Georgia Department of Audits and Accounts
Performance Audit Operations
Russell Hinton, State Auditor
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Why we did this review

In 2004, we issued a Program Evaluation entitled "Inmate Health Care" which evaluated the adequacy of care provided to inmates housed in Georgia Department of Corrections' (GDC) facilities. Typically, we perform a Follow-Up Review after approximately two years to provide an update on corrective actions taken by the agency. Based on the scope of the original report and our determination that significant changes have occurred within the GDC Health Program, this Special Examination was performed in place of a Follow-Up Review. A copy of the 2004 Program Evaluation report can be obtained through the contact information provided on the last page of this report.

Who we are

The Performance Audit Operations Division was established in 1971 to conduct in-depth reviews of state programs. The purpose of these reviews is to determine if programs are meeting their goals and objectives; provide measurements of program results and effectiveness; identify other means of meeting goals; evaluate the efficiency of resource allocation; and assess compliance with laws and regulations.

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Inmate Health Care

Inadequate staffing of central office positions in the Department of Corrections' Office of Health Services and of health care positions in the Department's correctional facilities has adversely impacted the system of health care provided to inmates.

What we found

In our 2004 Program Evaluation of Inmate Health Care, we found that the Office of Health Services (OHS) within the Georgia Department of Corrections (GDC) had "developed an extensive management control system to effectively manage all aspects of physical, mental, and dental health care." Although we recognized that problems were bound to exist in such a complex system, we concluded that "the quality of the inmate health care system is threatened by decreasing staffing levels that are a result of budget constraints." Other findings and recommended corrective actions were also presented.

Our re-examination of the Inmate Health Care Program within GDC found there has been a significant decrease in the size of the central office staff in OHS, which is responsible for ensuring inmates are provided the required constitutional level of care. As a result, many of the controls previously in place, such as conducting clinical audits, performing executive mortality reviews, and addressing recommendations from correctional health care experts, have deteriorated considerably. Furthermore, the inmate population growth from fiscal years 2005 to 2007 has outpaced the budgeted staff in GDC facilities who provide direct care services to inmates. Consequently, it is increasingly difficult for GDC to ensure it is providing the required constitutional level of care. The additional strain

placed on staff resources may increase the probability of experiencing bad health care outcomes, and in turn, present increased risk of lawsuits against GDC.

Our review also found that total health care costs have increased at a faster rate than in previous years, driven primarily by an increase in catastrophic inmate health cases. GDC health care costs for fiscal year 2011 are projected to total $278 million, which is approximately $99 million more than the $179 million expended in fiscal year 2006.

In its written response to the report, GDC noted that *"While the Office of Health Services does not challenge the data reported by the Department of Audits and Accounts we do, however, interpret the data a bit differently. As with any organization, improvement can be made by and in the Office of Health Services. The partnerships with our private and public healthcare partners are on solid ground and progress is being made through the maturization of these relationships. We appreciate the Department of Audits' Report and always welcome a third party look at our operations."*

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Background

Examination Purpose

The purpose of this examination was to determine if the management control system of GDC's Office of Health Services (OHS) was adequate to effectively manage the physical, mental, and dental health care provided to inmates. The OHS management control system was initially evaluated in our 2004 Program Evaluation in which we found that OHS had "developed an extensive management control system to effectively manage all aspects of physical, mental, and dental health care." In addition to reviewing the current management control system, we updated our projected correctional health care costs through 2011.

Purpose of Inmate Health Care

Inmates in the custody of either state, federal, or local correctional systems are entitled to a constitutionally required level of health care. OHS's purpose is to ensure adequate health care is provided to Georgia's state inmates in the most efficient, cost-effective, and humane manner possible, while protecting the public health and safety of the rest of the state's citizens.

Inmate Health Care Rights, Standards, and Delivery System

Generally, courts have held that inmates have a right to reasonable health care designed to meet their routine and emergency medical needs. Most notably, in *Estelle v. Gamble* (1976), the U.S. Supreme Court found that an inmate has the right to be free of "deliberate indifference to their serious health care needs" and that indifference is a violation of a person's Eighth Amendment protection against cruel and unusual punishment.

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, which may be defined in published recommendations by expert panels or organizations (such as the Centers for Disease Control and Prevention and the American Heart Association). Correctional health care programs may also use standards developed by the National Commission on Correctional Health Care and the American Correctional Association. GDC has defined its standard of care through Standard Operating Procedures (SOP) as well as a "Summary of Health Care Benefits."

Health care in GDC facilities is provided by a combination of three organizations:

- GDC's OHS is responsible for providing clinical and administrative oversight of care, managing the health care budget, determining staffing levels, and monitoring vendors. GDC-employed health care staff primarily include mental health counselors and dental staff (as shown in the **Appendix**).

- Georgia Correctional HealthCare (GCHC), a division of the Medical College of Georgia, manages physical health care operations in GDC

facilities and also negotiates and manages contracts with providers of health services (e.g., hospitals, specialty clinics, ambulance services, etc.) that cannot be provided within GDC facilities. GCHC employs the physicians, clinical practitioners, and most of the nurses.

- MHM Services, Inc. (MHM) is a health care staffing agency utilized primarily to employ psychiatrists, psychologists, and mental health counselors.

Scope and Methodology

The scope of this examination was based primarily on the information presented in the 2004 Program Evaluation report (entitled "Inmate Health Care") with additional topics covered as appropriate. The methodology included interviews with GDC and GCHC personnel and reviews of program documentation.

This report has been discussed with appropriate personnel in GDC and GCHC. A draft copy of the report was provided for GDC's review and they were invited to provide a written response, including any areas in which they plan to take corrective action. Pertinent sections from GDC's response have been included in the report as appropriate.

