying the need for additional infirmary beds.

GDC Response: *The Department agrees with this finding and resulting recommendations, sharing the concern of DOAA that there be sufficient specialized medical bed space to meet future demand. Accordingly, a number of steps have been taken to address these concerns:*

- *All medical bed space has been brought under the oversight of UM, to include ASMP acute care beds, transient beds and regional infirmary beds statewide. The goal is to ensure appropriate assignment along with a length of stay that is as long as is medically necessary, but not longer than needed to ensure efficient use of all medical beds.*

- *A budget request has been developed and submitted to convert the Culver Kidd Hospital on the grounds of Central State*

Hospital into a chronic care facility for inmates. The number and types of beds will be determined after further study, but would most certainly include Assisted Living Levels I and II, along with additional infirmary beds.

- *In concert with the above, a Request For Information (RFI) has been posted on the DOAS website, requesting information from prospective contractors to take an existing state facility and convert it to chronic care use. The due date for responses is December 3, 2004.*

- *As an option to the above, the Department has developed a plan that would call for the construction of a 150 bed chronic care facility on the grounds of Central State Prison in Macon, GA.*

- *A 16 bed infirmary is currently under construction at Coastal State Prison, which will add an important resource to the facilities in the SE Region.*

- *Funding has been allocated in FY05 to expand the infirmary at Autry State Prison, adding critical medical bed space to the SW Region.*

- *The GDC standard operating procedure governing infirmary care is currently being revised to upgrade and standardize the level of care provided by regional infirmaries. This is to enhance this valuable resource, enabling the Department to realize maximum benefit from the use of these beds.*

As these and other plans evolve, the Department will continue to work vigorously to meet the demand for specialized medical bed space. GDC regards health care delivery as a continuum of care, from infirmary level care at the local facility to the highest level of care, or acute care at an outside hospital. Medical bed space is an expensive commodity within the correctional system and GDC will continue to work to ensure that all medical bed space is used efficiently. Further, GDC will continue to develop plans as needed to extend the life of its existing infrastructure while ensuring that future bed space is sufficient to meet the demands of an aging inmate population.

Medical Transients

Medical transient inmates are at ASMP for medical procedures or testing that require more than one day to complete or that will prevent them from traveling following the appointment. Medical transient inmates should arrive at ASMP one day, have a medical appoint-ment within a day or two, and then return to their home facility a few days later.

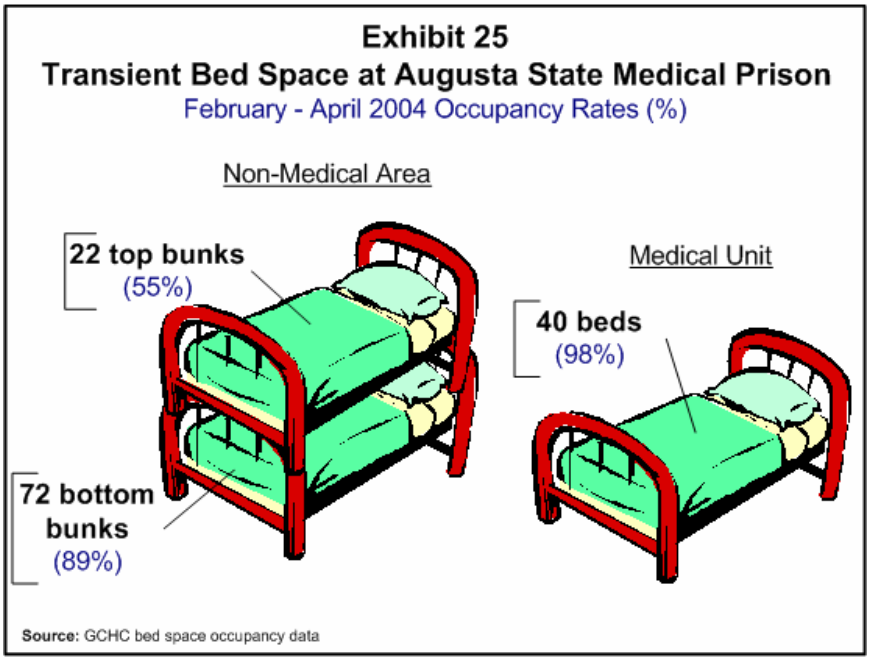
Recommendation No. 23

GDC should continue working to reduce the length of stay for medical transients at Augusta State Medical Prison (ASMP). Once the length of stay is reduced, GDC should assess the number of medical transient beds needed.

Medical transient beds are for inmates who require housing at ASMP for a short period of time – always less than 30 days and typically just a few days. Our review of ASMP bed space indicated a shortage of medical transient beds, which requires some inmates and transport officers to make lengthy trips to and from ASMP in a single day. This method of travel is more costly than the alternative method of transportation, a regularly scheduled GDC bus. This bed space shortage is worsened by the assignment of inmates to transient beds for extended lengths of stay.

ASMP has 134 medical transient beds located in the medical unit and in a non-medical area as shown in **Exhibit 25**. The severity of an inmate's medical condition determines the location and bed type that can be used. Sicker inmates require regular beds or bottom bunks.

Exhibit 25
Transient Bed Space at Augusta State Medical Prison
February - April 2004 Occupancy Rates (%)



Source: GCHC bed space occupancy data

As indicated in **Exhibit 25**, ASMP's transient medical unit beds and bottom bunks are near capacity. From February to April 2004, GCHC reports indicate that all 40 medical unit beds were occupied

31 of 63 days, with an average occupancy rate of 98%. Reports also indicate that the remaining 72 bottom bunks were 89% occupied.

