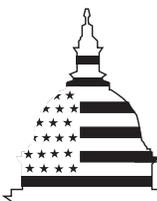


June 2004

DISTRICT OF COLUMBIA JAIL

Medical Services Generally Met Requirements and Costs Decreased, but Oversight Is Incomplete



G A O

Accountability * Integrity * Reliability



Highlights of [GAO-04-750](#), a report to the Chairman, Committee on Government Reform, U.S. House of Representatives

Why GAO Did This Study

Since the end of a court-ordered receivership overseeing medical services at the District of Columbia Jail in September 2000, the Department of Corrections (DoC) has contracted with the Center for Correctional Health and Policy Studies, Inc. (CCHPS) to provide inmate medical services. GAO was asked to provide information on (1) the medical services DoC contracted with CCHPS to provide, including CCHPS's monitoring of its services; (2) mechanisms DoC established to oversee CCHPS's services; (3) CCHPS's contract compliance and DoC's efforts to ensure compliance; and (4) the cost of medical services. To collect this information, GAO analyzed documents and interviewed officials from District agencies, CCHPS officials, and an independent reviewer hired by DoC to monitor medical services.

What GAO Recommends

GAO is recommending that the Mayor of the District of Columbia require the Director of DoC to (1) develop formal procedures, including collection of needed data, for determining whether CCHPS has met performance standards linked to monetary damages and for imposing these damages; and (2) ensure that CCHPS submits required quarterly and annual progress reports describing service problems and corrective actions. In reviewing a draft report, DoC did not comment on our recommendations, but provided additional information.

www.gao.gov/cgi-bin/getrpt?GAO-04-750.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Marcia Crosse at (202) 512-7119 or crossem@gao.gov.

DISTRICT OF COLUMBIA JAIL

Medical Services Generally Met Requirements and Costs Decreased, but Oversight Is Incomplete

What GAO Found

DoC has contracted with CCHPS to provide a broad range of medical services to inmates at the District of Columbia Jail and the Correctional Treatment Facility (CTF)—an adjacent overflow facility. Services include health screenings at intake; primary care services, including care for chronic conditions; mental health care; and specialty care. In addition, CCHPS assists DoC in helping inmates obtain services not included in the contract, such as specialty or emergency services that cannot be offered on-site. As part of the contract, CCHPS also established a quality improvement program to monitor its services. A key component of the program is a quarterly analysis of random samples of inmate medical records to measure how consistently CCHPS delivers required services.

DoC established several mechanisms to oversee CCHPS's delivery of medical services to inmates. For example, DoC retained an independent reviewer to monitor the services provided by CCHPS on a quarterly basis. In addition, the contract gives DoC authority to impose monetary damages on CCHPS if it fails to meet any of 12 requirements specified in the contract, most of which relate to providing key services to a minimum percentage of inmates. The contract also requires CCHPS to submit quarterly and annual progress reports describing quality problems identified by the independent reviewer or its own monitoring and actions taken to correct them.

Although available evidence indicates that CCHPS has generally complied with the terms of its contract, DoC has not exercised sufficient oversight to provide assurance that problems are not occurring or are quickly corrected. The independent reviewer has consistently found that CCHPS's services meet the contract's overall requirements for access to care and quality, but has also reported that CCHPS has not always met certain requirements. For example, while CCHPS recently improved its performance in providing timely follow-up services to inmates with abnormal chest x-ray results, the independent reviewer had repeatedly found problems in this area. DoC has not taken actions that would allow it to be assured of CCHPS's compliance with contract requirements linked to monetary damages. The agency has not collected data or developed a formal procedure to determine whether CCHPS has met the requirements, and it lacks a procedure to impose damages if warranted. Also, DoC has not regularly enforced the contract requirement that CCHPS submit quarterly and annual progress reports describing quality problems and corrective actions, and CCHPS has often not submitted these reports.

From 2000 to 2003, the average daily cost of providing medical services to a Jail inmate decreased by almost one-third, from about \$19 a day per inmate to about \$13 a day. In 2003, DoC consolidated the services provided to inmates in the Jail and the CTF under one contract with CCHPS. In that year, during which 17,431 inmates were admitted to the Jail and the CTF, the total cost of providing medical services at both facilities was about \$15.8 million.