Analysis of Management Control System

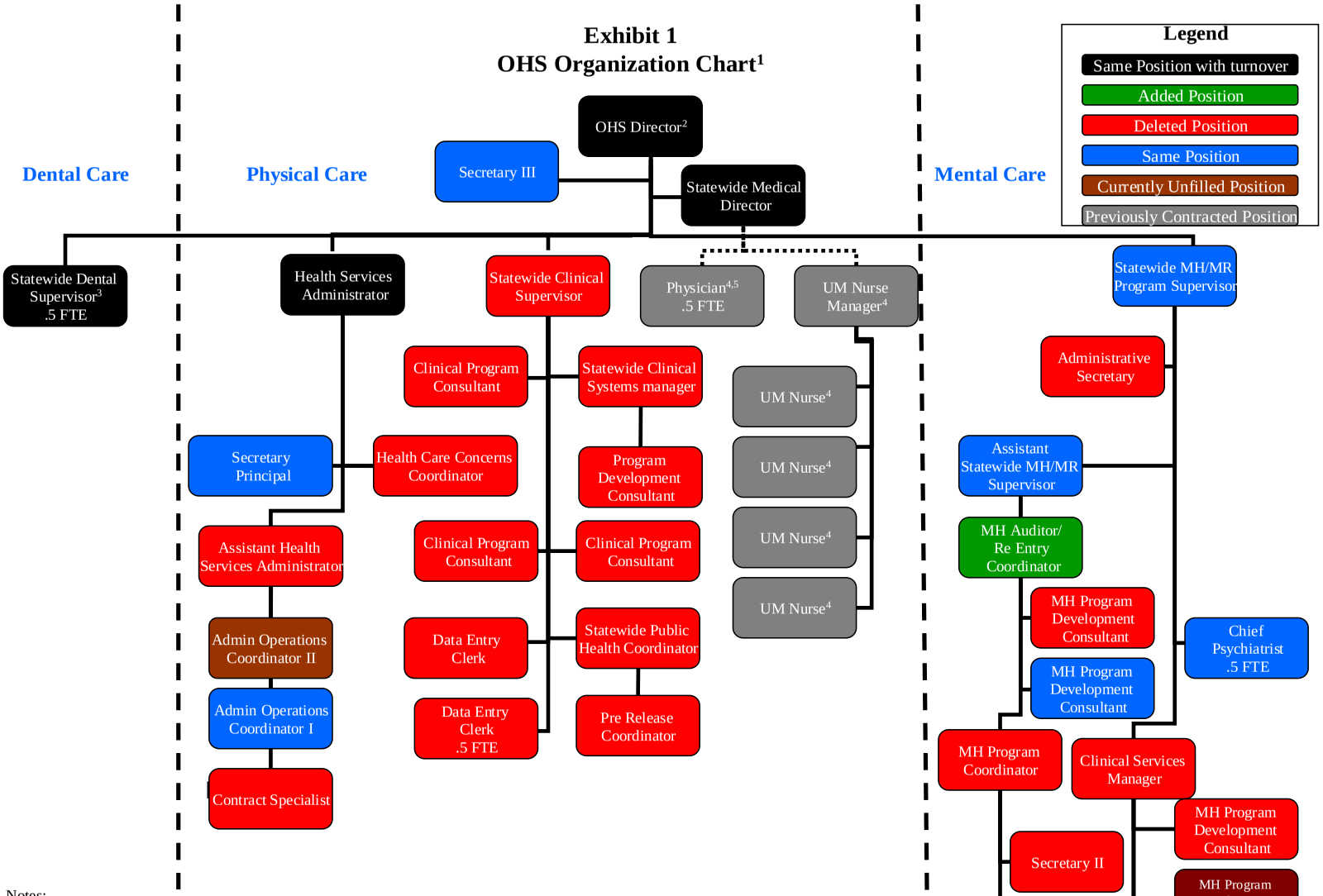
The significant reduction of OHS central office staff is adversely impacting OHS's ability to effectively manage all aspects of physical, mental, and dental health care.

Our review found that OHS central office staff decreased from 29.5 budgeted full-time equivalent (FTE) positions in 2004 to 13 FTEs in 2007. (Note: this does not include 5.5 positions in the Utilization Management (UM) function which were brought in-house in 2006; UM was previously operated by MHM.) The OHS organizational chart presented in **Exhibit 1** on the following page illustrates the positions that were eliminated, those that still exist, and those that have been created since the 2004 evaluation.

"Because litigation is so expensive, all efforts should be made to achieve voluntary compliance with national standards of care and gain accreditation. Facilities that meet community standards of care are much less likely to face class action or even individual lawsuits."
Source: Guidelines for the Management of an Adequate Delivery System by the National Institute of Corrections (2001).

The loss of the positions illustrated in the organization chart, as well as turnover in key OHS leadership positions and loss of institutional knowledge, has diminished OHS's "extensive management control system" that was in place in 2004. It should be noted some key positions have turned over more than once since 2004. The diminished management control system regarding physical, mental, and dental care is discussed in the following sections.

Exhibit 1
OHS Organization Chart[1]



Notes:
1. All positions represent a full-time equivalent (FTE) unless otherwise noted.
2. The OHS Director position has turned over twice since FY 2005.
3. The Statewide Dental Supervisor spends half of his time providing care to inmates.
4. The Utilization Management (UM) function was performed by MHM in FY 2005.
5. The UM Physician spends half of his time performing duties for GCHC.

Source: GDC records, Staff interviews

In its response to this finding, GDC wrote the following:

"In the Office of Health Services (OHS)…it was my belief that we had a number of redundant auditing and assessment processes in place. I [GDC Commissioner] directed that staff cuts be made to the OHS with the clear intent of monitoring our performance in managing our health care partners. If and when we determined that additional staff or resources needed to be returned to the OHS, these additions would be addressed based on the appropriate justification. After having our mental health program, physical health program, and general healthcare delivery system audited in CY 2007, it became apparent that some positions needed to be added back to OHS. As you found, I have authorized those changes in the staffing of OHS that I believe necessary to carry on the high level of service for which this Agency is known.