One reason for the high occupancy rate is the extended average length of stay for inmates in transient beds. While transient inmates should not be at AMSP for more than 30 days, nearly 45% of the 38 inmates housed in the medical unit transient beds on April 22, 2004 had been there for more than 30 days. Five had been there for more than 100 days, including one for nearly five years.

GDC is aware of the extended length of stay for medical transients and has begun to develop solutions to address this problem. Once the average length of stay is sufficiently reduced, GDC should determine whether additional transient beds are needed.

GDC Response: *The Department agrees with this finding and recommendation and will take steps to address this issue. The efficient utilization of medical bed space at ASMP is essential to making optimal use of this resource and to reduce the number of correctional officer transports. In this regard, a bed space and clinic tracking system has been implemented at ASMP for purposes of improving efficiency and reducing the length of stay in transient beds. GDC, in concert with GCHC will continue to monitor length of stay at ASMP and will work with the Corrections Division on the most efficient approach to medical transportation.*

Recommendation No. 24

In order to serve GDC's growing mental health population, additional male Supportive Living Units (SLU) and Crisis Stabilization Units (CSU) will be required.

GDC's male Supportive Living Units (SLU) and Crisis Stabilization Units (CSU) are near capacity. As a result, additional bed space will be required to service the growing mental health population. The lack of flexibility caused by high occupancy rates can result in inmates being housed in inappropriate settings.

Supportive Living Unit (Level III and IV)

- Special housing for seriously mentally ill inmates unable to live in the general inmate population
- House Level III and Level IV inmates, usually separately
- Male – 1,545 Level III beds (11 prisons) and 307 Level IV beds (three prisons)
- Female – 119 Level III beds (two prisons) and 25 Level IV beds (one prison)

Crisis Stabilization Unit (Level V)

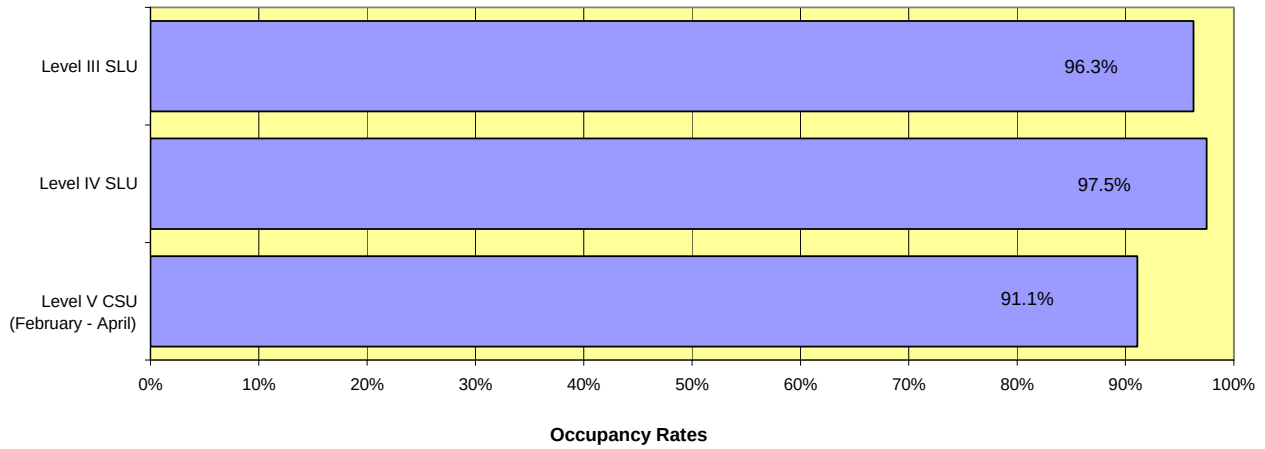
- Bed in an infirmary setting for an inmate suffering from a mental health crisis and in need of 24-hour health care
- Male – 34 beds (seven prisons)
- Female – 3 beds (one prison)

Lack of bed space for one mental health classification can impact available bed space for other classifications. If an inmate's mental health classification changes, the inmate's bed should be changed to one that corresponds to the new classification. Because of this movement within the system, a shortage of bed space at any level impacts the others. For example, if an inmate's classification changes from Level IV to III and Level III beds are unavailable, the inmate will continue to occupy the Level IV bed.

Flexibility in bed space also is necessary due to various security and physical health factors that limit the facilities where an inmate may be housed. For example, while GDC has 11 male prisons with Level III beds, only four of those facilities can accommodate wheelchair-bound inmates. When other factors such as the inmate's security level (medium, maximum, etc.), known enemies, gang affiliations, and other physical health problems are considered, the number of appropriate facilities is further reduced.

A review of the occupancy rates of Level III and Level IV SLUs and Level V CSUs indicated limited availability of male beds and no shortage of female beds. As shown in **Exhibit 26**, each category's occupancy rate exceeded 90% for the time periods reviewed. Additionally, male CSU beds were fully occupied on 9

Exhibit 26
Occupancy Rates of Male SLU/CSU Beds
May 2004



Note: The occupancy rates do not include Georgia State Prison's Level III and IV SLUs. GSP's mission includes housing inmates that had disciplinary problems in other GDC facilities. For this reason, the SLU beds are not available for any Level III or IV inmate.