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Abbreviations

ACA	American Correctional Association
CCA	Corrections Corporation of America
CCHPS	Center for Correctional Health and Policy Studies, Inc.
CTF	Correctional Treatment Facility
DMH	District of Columbia Department of Mental Health
DoC	District of Columbia Department of Corrections
DoH	District of Columbia Department of Health
FMCS	Family and Medical Counseling Services, Inc.
FTE	full-time equivalent
HIV	human immunodeficiency virus
LPN	licensed practical nurse
MAR	medication administration record
NCCHC	National Commission on Correctional Health Care
NP	nurse practitioner
PA	physician assistant
RN	registered nurse

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G A O

Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

June 30, 2004

The Honorable Tom Davis
Chairman
Committee on Government Reform
House of Representatives

Dear Mr. Chairman:

The District of Columbia Department of Corrections (DoC) is responsible for providing medical services to inmates of the District of Columbia Jail¹ and the Correctional Treatment Facility (CTF), an overflow facility adjacent to the Jail. From August 1995 until September 2000, medical services at the Jail were under the control of a court-ordered Receiver because DoC had not complied with repeated court orders to provide adequate care to inmates. The Receiver contracted with the Center for Correctional Health and Policy Studies, Inc. (CCHPS), a private not-for-profit organization, to provide medical services at the Jail beginning in March 2000.² When the receivership ended, the court returned responsibility for the Jail's medical services to DoC, which continued to contract with CCHPS. In April 2003, DoC expanded its contract with CCHPS to include medical services provided to inmates housed at the CTF.

In June 2000, shortly before the court terminated the receivership, we testified before the Subcommittee on the District of Columbia on selected issues related to medical services provided at the Jail.³ In response to questions about the cost and level of services, we reported that the per inmate cost of medical services at the Jail exceeded the cost in two other jurisdictions⁴ and that there were no specific criteria to determine an

¹The Jail is also known as the Central Detention Facility.

²The contract with CCHPS was renewable annually for up to 4 years after the initial contract year.

³See U.S. General Accounting Office, *District of Columbia Receivership: Selected Issues Related to Medical Services at the D.C. Jail*, [GAO/T-GGD-00-173](#) (Washington, D.C.: June 30, 2000).

⁴This earlier report reviewed costs and services in Baltimore and Prince George's County, Maryland.

acceptable level of medical services and staffing at the Jail. You asked us to obtain information on the District of Columbia's progress in providing medical services to inmates since the receivership ended and what mechanisms exist to monitor the quality of these services. We are reporting on (1) the medical services DoC has contracted with CCHPS to provide to inmates held at the Jail and the CTF, including CCHPS's monitoring of those services; (2) the mechanisms DoC established to oversee the services provided by CCHPS; (3) CCHPS's compliance with the requirements in its contract and DoC's efforts to ensure CCHPS's compliance; and (4) the cost of providing medical services at the Jail from 2000 to 2003 and the current cost of medical services at the Jail and the CTF.

To examine the medical services provided to inmates, CCHPS's monitoring of those services, and DoC's oversight of CCHPS's contract compliance, we analyzed documents and interviewed officials from DoC and CCHPS. In doing our work, we relied, in part, on reports by a national expert in correctional health care who was hired by DoC to conduct independent reviews of CCHPS's medical services. We interviewed this expert, referred to as the independent reviewer, and analyzed all of the quarterly reports he submitted to DoC. In addition, we analyzed a random sample of grievances submitted by Jail and CTF inmates from April 1, 2003, through October 31, 2003. Although we focused primarily on services provided by CCHPS, we also reviewed documents and interviewed officials about the medical services provided to inmates off-site that are not a part of the CCHPS contract. We also analyzed documents and interviewed officials from other District of Columbia agencies with responsibilities related to inmate health care and from national organizations that accredit correctional health care facilities. In addition, we reviewed our previous work related to medical services at the Jail. To determine the cost of providing medical services at the Jail and the CTF, we analyzed documents and interviewed officials from the District of Columbia Office of Contracting and Procurement; DoC, including its Office of the Chief Financial Officer; and CCHPS. We also examined independently audited accounting data from the District of Columbia Office of Financial Operations and Systems. We determined that the medical services cost information we used in our analysis was reliable. The scope of our work included medical services provided to CTF inmates only since April 2003, when DoC expanded its contract with CCHPS to include this facility. In reviewing DoC's activities, we assessed the agency's internal controls related to its contract with CCHPS. We did our work from August 2003 through June 2004 in accordance with generally accepted government auditing standards. (See app. I for additional details on our scope and methodology, including our cost calculations.)