I have authorized the hiring of two additional mental health program managers, an assistant director, a part time physician, and a business analyst to complement the staff in OHS. I expect that these additions to our team will be sufficient to address the concerns that the Department of Audits and our Clinical Consultants have expressed."

The frequency of physical health auditing conducted by GDC in state prisons has not improved and GDC no longer conducts physical health audits at probation detention centers or county correctional institutions. Additionally, OHS no longer manages the auditing process and is less involved in monitoring the results of these audits.

In 2004, OHS scheduled and managed health services audits at state prisons, probation detention centers, and other GDC facilities. In its response to the 2004 Evaluation, GDC agreed with the recommendation that auditing should occur more frequently and stated its intention to return to annual auditing. It also added that "the OHS audit methodology was born out of past litigation."

Our review found that GDC has not established an annual auditing schedule for state prisons as it indicated in the 2004 Evaluation. Currently, GDC conducts comprehensive audits[1] approximately once every two years for state prisons, which is the same frequency with which they were conducted in calendar years 2000 through 2003. We also found that GDC no longer evaluates physical health services in probation detention centers or in county correctional institutions.

"Quality assurance has been defined as a 'process of ongoing monitoring and evaluation to assess the adequacy and appropriateness of the care provided and to institute corrective action as needed'…It is an essential aspect of any well-run system…."
Source: Guidelines for the Management of an Adequate Delivery System by the National Institute of Corrections (2001).

Our review also found that OHS no longer has the authority to schedule audits of physical care as was the case in 2004. This function is now coordinated by the GDC Office of Investigation and Compliance (OIC). Furthermore, since OHS no longer employs a Statewide Clinical Supervisor or subordinate staff (see the organization chart on the previous page), which previously oversaw the auditing function, OHS is less involved in monitoring findings and

[1] Clinical audits of the physical health care provided in state prisons are currently conducted as part of a larger "comprehensive audit" which also includes the evaluation of other facility operations, such as security and personnel.

corrective actions related to physical health services. Interviews with current OHS staff stated they may not be aware of issues arising from a clinical audit and that there is no process to ensure they receive copies of all audit reports.

In its response to this finding, GDC wrote the following:

"The management philosophy of the Office of Health Services has transformed since 2004. It was decided to transfer primary responsibility for the conducting of audits to GDC's healthcare partners, GCHC and MHM. GDC staff continue to be involved in conducting the audits, but the scheduling and reporting of the audit findings is now a responsibility of our healthcare partners. GDC continues to oversee the corrective action plans. The report is correct in stating that GDC does not conduct regular audits of probation detention centers, county correctional facilities, and private prisons. GDC's Office of Investigations and Compliance schedules an annual comprehensive audit of each of the state prisons. These audits include healthcare audits. In addition, our healthcare partners schedule an additional audit each year of each state prison. Corrective action plans are developed and monitored by GCHC, MHM, and GDC."

OHS does not perform executive mortality reviews of inmate deaths and is unable to locate medical files for many deceased inmates.

At the time of our 2004 evaluation, OHS conducted, as part of its extensive management control system, Executive Mortality Reviews of inmate death cases "to ascertain the housing facilities' compliance with OHS standards of care." We also noted that the mortality review process was 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."

Our review of OHS files for inmate death records for calendar years 2005 and 2006 revealed that only 30 of 233 deaths (excluding executions) had evidence that OHS clinical staff performed a mortality review. OHS explained that they ceased doing on-the-record mortality reviews in late 2005 because of a court case in the 9th U.S. Circuit Court of Appeals (West Coast) that potentially jeopardized the confidential nature of these reviews. It should be noted, however, that only one of the 30 cases which were reviewed occurred after the departure of prior OHS leadership staff, suggesting that OHS staff turnover may also have contributed to the discontinuation of the executive mortality review process.

"Maintenance of medical records is 'a necessity' (Johnson-El v. Schoemehl, 1989), and numerous courts have condemned the failure to maintain an organized and complete system of health care records."
Source: Guidelines for the Management of an Adequate Delivery System by the National Institute of Corrections (2001).

Our review also found OHS was unable to locate files for 86 of the 203 deaths not reviewed. While OHS staff was unable to locate these files, staff stated they were continuing to search for them, including making contact with GDC facilities to determine if these files were still at the inmate's home facility at the time of death. According to GDC's SOP, the home facility is responsible for completing its own mortality review within 15 working days of the death and for submitting necessary health records to OHS within 20 working days.

OHS and GDC Legal Services do not disagree that executive mortality reviews are valuable. Although an Executive Mortality Review Committee was re-established in

May 2006 and OHS drafted new procedures for performing these reviews, the process had not been re-started as of the time of our evaluation.

In its response to this finding, GDC wrote the following:

"*A Federal Court ruling in 2005 declared physician peer reviews regarding inmate deaths to be discoverable in litigation. This is the only type of medical peer reviews to be so declared. Written peer reviews were temporarily discontinued. The report correctly states that 86 of 203 files on deceased inmates could not be located at the time of the audit. In his annual report, [GDC's physical health care consultant] reported that OHS was indeed behind in conducting peer mortality reviews. He recommended that '(GDC) continue with a process that includes a local death review…and then that death review along with a copy of the (inmate) record should be available for a review by an external reviewer.' Approval has been granted to contract with an external reviewer for the purpose of mortality reviews. To date, 41 of the 86 misplaced files have been located. Concerted efforts are underway to locate the remaining files. A system has been developed to identify, track, and locate files of deceased inmates.*"

Recommendations made by nationally-recognized correctional health care experts have not been sufficiently addressed.