Source: GDC Records

(14%) of 64 days reviewed and were at least 80% occupied on 60 of 64 days (93.8%). The occupancy rates are cumulative for all male units. Individual units may have higher or lower occupancy rates.

The high occupancy rates and generally tight bed space in the GDC system have contributed to problems with the placement of mental health inmates. The following bed space management problems were noted:

- According to GDC's Statewide Mental Health/Mental Retardation Supervisor, in June 2004 there were an estimated 60 inmates or detainees whose mental health classification had been decreased to Level II but who still remained in an SLU bed. These inmates were continuing to occupy SLU beds because there were no available general population beds in facilities capable of handling their security and mental health levels.

- According to GDC records, in early June 2004 there were approximately 90 inmates classified as Level III or Level IV in a diagnostic facility awaiting transfer to another prison.

- Male inmates remain in CSU beds after their crisis has ended due to a lack of SLU bed space. CSU beds were occupied 9% of the time by inmates who had been discharged from the CSU.

- According to a June 2004 memo from the Department of Human Resources to GDC, Level VI inmates temporarily housed at Central State Hospital remain an average of 10 days after discharge. GDC officials stated that they are frequently waiting for an SLU bed to open before the inmate can be moved.

GDC officials have determined that additional mental health bed space is needed and intend to request additional funding. While additional bed space is reasonable given the current caseload and expected growth, officials should be aware that even though the mental health caseload has grown 26% since the beginning of fiscal year 2002, the growth has not been nearly as significant for the Level III and Level IV inmates that utilize SLU and CSU beds. The Level III male population has grown by 10.3% during the

period, but the Level IV male population has been relatively stable.

When requesting additional SLU and CSU beds, GDC also should consider the number of inmates housed in these beds inappropriately and the impact that an increase in one type will have on the others. For instance, an increase in SLU beds will free those CSU beds currently occupied by discharged inmates awaiting an SLU bed. For this reason, it may not be necessary to increase all types of mental health beds at one time.

GDC Response: *The Department agrees with this recommendation. Accordingly, GDC has prepared and submitted an FY06 budget request to fund resources necessary for the expansion of mental health beds within the system. In addition, the appropriate use of mental health bed space is essential to achieving efficient use of available beds. The utilization management of MH/MR caseloads through MHM is an important part of this process. This requirement has been built into the aforementioned RFQ for mental health services in greater detail. The goal is to ensure that the assignment of MH/MR inmates to mental health beds is consistent with the level of pathology and in keeping with clinical integrity.*

Recommendation No. 25

Since GDC currently has a largely paper-based health care information system, it should continue to pursue the use of electronic systems to increase efficiency.

GDC's health care information system is paper-based and requires facility providers to spend a significant amount of time completing paperwork. During visits to correctional facilities, health care staff stated that paperwork was excessive and duplicative. While staff understood the necessity of documenting the information, they frequently stated that the system could be streamlined through combining forms and reports, and utilizing computerization to a greater extent. Examples of inefficient paper-based system include:

- There are approximately 20 required documents to track various items, including when inmates need physical

examinations and the status of requests for appointments with specialists.

- A request for an inmate to see a specialist must be recorded in three places – a facility physician completes an appointment request form, a clerk enters the information into a network database for review and approval by Utilization Management, and the information is written on a tracking log.

GDC officials recognize the inefficiency of the current system and have taken various steps in an attempt to streamline operations. In September 2002, GDC issued a Request for Information (RFI) for an electronic medical record and clinic information system. Subsequent to the RFI, GDC officials decided not to pursue procurement due to an expected cost of tens of millions of dollars and the logistical difficulties associated with implementing such a system. During fiscal year 2004, OHS officials undertook several smaller initiatives. Those included an internet-based method of tracking lab tests and results, an internet-based scheduling system to eliminate many tracking logs, and pharmacy software to allow GDC pharmacies to share prescription records.

GDC should continue to study the feasibility of implementing a comprehensive electronic health care information system.

GDC Response: *The Department is in agreement with this recommendation and is committed long term to having an electronic health care information system. This being stated, however, given the anticipated cost of this undertaking, the Department will choose to be very deliberate in making these decisions. Before making enormously expensive investments in software development and in upgrading of the IT infrastructure, the Department will look to the industry to create a reliable and efficient product first. This will remain a focus of long term planning.*

Other Recommendations

Recommendation No. 26

OHS should expand its requirement for pre-employment drug testing to include MHM facility-level health care staff.

Only a portion of the health care employees working in GDC-operated correctional facilities currently undergo pre-employment drug testing. GDC and GCHC routinely drug-screen all potential employees, while the dental staff, psychologists, psychiatrists, and mental health counselors employed by MHM are not. This difference creates disparities across the health care system, as well as within single position-types. As of fiscal year 2005, only 78.4% of mental health counselor positions and 66.3% of dentist positions are subject to pre-employment drug screening because the remaining positions are filled by MHM.

In order to ensure all correctional health care employees meet the same minimum pre-employment standards, the drug testing requirement should be extended to include all facility-level MHM staff.

GDC Response: *The Department agrees with this recommendation. Accordingly, language has been added to the aforementioned RFQs for rebidding mental health and dental services to require pre-employment drug testing.*

Recommendation No. 27

GCHC and MHM should notify OHS of all restrictions ordered by state licensing boards on the ability of facility-level health care staff to work in a health care setting.

Currently, no procedure exists to ensure that OHS is aware of all Board-ordered restrictions on a practitioners' ability to work. Licensing board orders indicate current work restrictions, such as the inability to work around narcotics, and provide information on individuals' past performance.