Results in Brief

DoC has contracted with CCHPS to provide a broad range of medical services to inmates of the Jail and the CTF, and the types of services available have changed little since CCHPS began providing care in 2000. These services include physical and mental health screening when inmates are admitted; primary care; mental health care; and chronic and specialty care, such as dental and orthopedic services. CCHPS also assists DoC in helping inmates obtain services not included in the contract, such as specialty care and emergency medical services that cannot be offered at the Jail or the CTF and community-based medical services for inmates after they are released. CCHPS has established a quality improvement program to fulfill its obligation to monitor the quality of its services. A key component of this program is a quarterly analysis of random samples of inmate medical records; these analyses use standardized performance assessment instruments to provide CCHPS with quantitative data measuring how consistently it delivers required services to inmates.

DoC established several mechanisms to oversee CCHPS's delivery of medical services to inmates at the Jail and the CTF. DoC's contract with CCHPS gives DoC authority to impose monetary damages on CCHPS if it fails to meet any of 12 requirements specified in the contract, most of which relate to providing key services to a minimum percentage of inmates. For example, DoC may impose damages if CCHPS does not conduct an intake screening within 24 hours for 95 percent of inmates. In addition, DoC's contract with CCHPS requires CCHPS to submit quarterly and annual progress reports that discuss any quality problems and the actions taken to correct them. DoC's independent reviewer monitors the services provided by CCHPS on a quarterly basis. During his reviews, the independent reviewer uses the same performance assessment instruments as CCHPS to monitor both CCHPS's delivery of medical services and the accuracy of CCHPS's internal performance analyses. The independent reviewer does not, however, specifically review CCHPS's compliance with the contract requirements associated with monetary damages.

Although available evidence indicates that CCHPS has generally complied with the terms of its contract, DoC has not exercised sufficient oversight to provide assurance that problems either are not occurring or are quickly corrected. The independent reviewer has consistently found that the medical services CCHPS provides to inmates meet the contract's requirements for access to care and quality. In addition, CCHPS has generally met the contract requirement that it implement a quality improvement program. For example, CCHPS has regularly used the performance assessment instruments to monitor its services, and the independent reviewer has concluded that CCHPS's assessments with these

instruments are accurate. However, in a few areas CCHPS has not always met the contract's medical services and monitoring requirements. For example, while CCHPS recently improved its performance in providing timely follow-up to inmates with abnormal chest x-ray results, the independent reviewer had repeatedly found problems in this area since 2000. Although the independent reviewer provides DoC with important information about CCHPS's performance, other limitations in DoC's oversight of CCHPS's services may hinder the agency's ability to be assured of CCHPS's compliance with the contract. For example, DoC lacks the necessary data and a formal procedure to determine whether CCHPS has met contract requirements linked to monetary damages; it also lacks a procedure to impose damages if they are warranted. In addition, DoC has not regularly enforced the contract requirement that CCHPS submit quarterly and annual progress reports describing quality problems and corrective actions. CCHPS has never submitted the quarterly reports and has not submitted all the required annual reports.

From 2000 to 2003, the average daily cost of providing medical services to a Jail inmate decreased by almost one-third, from about \$19 a day per inmate to about \$13 a day. This decrease in per inmate costs occurred because the total cost of providing medical services at the Jail decreased by about 3 percent during this period, while the average inmate population rose by about 41 percent. DoC and CCHPS officials told us that they controlled total costs by various means, including controlling personnel expenditures. On April 1, 2003, DoC consolidated the services provided to inmates in the Jail and the CTF under one contract with CCHPS. This contract revision also introduced a new pricing structure, which simplified DoC's administration of the contract. DoC now pays CCHPS on a per inmate basis, using a rate schedule ranging from \$13.00 to \$14.75 a day per inmate, depending on the size of the inmate population. In contract year 2003, which ended March 31, 2004, the total cost of providing medical services at the Jail and the CTF was about \$15.8 million; during that year 17,431 inmates were admitted to the two facilities.

We are recommending that the Mayor require the Director of DoC to develop formal procedures, including collection of needed data, for regularly assessing whether CCHPS has met contract requirements linked to monetary damages and for imposing these damages. We are also recommending that the Mayor require the Director of DoC to ensure that CCHPS submits required quarterly and annual progress reports on identified problems and corrective actions.

We provided a draft of this report to DoC for comment. In its response, DoC did not comment on our recommendations, but provided additional information about its contract with CCHPS and medical services for inmates of the Jail and the CTF. In addition, DoC elaborated on its oversight of the medical services provided by CCHPS.