In 2004, we commended OHS for annually contracting with correctional health care experts in both mental health care and physical health care. We also determined that the expert recommendations were given "serious consideration by OHS and [were] actively addressed."

Although GDC continues to hire correctional health care experts to perform annual evaluations of physical and mental care, we found that some of the significant and persistent problems have not been sufficiently addressed and may continue to deteriorate.

Physical Care Evaluations
At the time of our review, the last complete evaluation of physical health care was performed in July 2006. The report summarizing findings on the status of physical health care noted the following areas:

- Mortality Review: The evaluator specifically noted the need for OHS to review the medical files and documentation of the mortality review performed at the inmate's home facility.

- Health Care Grievances: The evaluator found that 0 of 150 health grievances filed by inmates and reviewed by the inmate facility in a two-month period were found to be valid. In such cases, the evaluator concluded, "one has to suspect that the method of determining validity may in fact be biased."

- Concerns over OHS turnover: "Virtually all of the leadership people who I [the evaluator] met with during my June 2005 visit have either retired or moved on. Prior to my arrival this clearly raised some concerns for me."

- Workload of the Statewide Medical Director: "I am particularly concerned about the multiple responsibilities that [the Statewide Medical Director]

must now acquit. These include her large UM responsibilities as well as the medical director role, which includes participating in audits at least two weeks a month" as well as managing clinical policies and standard operating procedures, handling medical reprieves, working with inmate families, providing clinical training and other duties.

Mental Care Evaluations

The evaluations of mental care over the last four years have addressed staffing problems which appear to be getting worse. The 2004 summary report cited inadequate mental health staffing as a "major issue." The follow-up in 2005 further cautioned that "these problems remain as previously described, which has had a significant negative impact on the mental health services being provided to many GDC inmates." The 2006 and 2007 reports repeat this finding that no significant change had taken place. In 2007, the evaluator concluded:

> "the operation of the mental health department…remains very hampered by decreasing staff allocations and vacancies as previously summarized. The ability of the central office to identify, and generally fix, problems identified via the [continuous quality improvement] process has continued to decrease for reasons that include decreased and limited central office staffing allocations, lack of an adequate management information system at the present time, and the staffing allocation issues in the field as described elsewhere in this report."

In its response to this finding, GDC wrote the following:

"While all recommendations of our consultants are given attention, due to budget and staffing limitations, all recommendations cannot be implemented. Considerable credibility is given to the recommendations of our consultants and attempts are made to adopt and implement their recommendations each and every year."

GDC does not analyze health care audit scores and grievance data to review and manage the delivery of health care.

In 2004, we recommended that OHS should analyze data on health care quality indicators to more effectively manage the delivery of health care. In general, GDC agreed with this recommendation and also added, "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."

Our review has determined that no plan to track risk management indicators has been developed. Although GDC collects information on various aspects of health care operations, the information is not used to assess the quality of care being provided. For example, GDC comprehensive audits and GCHC regional reviews generate audit scores on various aspects of a facility's physical health care operations. OHS does not utilize these audit scores to identify patterns or trends in the physical care provided.

Similarly, although OIC enters inmate grievances into GDCs Offender Tracking Information System (OTIS), neither OIC nor OHS generates reports from OTIS to

identify patterns in grievances related to physical, mental, or dental health. Also, based on our review of 2006 data, there was a significant difference between the number of grievances entered into OTIS by OIC and the number of grievances which OHS had a record of receiving.

In its response to this finding, GDC wrote the following:

"Through GDC's Office of Information Technology, a mental health module to our SCRIBE operating system has been developed that will collect risk management, performance management, and outcome data in our mental health program. Through our Third Party Administrator, OHS receives data regularly that is being analyzed for risk management utilization... While the report is correct in stating that we currently do not have information to assess the quality of care, we do have a plan for developing that data and are assessing the quality of care via audits. In June 2007 the responsibility for managing inmate healthcare grievances was assumed by the Office of Health Services. More attention is being directed to grievances now than in the past."

The backlog of Utilization Management (UM) requests and appointments pending have increased.