As of July 2004, GCHC and MHM were budgeted over 1,200 health care staff positions. Of these, OHS management performs

pre-employment review of the credentials of GCHC physicians only. GCHC's 51.2 physician positions account for only 4.2% of all contractor positions.

A review of 132 employee files[7] identified six with Board orders, including 3 of 13 MHM psychiatrists. One psychiatrist had his Georgia and Florida medical licenses revoked due to numerous disciplinary actions, and was on five-year probation when hired. The other two psychiatrists had past Board orders restricting their ability to practice due to chemical dependency issues. Although all three psychiatrists met GDC's hiring requirements, this licensure history may have raised questions about their fitness for the positions or provided GDC with necessary information to adequately monitor their performance.

Since OHS is responsible for the provision of health care and the oversight of vendors that provide health care to inmates, it should develop a procedure to ensure that GCHC and MHM inform OHS of all Board-ordered restrictions on practitioners' ability to work. Such notification should include pre-employment credentials, as well as any changes to licensure status.

GDC Response: *The Department agrees with this recommendation. Steps will be taken in the procurement process for rebidding mental health and dental services to require notification of licensure status. Further, GDC will make the same standard apply to GCHC on all future hiring decisions.*

Recommendation No. 28

OHS and GCHC should continue with the implementation of controls to ensure that all health care employees maintain active licensure.

Each correctional facility has responsibility for maintaining records of its health care employees' credentials.[8] However,

[7] The review consisted of a sample of physicians, physician assistants, nurses, dentists, psychologists, psychiatrists, and pharmacists.

[8] Credentials include such items as an active professional license, malpractice insurance, a criminal background check, and pre-employment references.

neither OHS nor GCHC currently have controls in place to ensure that facilities verify physical health care employees' licenses are renewed as required. In addition, there is no process in place for facilities to notify OHS if changes in employees' licensure status occur. Such changes may affect the employees' ability to work in the health care setting, or otherwise influence their continued employment.

Both OHS and GCHC have recently initiated processes to provide management with assurances that all employees maintain up-to-date licensure.

- GDC policy states that each facility is to conduct an annual credentials review using a standardized checklist. Records of the findings are to be kept on file for OHS review during clinical audits. Although these credentials are checked for mental health and dental health care staff, no such review is conducted for the physical health care employees.

  In response to our inquiries, OHS initiated a plan to require that facilities report the results of their annual credentials review of physical health care staff to regional GCHC managers, as well as to OHS clinical audit team. This process, which began in August 2004, provides OHS with adequate assurance that physical health care staff are maintaining up-to-date licenses.

- Although GCHC maintains copies of credentials obtained at the time of employment, these records are not updated as licenses are renewed. A random review of employee files found that 14 of 17 (82%) did not contain current active licenses.[9] MCG's Human Resources Division initiated a process in April 2004 to update all staff credentials on file, which will include GCHC physical health care staff. It is recommended that these updates continue on an ongoing basis.

It should be noted that MHM conducts its own annual review of its employees' credentials.

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[9] The audit team was able to find current active licensing information for the employees' files that contained expired licenses.

In order to meet GDC employment requirements, all employees must maintain current licensure. OHS and GCHC should continue with their plans to monitor facilities' review and maintenance of current licensure information; and should establish a procedure whereby any changes in licensure status are reported to management for employment consideration.

GDC Response: *The Department agrees with this finding and recommendation. Accordingly, OHS and GCHC will continue to work together to ensure that there is proper oversight of the credentialing and licensure process. In this regard, the GDC standard operating procedure on credentialing and licensure is currently being revised to incorporate DOAA recommendations. It will also include a requirement for an annual credential/licensure self audit by each facility. The results will be sent to GCHC managers who will present the information at the appropriate OHS Audit Team meeting. In addition to the requirement for on-site record keeping, OHS will add this to the audit process on all future audits.*

Appendix A

Georgia Department of Corrections Facility and Health Care Information [1]

Facility Information				Physical Health			Mental Health			
Facility	Location	Highest Security Level	Capacity	Budgeted Physical Care Staff (FTE) [2]	Infirmary? / # Beds [3]	Observation Unit? / # Beds [4]	CSU? / # Beds [5]	Highest MH Level	Budgeted Mental Care Staff (FTE) [6]	MH Caseload [7]
State Prisons										
Arrendale [8]	Alto	Maximum	1,200	28.6	Yes / 12	No	Yes / 6	III	17.2	269
Autry	Pelham	Close	1,528	21.8	No	No	No	III	22.4	429
Baldwin [8]	Hardwick	Medium	771	36.4	Yes / 12	No	Yes / 4	V	18.5	239
Bostick	Hardwick	Close	694	18	No	No	No	II	3	125
Burruss	Forsyth	Medium	300	2.4	No	No	No	No MH	0	0
Calhoun	Morgan	Close	1,240	21	Yes / 4	Yes / 4	No	III	6.1	217
Central	Macon	Medium	813	14.1	No	No	No	III	13	277
Coastal [8]	Garden City	Maximum	1,498	22.1	No	No	No	IV	16.5	374
Dodge	Chester	Medium	1,176	13.8	No	No	No	No MH	0	0
Dooly	Unadilla	Medium	1,232	12.3	No	Yes / 4	No	No MH	0	0
GDCP [8]	Jackson	Maximum	1,818	41	Yes / 13	No	Yes / 2	IV	21	415
GSP	Reidsville	Maximum	1,208	32.6	Yes / 11	No	Yes / 6	V	19.5	358
Hancock	Sparta	Close	1,368	17.3	No	Yes / 4	No	No MH	0	0
Hays	Trion	Close	1,234	18	Yes / 9	No	No	II	2.75	203
Homerville	Homerville	Medium	200	2.25	No	No	No	No MH	0	0
Johnson	Wrightsville	Medium	1,005	18	No	No	No	III	10.5	250
Lee	Leesburg	Medium	720	8	No	No	No	No MH	0	0
Lowndes	Valdosta	Medium	298	2.2	No	No	No	No MH	0	0
Macon	Oglethorpe	Close	1,344	18	Yes / 8	No	No	No MH	0	0
Mens	Hardwick	Medium	666	18.6	No	No	No	II	4	111
Metro [8]	Atlanta	Close / Maximum	905	36	Yes / 10	No	Yes / 3	V	29	474
Milan	Milan	Medium	256	2.2	No	No	No	No MH	0	0
Montgomery	Mt. Vernon	Medium	384	3.45	No	No	No	No MH	0	0
Phillips	Buford	Close	1,020	21.65	Yes / 7	No	Yes / 5	IV	29.5	305
Pulaski	Hawkinsville	Maximum	1,066	28.6	Yes / 6	No	No	III	13	421
Rivers	Hardwick	Medium	1,100	11.8	No	No	No	II	7	128
Rogers	Reidsville	Medium	1,280	13	No	No	No	II	5	150
Rutledge	Columbus	Medium	586	10.9	No	No	No	III	14	274
Scott	Hardwick	Medium	1,243	11.8	No	No	No	II	1	159
Smith	Glennville	Close	1,188	15	No	Yes / 8	No	No MH	0	0
Telfair	Helena	Close	1,088	12.8	No	Yes / 4	No	No MH	0	0
Valdosta	Valdosta	Close / Medium	764	14.6	Yes / 7	No	Yes / 4	IV	24	383
Walker	Rock Springs	Medium	615	4.2	No	No	No	No MH	0	0
Ware	Waycross	Close	1,176	20.05	Yes / 12	No	No	No MH	0	0
Washington	Davisboro	Close	1,048	23.2	No	Yes / 4	No	II	17.5	440
Wayne	Odum	Medium	200	2.2	No	No	No	No MH	0	0
Wilcox	Abbeville	Medium	1,410	14.5	No	Yes / 4	No	No MH	0	0
State Prison Total			**35,642**	**612.40**	**12 infirmaries, 111 beds**	**7 Observation Units, 32 beds**	**7 Crisis Stabilization Units, 30 beds**	**21 Prisons have MH inmates**	**296.45** [9]	**6,001**
Medical Prisons										
Augusta State Medical Prison [8]	**Grovetown**	**Close / Maximum**	**1,248**	**114.6**	**75 beds** [10]	**No**	**1 CSU / 7 beds**	**V**	**24**	**220**

Source: Georgia Department of Corrections

Appendix A (continued)

Georgia Department of Corrections Facility and Health Care Information [1]

Facility Information				Physical Health			Mental Health			
Facility	Location	Highest Security Level	Capacity	Budgeted Physical Care Staff (FTE) [2]	Infirmary? / # Beds [3]	Observation Unit? / # Beds [4]	CSU? / # Beds [5]	Highest MH Level	Budgeted Mental Care Staff (FTE) [6]	MH Caseload [7]
Probation Detention Centers										
C. H. Colwell	Blairsville	Minimum	208	2.2	No	No	No	No MH	0	0
Central	Cadwell	Minimum	198	2.7	No	No	No	No MH	0	0
Davisboro	Davisboro	Minimum	150	0	No	No	No	II	Shares 2 FTE with Washington SP	79
Emanuel County	Twin City	Minimum	220	2.7	No	No	No	II	1.5 + additional 1 FTE shared with Women's PDC and Rogers SP	63
I. W. Davis	Jefferson	Minimum	200	2.2	No	No	No	II	2 + additional 2 FTE shared with Arrendale SP	55
Larmore	College Park	Minimum	198	2.7	No	No	No	No MH	0	0
McEver	Perry	Minimum	192	2.7	No	No	No	No MH	0	0
Northwest	Cedartown	Minimum	204	2.7	No	No	No	No MH	0	0
Patten	Lakeland	Minimum	216	2.7	No	No	No	II	2.5 + additional 3 FTE shared with Valdosta SP	91
Paulding County	Dallas	Minimum	216	2.7	No	No	No	No MH	0	0
Phillips	Buford	Minimum	50	0	No	No	No	No MH	0	0
Rockdale/Dekalb	Conyers	Minimum	206	2.7	No	No	No	No MH	0	0
Smith	Glennville	Minimum	98	0	No	No	No	No MH	0	0
Southeast	Claxton	Minimum	198	2.7	No	No	No	No MH	0	0
Southwest	Moultrie	Minimum	198	2.7	No	No	No	No MH	0	0
Terrell	Dawson	Minimum	192	2.7	No	No	No	No MH	0	0
Treutlen	Soperton	Minimum	364	4.3	No	No	No	No MH	0	0
West Central	Zebulon	Minimum	184	4.2	No	No	No	II	2 + additional 3 FTE shared with GDCP	61
Western	Butler	Minimum	200	2.2	No	No	No	II	2 + additional 2 FTE shared with Rutledge SP	52
Womens	Claxton	Minimum	198	3.7	No	No	No	III	Shares 1 FTE with Emanuel PDC and Rogers SP	52
Probation-Detention Center Total			**3,890**	**48.5**	**0 infirmaries, 0 beds**	**0 Observation Units, 0 beds**	**0 Crisis Stabilization Units, 0 beds**	**7 PDC's have MH probationers**	**10 dedicated FTE + 13 additional shared FTE**	**453**