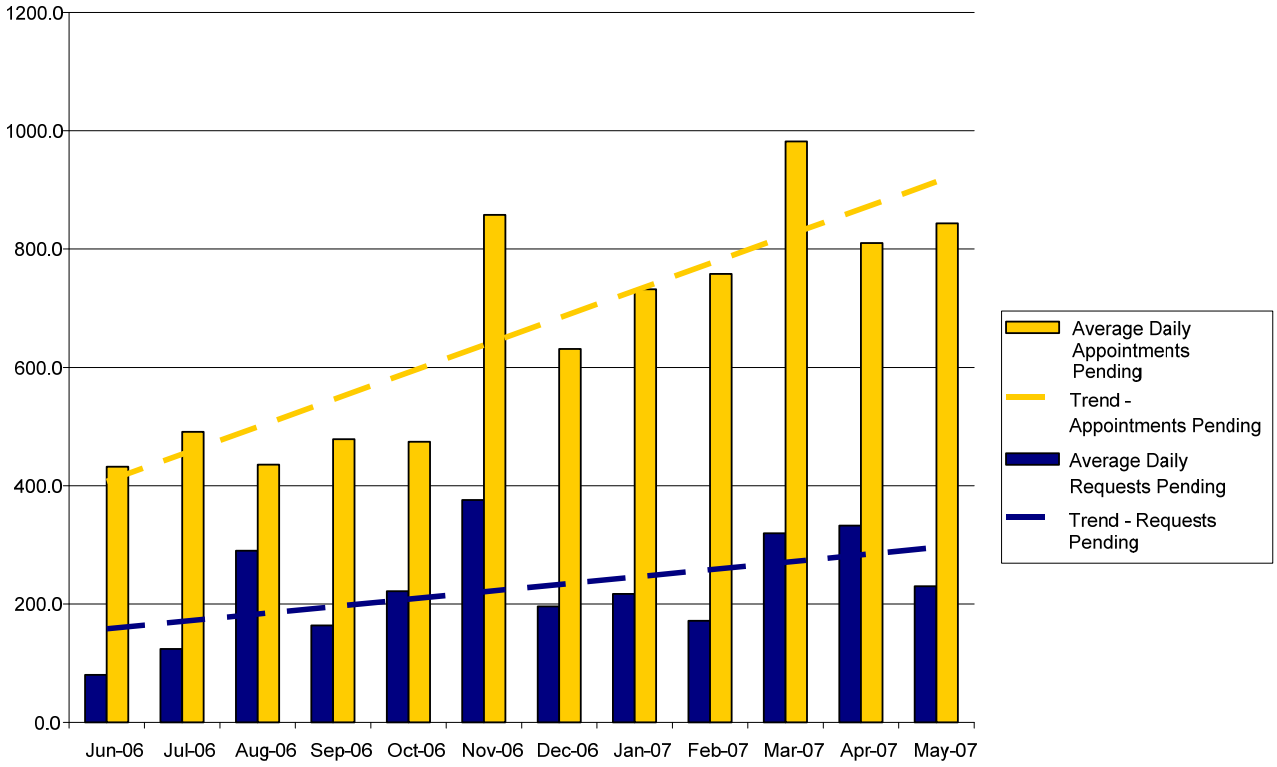
In the 2004 report, we noted that many of the inmate appointments needed with medical specialists occurred outside of GDC's established timeframes.

Utilization Management (UM) is a cost-containment function utilized by GDC to ensure that specialty appointments for various inmate health services are appropriate and necessary.[2] Requests for specialty services are sent to the UM staff and reviewed for appropriateness based on applicable SOPs. Inmates whose requests are approved are subsequently scheduled for an appointment with a provider.

From our review of recent UM data, it appears there is a growing backlog of requests pending review by UM staff nurses, as well as an increasing number of approved requests (appointments) that have yet to occur, as shown by **Exhibit 2** on the next page.

[2] UM was previously operated by MHM staff; GDC brought this function into OHS in January 2006.

Exhibit 2
Average Monthly UM Requests and Appointments Pending



Source: UM Data

OHS staff stated they were aware of the increasing backlog and explained that turnover in health care staff and continuing changes in the network of outside health care providers used by GCHC were contributing to the difficulty in scheduling appointments. OHS has also proposed changes to the UM SOPs, including the timeframes within which appointments must take place, but these had not been approved. An additional physician was also recently hired to assist the UM function.

In its response to this finding, GDC wrote the following:

"As with other areas, staffing for UM has not increased at the same level as the inmate population. Not only has the number of inmates increased, the average age of the inmate population as well as the inmates' average length of stay has increased, resulting in more healthcare problems needing treatment. A business process evaluation of the UM system is being planned for FY 08."

Risk may be increasing in Dental Care.

Our interviews with OHS staff indicated that dental health was an area of significant risk to GDC. The risk factors include the lack of dental staff in GDC facilities, the vacancy of the Statewide Dental Supervisor position for approximately two years, and the lack of dental auditing being performed during this period. Although, nationally, inmate litigation in dental health has not been successful, it may only take one successful case to increase the risk of litigation to GDC.

Analysis of Facility Health Care Staffing

Our 2004 report concluded that the "quality of the inmate health care system is threatened by decreased staffing levels that are a result of budget constraints." GDC agreed with this conclusion and wrote in its response, "Staffing of health services within correctional institutions is becoming increasingly difficult to maintain" and that "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."

Our review of health care staffing in GDC facilities found an overall increase of approximately 3% from fiscal year 2005 to fiscal year 2007 as shown in **Exhibit 3** below. During this period, however, the inmate population in GDC facilities increased by approximately 10%, resulting in the ratio of inmates to total health care staff increasing. Staffing related to physical, mental and dental care areas is discussed in more detail in the following sections.

"Most cases in which courts have found constitutional violations of inmates' rights to health care were fostered by the demands made on an overburdened staff coping with too few resources. No amount of concern or good faith effort by medical staff can overcome inadequate financing, and it is perhaps in this area that the courts have made their greatest contribution by prompting and, if necessary, forcing governmental decision makers to appropriate the funds necessary to maintain humane health care."
Source: Guidelines for the Management of an Adequate Delivery System by the National Institute of Corrections (2001).

Exhibit 3
Budgeted Staffing in GDC Facilities (FTEs)

	Fiscal Year		Change	
	2005	***2007***	***#***	***%***
Physical Care	1,031.10	1,065.00	33.90	3.3%
Mental Care	356.45	395.10	38.65	10.6%
Dental Care	57.00	57.75	0.75	1.3%
Other	61.50	36.00	-25.50	-37.6%
Total	**1,506.05**	**1,553.85**	**47.80**	**3.2%**

Source: GDC Staffing Plans

Physical Care Staff

Although the physical care staff increased by 3.3% as shown in **Exhibit 3**, much of this increase was due to additional "support" personnel (see the **Appendix** for more detail on staffing changes). Isolating the "direct" physical care FTEs (physicians, clinical practitioners, and physical care nurses) indicates an increase of only 3.2 FTEs as shown in **Exhibit 4** on the following page. Relative to the increase in inmates over this period, there are approximately five more inmates per "direct" care position than were budgeted for in fiscal year 2005, a 9.8% increase in two years.

Exhibit 4
Budgeted Direct Physical Care Staff (FTEs)

	Fiscal Year		Change	
	2005	***2007***	***#***	***%***
Physicians	51.70	49.40	-2.30	-4.4%
Clinical Practicioners	52.15	56.95	4.80	9.2%
Nurses	695.25	695.95	0.70	0.1%
Total Direct Care Staff	799.10	802.30	3.20	0.4%
GDC Facility Avg Daily Population*	44,276	48,822	4,546	10.3%
Inmates per Direct Care FTE	55.41	60.85	5.45	9.8%

*Population counts do not include contracted private and county prisons.

Source: GDC Staffing and Inmate Population Data

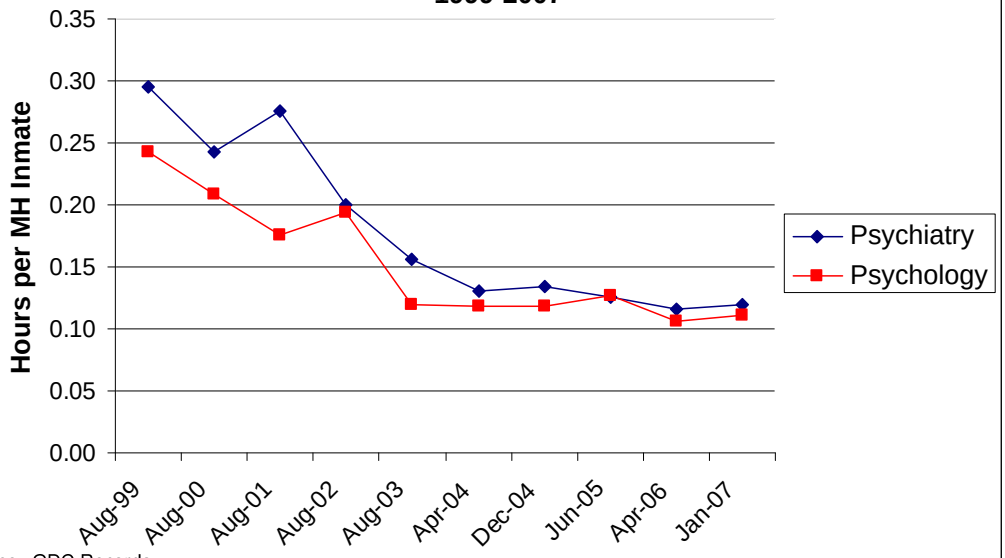
Mental Care Staff

Since fiscal year 2005, the number of budgeted mental health counselor positions has increased by approximately 15% (see the **Appendix**) while the inmate population on the mental health caseload increased by 12.2% (from 7,034 to 7,968). However, OHS estimated that they were still 42 counselors short (about 20%) of their target counselor-to-inmate ratios and that 10 of 26 facilities with a mental health caseload are understaffed according to these ratios. It should be noted that OHS had 27 vacant counselor positions as of April 2007.

Our review also found no improvement in psychology and psychiatry staffing relative to the mental health caseload as illustrated in **Exhibit 5** on the following page. From December 2004 to January 2007, psychology hours increased by 4.8% (from 840 to 880 hours) and psychiatry hours were unchanged, while, as noted above, the inmate population on the mental health caseload increased by 12.2%. Although there is no established ratio of psychology or psychiatry staff hours to the mental health inmate population, the annual mental health evaluations from 2004 through 2007 discusses the lack of mental health staffing and its adverse impact on mental care (see page 6 for the discussion of the mental health evaluation).

"Denial of adequate mental health care for serious mental health needs may violate the eighth amendment under the same deliberate indifference standard applied to other medical needs… Additionally, there must be some means of separating severely mentally ill inmates from the mentally healthy. Mixing mentally ill inmates with those who are not mentally ill may violate the rights of both groups."
Source: Guidelines for the Management of an Adequate Delivery System by the National Institute of Corrections (2001).

Exhibit 5
Psychiatry and Psychology Hours per Inmate on MH Caseload
1999-2007



Source: GDC Records

Dental Care Staff

The number of budgeted dentist positions for GDC facilities has decreased by .5 FTE from fiscal year 2005 to fiscal year 2007. As a result of the increasing inmate population, the number of inmates per dentist has increased to 2,100, as shown in **Exhibit 6** below. Therefore, GDC would have required approximately nine additional dentist positions to meet its target ratio of 1,500 during fiscal year 2007.

In its fiscal year 2008 budget request, GDC stated a new target of 1,200 inmates per dentist. Although GDC was appropriated funds to hire three more dentists, bringing the total to 26.25 FTEs, GDC will now require approximately 16 additional dentists (approximately 42 total dentists) to attain the new goal.

Exhibit 6
Dentist Staffing in GDC Facilities

	FY 2005	FY 2007	FY 2008
Budgeted Dentist FTEs	23.75	23.25	26.25
Avg Daily GDC Population	44,276	48,822	50,877 *(projected)*
Inmates per Dentist	1,864	2,100	1,938
GDC Targeted Inmates per Dentist	1,500	1,500	1,200
Additional Dentists Needed to Reach Target	5.77	9.30	16.15

Source: GDC Staffing and Inmate Population Data

Analysis of Correctional Health Care Costs

Health Care Cost Projection

In our 2004 report, we projected that costs per inmate would grow by 4% per year, resulting in fiscal year 2006 total GDC health care costs of approximately $171.1 million.

Exhibit 7 below shows that total GDC health care costs for fiscal year 2006 were $179.3 million, which is $8.2 million above our 2004 projection. According to GCHC, one of the reasons for the higher costs has been the increase in health care expenses for catastrophic inmate health claims. While GCHC financial reports show they paid $7.4 million in medical claims for the 100 costliest inmates in fiscal year 2004, this amount grew to over $13.8 million by fiscal year 2006, and was projected to be approximately $18.5 million for fiscal year 2007; this equates to a 35.5% annual increase in this category. Partly as a result of the 100 costliest inmates, GDC stated it was approximately $10.1 million over budget for its Health Program in fiscal year 2007. At the time of our evaluation, GDC expected this amount to be paid for with reserve funds from telephone commissions and commissary revenues, and that this would deplete all of these reserve funds.