Source: Georgia Department of Corrections

Appendix A (continued)

Georgia Department of Corrections Facility and Health Care Information [1]

Facility Information				Physical Health			Mental Health			
Facility	Location	Highest Security Level	Capacity	Budgeted Physical Care Staff (FTE) [2]	Infirmary? / # Beds [3]	Observation Unit? / # Beds [4]	CSU? / # Beds [5]	Highest MH Level	Budgeted Mental Care Staff (FTE) [6]	MH Caseload [7]
Diversion Centers										
Albany	Albany	N/A	68	0	No	No	No	No MH	0	0
Alcovy	Monroe	N/A	50	0	No	No	No	No MH	0	0
Athens	Athens	N/A	75	0	No	No	No	No MH	0	0
Augusta	Augusta	N/A	96	0	No	No	No	No MH	0	0
Bainbridge [11]	Bainbridge	N/A	192	3.2	No	No	No	II	2 dedicated FTE + 2.4 FTE shared with Autry SP	42
Clayton	Forest Park	N/A	50	0	No	No	No	No MH	0	0
Columbus	Columbus	N/A	75	0	No	No	No	No MH	0	0
Gainesville	Gainesville	N/A	100	0	No	No	No	No MH	0	0
Gateway	Atlanta	N/A	106	0.35	No	No	No	No MH	0	0
Griffin	Griffin	N/A	76	0	No	No	No	No MH	0	0
Jimmy Helms	Atlanta	N/A	100	0	No	No	No	No MH	0	0
Macon	Macon	N/A	104	0.2	No	No	No	No MH	0	0
Rome	Rome	N/A	100	0	No	No	No	No MH	0	0
Thomasville	Thomasville	N/A	52	0	No	No	No	No MH	0	0
Tommy M Rouse	Waycross	N/A	75	0	No	No	No	No MH	0	0
Diversion Center Total			**1,319**	**3.75**	**0 infirmaries, 0 beds**	**0 Observation Units, 0 beds**	**0 Crisis Stabilization Units, 0 beds**	**1 Diversion Center has MH probationers**	**2 FTE + 2.4 shared FTE**	**42**
Transitional Centers										
Albany	Albany	Minimum	150	0.65	No	No	No	No MH	0	0
Atlanta	Atlanta	Minimum	245	1.95	No	No	No	No MH	0	0
Augusta	Augusta	Minimum	200	1.05	No	No	No	No MH	0	0
Clayton	Forest Park	Minimum	200	1.1	No	No	No	No MH	0	0
Coastal	Savannah	Minimum	200	1.05	No	No	No	No MH	0	0
LaGrange	LaGrange	Minimum	150	0.6	No	No	No	No MH	0	0
Macon	Macon	Minimum	150	0.7	No	No	No	No MH	0	0
Metro	Atlanta	Minimum	224	1.2	No	No	No	No MH	0	0
Savannah	Savannah	Minimum	200	1.45	No	No	No	No MH	0	0
Transitional Center Total			**1,719**	**9.75**	**0 infirmaries, 0 beds**	**0 Observation Units, 0 beds**	**0 Crisis Stabilization Units, 0 beds**	**No MH inmates**	**0**	**0**
Boot Camps [12]										
Baldwin	Hardwick	Close	240	0	No	No	No	No MH	0	0
Burruss	Forsyth	Medium	148	0	No	No	No	No MH	0	0
Dodge	Chester	Close	80	0	No	No	No	No MH	0	0
Hays	Trion	Medium	192	0	No	No	No	No MH	0	0
Montgomery	Mt. Vernon	Close	88	0	No	No	No	No MH	0	0
Scott (Probation)	Hardwick	Medium	160	0	No	No	No	No MH	0	0
West Georgia	Bremen	Maximum	150	2.7	No	No	No	No MH	0	0
Boot Camp Total			**1,058**	**2.7**	**0 infirmaries, 0 beds**	**0 Observation Units, 0 beds**	**0 Crisis Stabilization Units, 0 beds**	**No MH inmates**	**0**	**0**

Source: Georgia Department of Corrections

Appendix A (continued)

Georgia Department of Corrections Facility and Health Care Information [1]

Facility Information				Physical Health			Mental Health			
Facility	Location	Highest Security Level	Capacity	Budgeted Physical Care Staff (FTE) [2]	Infirmary? / # Beds [3]	Observation Unit? / # Beds [4]	CSU? / # Beds [5]	Highest MH Level	Budgeted Mental Care Staff (FTE) [6]	MH Caseload [7]
Parole Revocation Center / Pre-Release Center										
Whitworth	Hartwell	N/A	436	4.7	No	No	No	II	1.5 dedicated FTE + 2.5 FTE shared with Baldwin SP	44
GDC Facility Totals	There are 90 GDC-run facilities		45,312	796	12 State Prison infirmaries + ASMP / 186 beds	7 Observation Units, 32 beds	8 Crisis Stabilization Units, 37 beds	31 GDC facilities have MH inmates	351.4 Total (333.5 FTE dedicated MH personnel + 17.9 shared FTE's)	6,760

Notes:

1 Information in the table is provided as of July 1, 2004 unless otherwise noted.

2 Physical care staff included are only the full-time equivalent positions that provide direct physical care to inmates: Physicians, Clinical Practioners (Physician Assistants and Nurse Practitioners), Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nurse Assistants (CNA).