Exhibit 7
Total Health Care Cost Projection, Fiscal Years 2007 - 2011

	Actual	Projected					Annual Increase
	FY 2006	FY 2007 [1]	FY 2008	FY 2009	FY 2010	FY 2011	FY 2007 - 2011
Inmate Population [2]	46,458	48,822	50,877	53,019	55,251	57,578	4.21%
Cost Per Inmate [3]	3,860	4,037	4,221	4,414	4,616	4,826	4.57%
Total Costs	$179,344,251	$197,080,382	$214,760,135	$234,025,910	$255,019,986	$277,897,405	8.97%

Notes:
1. For fiscal year 2007, the average daily inmate population was available and is presented; total correctional health care expenditures, however, were not available and are projected.
2. This population includes inmates in GDC-operated facilities only, excluding county and privately operated prisons. The projected annual increase of 4.21% in inmate population is based on a study by Rosser International, which is a GDC consultant.
3. The projected annual increase of 4.57% in inmate health care costs is based on historical increases from fiscal year 2003 to fiscal year 2006.

Sources: GDC inmate population and financial records, Rosser International population analysis

Exhibit 7 also shows an updated five-year projection for fiscal years 2007 through 2011. The increase in the health care cost per inmate is based on GDC historical data while the projected increase in the inmate population is based on a population analysis performed by a GDC consultant (Rosser International). In fiscal year 2011, it is projected that total GDC health care costs may be $278 million, which is approximately $99 million higher than was expended in fiscal year 2006.

Decrease in Infirmary Beds

Our review determined that the number of functional male infirmary beds in GDC state prisons decreased from 170 in 2004 to 156 in 2007. This is primarily due to the conversion of Lee Arrendale State Prison to a female prison in 2005. As the inmate population increased during this period, the utilization of these beds has, likewise, increased from 83% to 91%.

To quantify the impact of bed space utilization on physical health care costs, GDC recently estimated that 5.7 inmate hospital days per week (approximately 296 days per year) could have been avoided had an infirmary bed within a GDC prison been available. At the estimated daily average cost of $3,681 GDC pays hospitals for an admitted inmate, this totals over $1 million annually. Although no calculation has been performed to estimate how much it currently costs to operate a prison infirmary bed, OHS and GCHC staff agreed this cost is low. At the time of this report, OHS staff stated that 10 male infirmary beds at Lee Arrendale State Prison would reopen in early fiscal year 2008.

Other States' Correctional Health Care Costs

In order to compare costs to other states we obtained information from three of the four states surveyed in our 2004 report. **Exhibit 8** shows the health care cost per inmate from 2003 through 2006 for these three states. Although the per-inmate cost increase varied among the states, their average cost increase was 4.14%, slightly less than Georgia's 4.57% cost increase. According to the annual *Corrections Compendium* produced by the American Correctional Association (ACA), the annual per-inmate health care costs in state fiscal year 2005 for the 39 states responding to the survey ranged from $2,205 (Texas) to $6,030 (Wyoming). The average for these 39 states was $3,871.

Exhibit 8
Selected State Health Care Costs per Inmate

	2003	2004	2005	2006	Average Annual Increase, 2003-2006
Georgia	$3,376	$3,442	$3,760	$3,860	4.57%
Michigan	$5,426	$4,946	$5,388	$5,929	3.00%
Pennsylvania	$3,917	$4,123	$4,271	$4,418	4.09%
Virginia	$3,037	$3,221	$3,389	$3,637	6.19%

Source: Georgia, Michigan, Pennsylvania, and Virginia records

GDC and GCHC continue to employ the same cost containment measures used in 2004.

In 2004, we reported that GDC and GCHC had established a number of permanent cost containment measures including controls over pharmacy operations, negotiating provider contract rates, using telemedicine, collecting inmate co-payments, and using utilization management. Additionally, we concluded that GDC's use of mandatory staffing vacancy rates also contributed to lowering costs, although this measure could not be sustained without negatively impacting the quality of care. GDC agreed with this finding.

Our updated review found that the permanent cost containment measures are still in place. In particular, it appears GCHC's efforts in actively managing pharmacy operations and the drug formulary as well as negotiating discounts with hospitals and other outside care providers have been effective in containing costs in these areas. We also noted that GDC brought the utilization management (UM) function in house, whereas it had previously been contracted out to MHM.

GCHC still achieves competitive discounts rates with outside health care providers.

In 2004, we reported on a 2003 analysis by Price Waterhouse Coopers (PwC) that GCHC discount rates negotiated with outside health care providers during fiscal year 2002 were competitive with discounts attained by comparable "commercial/employer" health care plans.

As part of our review, we agreed to update the comparison of provider discount rates achieved by GCHC to the rates achieved by the State Health Benefit Plan (SHBP). Although we were unable to perform an adequate comparison on a provider-by-provider basis, we determined that the discount rates achieved by GCHC, in aggregate, appear to be competitive with SHBP rates (given that some providers are reluctant to provide care to inmates).

GDC and GCHC should consider contracting with outside professional consultants to perform more detailed analyses of these rates to ensure GCHC continues to achieve competitive discount rates with health care providers.

Before moving forward with a proposal to outsource the physical health care services agreement currently in place with GCHC, GDC should quantify the potential risks and benefits.

Our 2004 report found that OHS had established numerous management and operational controls over the correctional health care system. This included controls over its relationship with GCHC, a division of MCG. GDC agreed with this assessment, stating, "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."

During our review, we were informed that GDC has considered the possibility of outsourcing the health care agreement currently in place with GCHC. We also learned that AT Kearney, in its role as a procurement consultant for the state, reviewed this proposal and advised GDC that this action presented considerable risk as it would involve rebuilding the complex health care delivery system already in place. We agree with AT Kearney's assessment, and agree that the partnership between GDC and MCG has served the state well.

According to the 2007 evaluation performed by GDC's physical health care consultant:

> *"it is clear to me that despite a dramatic reduction in resources in central office, at least at Central State Prison, the program continues to perform quite satisfactorily. This has to be attributed to the stability of the Georgia Department of Corrections' partnership with [GCHC]. The leadership of GCHC has been involved with the GDC now for several years, at both regional and central office levels. They have been able to maintain stability of staffing at the institutions, which has allowed the programs to sustain their level of clinical quality...There is no question in my mind that if the Department chose to enter into the competitive bid process in which vendors may change every three years or every five years, the ability to sustain these programs would be dramatically handicapped."*

Furthermore, according to the Association of Government Accountants (AGA), the decision to outsource should only be made after performing appropriate cost analyses and feasibility studies. Before proceeding with a proposal to outsource the provision of physical health care, GDC should do the following:

- Assess and quantify GCHC's current performance as the provider of physical health care for Georgia's state inmates;

- Quantify and document the expected net benefits from moving to a private vendor. GDC should also consider all contract management controls and performance monitoring activities that would be needed to effectively monitor this new relationship.

"Some state systems have contracted out their entire health care delivery system. The use of independent contractors, however, does not relieve the institution (or the contractors) of legal responsibility for health care."
Source: Guidelines for the Management of an Adequate Delivery System by the National Institute of Corrections (2001).

Appendix

Budgeted Inmate Health Care Staffing in GDC Facilities

Fiscal Years 2005 and 2007

	GDC			GCHC			MHM			Total		
	2005	2007	% Change	2005	2007	% Change	2005	2007	% Change	2005	2007	% Change
Physical												
Physicians	0.50	0.00	-100.0%	51.20	49.40	-3.5%	0.00	0.00	N/A	51.70	49.40	-4.4%
Clinical Practicioners	0.00	0.00	N/A	52.15	56.95	9.2%	0.00	0.00	N/A	52.15	56.95	9.2%
Nurses	36.00	25.00	-30.6%	659.25	670.95	1.8%	0.00	0.00	N/A	695.25	695.95	0.1%
Pharmacy	6.00	4.00	-33.3%	63.80	70.40	10.3%	0.00	0.00	N/A	69.80	74.40	6.6%
Field Administrative Staff	0.00	0.00	N/A	36.00	37.50	4.2%	0.00	0.00	N/A	36.00	37.50	4.2%
Support Staff	1.00	0.00	-100.0%	85.70	108.30	26.4%	0.00	0.00	N/A	86.70	108.30	24.9%
Other Staff	5.00	4.00	-20.0%	34.50	38.50	11.6%	0.00	0.00	N/A	39.50	42.50	7.6%
Total Physical Health Care Staff	48.50	33.00	-32.0%	982.60	1032.00	5.0%	0.00	0.00	N/A	1,031.10	1,065.00	3.3%
Mental												
Psychiatrists	0.00	0.00	0.0%	0.00	0.00	N/A	21.25	23.80	12.0%	21.25	23.80	12.0%
Psychologists	0.00	0.00	0.0%	0.00	0.00	N/A	20.50	20.50	0.0%	20.50	20.50	0.0%
Counselors	134.50	131.00	-2.6%	0.00	0.00	N/A	37.00	66.00	78.4%	171.50	197.00	14.9%
Mental Health Nurses	0.00	0.00	N/A	72.70	87.30	20.1%	2.00	1.50	-25.0%	74.70	88.80	18.9%
Field Administrative Staff	16.00	15.00	-6.3%	0.00	0.00	N/A	3.00	4.00	33.3%	19.00	19.00	0.0%
Other Mental Health Staff	36.50	32.00	-12.3%	9.00	7.00	-22.2%	4.00	7.00	75.0%	49.50	46.00	-7.1%
Total Mental Health Care Staff	187.00	178.00	-4.8%	81.70	94.30	15.4%	87.75	122.80	39.9%	356.45	395.10	10.8%
Dental												
Dentists	15.75	12.50	-20.6%	1.00	1.00	0.0%	7.00	9.75	39.3%	23.75	23.25	-2.1%
Dental Hygienists	6.00	5.00	-16.7%	0.50	0.50	0.0%	0.00	0.00	N/A	6.50	5.50	-15.4%
Dental Assistants	23.75	23.00	-3.2%	1.00	1.00	0.0%	2.00	5.00	150.0%	26.75	29.00	8.4%
Total Dental Health Care Staff	45.50	40.50	-11.0%	2.50	2.50	0.0%	9.00	14.75	63.9%	57.00	57.75	1.3%
Other												
Clerk	17.00	13.00	-23.5%	0.00	0.00	N/A	3.00	0.00	-100.0%	20.00	13.00	-35.0%
Secretary	28.50	23.00	-19.3%	13.00	0.00	-100.0%	0.00	0.00	N/A	41.50	23.00	-44.6%
Total Other Staff	45.50	36.00	-20.9%	13.00	0.00	-100.0%	3.00	0.00	-100.0%	61.50	36.00	-41.5%
Total Budgeted Facility Staff	**326.50**	**287.50**	**-11.9%**	**1,079.80**	**1,128.80**	**4.5%**	**99.75**	**137.55**	**37.9%**	**1,506.05**	**1,553.85**	**3.2%**

Source: FY 2005 and 2007 Staffing Plans

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