3 Infirmary/Beds: Designated medical units within a state prison set up for the purpose of caring for inmates with medical needs requiring attention for 24 hours or longer but who are not in need of hospital care. Infirmary beds are current as of April 30, 2004.

4 Observation Unit/Beds: Designated medical areas within a state prison where patients require infirmary-level care but for less than 24 hours. Observation beds are current as of November 2003.

5 Crisis Stabilization Unit (CSU)/Beds: Designated infirmary areas operated for the purpose of treating mental health inmates or probationers in crisis and in need of 24-hour mental health care attention in a safe environment. CSU beds are current as of April 30, 2004.

6 Mental health care staff included are only the full-time equivalent positions that provide direct mental health care to inmates: Psychiatrists, Psychologists, Mental Health Nurses (RN, LPN, and Clinical Nurse Specialists), Counselors, Activity Therapists, Behavior Specialists, 1 Psychometric Specialist, 1 Mental Health Social Worker, and 1 Chaplain. Also, mental health FTEs provided for state prisons are only the dedicated resources for those facilities. Additional MH personnel shared with other facilities are listed in the non state prison sections in the appendix.

7 The Mental Health Caseload for a facility is the number of inmates/probationers classified as a Level II or higher (i.e. require mental health attention). Caseload and maximum MH level are current as of May 2004.

8 Arrendale, Augusta State Medical Prison (ASMP), Baldwin, Coastal, Georgia Diagnostic & Classification Prison (GDCP; also called Jackson), and Metro (female) are the six diagnostic prisons in the GDC system. Inmates entering the GDC correctional system are sent through one of these facilities for diagnostic health care screening.

9 The total budgeted mental health care staff for state prisons presented in the table includes two positions not assigned to a specific facility. These positions provide mental health care services to the five state prisons making up the Central Region Complex (CRC) - Baldwin, Bostick, Men's, Rivers, and Scott.

10 ASMP has seven nursing units, four of which provide 24-hour infirmary-level care with 75 total beds: two Acute Care Units with 40 total beds, one Post-Op unit with 15 beds, and one Assisted Living Unit with 20 beds.

11 Bainbridge is a Diversion Center but also serves as a Substance Abuse Treatment Center (SATC).

12 As of June 30, 2004 the GDC boot camps included one Probation Boot Camp (Scott) and the other six are Inmate Boot Camps. West Georgia Inmate Boot Camp is assigned its own physical health care staff as it is a stand-alone facility while the other six share physical health care staff assigned to the state prison located on the same property and with the same name (Baldwin, Burruss, Dodge, Hays, Montgomery, Scott).

Source: Georgia Department of Corrections

Appendix B
GCHC Expenditures
Fiscal Year 2003

GCHC Personal Services		**$44,980,476**
Temporary Agency Staffing:		
Administrative and Other Temporary	$51,974	
Physicians	1,294,877	
Nursing	5,635,833	
Pharmacists	344,134	
Total Temporary Agency Staffing		7,326,818
Total Staffing Costs		**52,307,294**
Travel		175,833
Operating Expenses		4,477,436
Pharmacy		21,419,543
Direct Costs:		
Hospital Inpatient Costs	$15,322,304	
Hospital Outpatient Costs	6,575,498	
Physician Fees	2,775,794	
Professional Services (Non-Physicians)	528,983	
Emergency Services	1,594,941	
Patient Transport	660,753	
Dialysis Services	1,015,299	
Laboratory Services	3,268,159	
Radiology	1,585,927	
Optometry	567,687	
Dental Services	N/A	
Prosthetics (Dental)	99,469	
Prosthetics (Non-Dental)	169,926	
Unclassified	262,354	
Total Direct Care		**34,427,094**
Equipment		471,338
Total Expenditures		**113,278,538**
Less Psychotropic Drug Reimbursement [1]		(5,962,627)
Net Expenditures		**$107,315,911**

1 GCHC purchases psychotropic drugs, but the psychotropic drug expenditure is part of the contract with MHM. GDC reimburses GCHC as opposed to paying MHM for the cost of the psychotropic drugs.

Source: GCHC Expenditure Records

Appendix C
Employee Survey Results[(1)]

Question	Agree	Disagree	Don't Know
The Office of Health Services' purpose has been clearly communicated to me	**64%**	28%	5%
My daily work (or assigned tasks) is significantly different than what I understand my official job duties to be.	15%	**84%**	0%
I routinely work additional, unpaid, time to complete my work.	37%	**63%**	0%
My responsibilities and authority have been made clear to me by my supervisor and are appropriate.	**80%**	17%	1%
I have adequate time to manage and guide the number of employees I supervise.	**47%**	23%	15%
I receive feedback about my performance from my supervisor on a regular basis.	**67%**	29%	2%
I receive appropriate training to perform my job effectively.	**75%**	19%	6%
At my facility, inmates' medical privacy is respected to the extent possible within the security environment.	**87%**	8%	5%
In my facility, inmate feedback regarding the quality of healthcare provided (as through formal grievances) is respected and taken seriously.	**77%**	12%	10%
Grievances issued by inmates in my facility are followed-up on in a timely and effective manner.	**64%**	10%	25%
Inmates frequently report to me that they have difficulty receiving medical services.	35%	**60%**	5%
Inmates in my facility have adequate access to the health care system.	**78%**	12%	10%
Inmates are aware of how to submit medical care requests.	**93%**	1%	6%
Inmates in my facility are charged for services in accordance with written Department policies.	**82%**	0%	18%
When inmates are transferred to my facility, all of their relevant medical records and medications are with them.	33%	**46%**	20%
My work unit (i.e., mental, dental, or physical health care) is staffed by individuals with the necessary knowledge, skill, and training to perform their job adequately.	**74%**	19%	5%
Timesheet records for staff in my facility accurately reflect the hours worked.	**59%**	16%	24%
Staff members in my work unit are treated fairly and justly.	**60%**	32%	6%
In my facility, staff are routinely asked to complete work outside of the scope of their primary function.	32%	**55%**	12%
Because staff are regularly asked to complete duties outside of the scope of their primary function (e.g., physical health nurses are asked to fill out mental health logs), the quality of their primary work and/or their ability to complete it suffers.	30%	**45%**	20%
If an employee in my work unit was not performing at the expected or required level (including quality of performance and timeliness of work), these deficiencies would be identified in a timely manner.	**58%**	28%	13%
In my facility, there are clear lines of responsibility.	**71%**	26%	2%
The goals and objectives of the Office of Health Services and my employer are in agreement.	**58%**	13%	28%
There is sufficient designated bed space (including SLU beds, infirmary beds, etc.) to treat inmates according to the SOPs.	**44%**	32%	21%
The turnover rate negatively impacts the quality of work of my work unit.	**51%**	39%	9%
Pharmaceutical supplies in my facility are adequately controlled and accounted for.	**66%**	7%	26%
When workload is light in one unit, employees shift to assist with the workload of other units.	**41%**	35%	19%
My unit has the appropriate number of staff to complete our duties.	31%	**66%**	1%
My unit has the appropriate tools to complete our duties.	**60%**	34%	4%
All security staff are appropriately trained regarding an inmate's medical privacy.	**40%**	19%	39%
Security staff are adequately trained in how to identify inmates who should be referred for mental health services.	**44%**	24%	32%
Security staff are adequately trained in how to identify inmates who should be referred for physical health services.	**43%**	25%	31%
OHS clinical audits accurately identify and address the underlying problems that relate to deficiencies in our work.	**47%**	23%	30%
OHS clinical audits objectively and consistently review the work of my unit.	**57%**	17%	25%
OHS clinical audits result in corrective action being taken by my work unit.	**67%**	7%	26%
Security and non-healthcare facility staff at my facility respect the findings of OHS clinical audits and facilitate implementation of corrective action plans.	**53%**	15%	32%
The official policies and procedures of the Department accurately reflect the work in my facility's healthcare unit.	**71%**	12%	17%
The Department's SOPs are up to date with current best practices in the field.	**61%**	17%	21%
Employees in my unit are aware of and have access to current policies and procedures to guide them in their work.	**90%**	8%	1%
The use of Utilization Management for physical health care has streamlined processes and limited unnecessary consultations and inmate transfers.	**35%**	25%	40%
Inmates have not received necessary medical care due to Utilization Management's refusal for services.	14%	**42%**	44%
The existing reporting relationships/structure in health services encourage inter-unit communication.	**46%**	29%	25%
The existing reporting relationships/structure in health services encourage coordination of staff and other resources between units.	**47%**	30%	23%
Inmates receive quality medical care at ASMP.	**48%**	9%	43%
Inmates in my facility report being mistreated at ASMP.	24%	**45%**	31%

[(1)] Percentages do not equal 100% because answers left blank and "Not Applicable" responses are not shown.

Response does not favorably reflect on GCHC Operations
Response favorably reflects on GCHC Operations

Source: Survey of GDC, GCHC, and MHM facility staff

Appendix D
GDC Medical Beds
April 2004

Type of Bed	Description	Number of Beds
ASMP Medical Building	**All units except transient have 24-hour nursing coverage.**	**115 Male**
Acute Care	For inmates recovering from injury or illness who are in need of constant medical attention.	40 Male
Assisted Living Level 2	Similar to a nursing home; inmates are unable to conduct many basic activities of daily living.	20 Male
Pre-Op/Post-Op	For inmates to prepare for or recover from surgery.	15 Male
Transient	For temporary ASMP inmates expected to remain for less than 30 days while undergoing testing or treatment.	40 Male
ASMP Building 14	**Units do not have 24-hour nursing coverage.**	**165 Male**
Transient	For temporary ASMP inmates expected to remain for less than 30 days while undergoing testing or treatment. Inmates are typically in better condition than transient inmates assigned to ASMP Medical Building.	94 Male
Med-4	For temporary ASMP inmates expected to remain for more than 30 days while undergoing testing or treatment such as chemotherapy or physical therapy.	48 Male
Respiratory	For inmates that need oxygen equipment. The equipment requires electrical outlets, which are not provided for a typical inmate bed.	23 Male
State Prison Infirmary	**For inmates in need of 24-hour skilled nursing care due to injury or illness but not in need of higher level of care available in a hospital. 12 State Prisons have an infirmary (not including ASMP)**	**95 Male** **16 Female**

Source: GDC records and interviews of GDC personnel

For additional information, please contact John S. Abbey, Director,
Performance Audit Operations Division, at 404-657-5220.

Copies of the Program Evaluation can be obtained by calling the number above or on our website:
http://www.audits.state.ga.us/internet/pao/rpt_main.html