Background

The District of Columbia Jail and CTF house inmates awaiting trial or who have been sentenced for misdemeanors.⁵ The Jail was opened in 1976, and from 1985 to July 2002, a court order limited the population to 1,674 inmates. Since July 2002 the population has grown, and during March 2004, the facility had an average daily population of 2,357. In addition to serving as an overflow facility, the CTF houses pregnant inmates, inmates with disabilities who need medical services, inmates in witness protection, and inmates who need to be separated from the general inmate population. Opened in 1992, the CTF is operated by a private company, the Corrections Corporation of America (CCA), under a contract with DoC. During March 2004, the CTF had an average daily population of 1,197.

In 1995, the U.S. District Court for the District of Columbia removed medical services at the Jail from DoC's control, placing these services under the temporary supervision of a court-appointed Receiver. This removal resulted from the District of Columbia's failure to address problems identified in two lawsuits brought against the Jail in 1971 and 1975, which alleged that DoC was failing to provide minimally adequate medical care for inmates.⁶ Before it terminated the receivership in 2000, the Court hired a national expert in correctional health care to conduct an independent quality review of medical services provided by CCHPS to inmates at the Jail. DoC subsequently contracted directly with this expert to help develop a set of performance assessment instruments for

⁵While terms of incarceration may vary, under District of Columbia law, convictions for many misdemeanors can result in incarceration for up to 180 days. *See e.g.*, D.C. Code § 22-404; § 22-1510; § 22-3232; § 47-4101. In addition to pretrial detainees and convicted prisoners, the Jail and the CTF also house inmates waiting for transfer to other correctional facilities, including Federal Bureau of Prisons facilities, as well as inmates who have been returned to the District of Columbia area for various reasons, including parole hearings or court testimonies.

⁶*See Campbell v. McGruder*, 416 F.Supp. (D.D.C. May 24, 1976), 580 F.2d 521 (D.C. Circ. 1978) and *Inmates of D.C. Jail v. Jackson*, 416 F. Supp 111 (D.D.C. May 24, 1976). The CTF was not part of these lawsuits.

reviewing CCHPS's clinical services and monitoring activities⁷ and to conduct quarterly on-site reviews of CCHPS.

DoC has a constitutional obligation to ensure that medical care is provided to inmates in its custody,⁸ and DoC's contract with CCHPS requires CCHPS to provide comprehensive medical services to all inmates assigned to the Jail and the CTF and to establish a quality improvement program to monitor the quality of medical services it provides. In some areas, particularly the assessment of inmates' health when they are admitted to the facilities, the contract lists specific services that CCHPS must provide, such as certain diagnostic tests. In other areas, such as services for inmates with chronic conditions, the requirement to provide care is less detailed. In addition to describing services that CCHPS is required to provide, the contract states that DoC can impose monetary damages⁹ on CCHPS if it does not meet 12 specific requirements. (See app. II for a description of the contract requirements that are linked to monetary damages.) Compliance with the requirements is to be determined through monitoring by DoC or its designee.

The contract with DoC also requires that CCHPS acquire and maintain accreditation for its medical services. The Jail's medical services are accredited by the National Commission on Correctional Health Care (NCCHC), while the CTF is accredited by the American Correctional Association (ACA). NCCHC and ACA, both national, not-for-profit organizations, offer voluntary accreditation processes for medical services provided in correctional facilities; relatively few jails nationwide are accredited by these organizations.¹⁰ NCCHC accredits only a correctional facility's medical services, while ACA accredits all aspects of the correctional facility, including medical services. Both organizations have

⁷The instruments were developed jointly by the independent reviewer, CCHPS, and DoC.

⁸The Eighth Amendment to the Constitution of the United States prohibits "cruel and unusual punishment." The U.S. Supreme Court, in *Estelle v. Gamble*, concluded that "deliberate indifference to the serious medical needs of prisoners" violates this prohibition. 429 U.S. 97 104 (1976).

⁹Monetary damages, also referred to as liquidated damages, are amounts stipulated in a contract that a contractor agrees to pay for failing to comply with contractual requirements, such as requirements that work be completed by a certain time.

¹⁰There are currently over 3,000 jails nationwide. According to NCCHC, as of March 2004, approximately 232 jails had been accredited through its voluntary program. As of November 2003, approximately 165 jails had been or were in the process of becoming accredited by ACA's voluntary program.

developed detailed accreditation standards that include, for example, specific elements that are required in an inmate's initial medical assessment and in a facility's quality improvement program. The accreditation process for both organizations includes on-site inspections of the facility every 3 years and submission of an annual report certifying that the facility continues to be in compliance with the accreditation standards. During on-site inspections, inspectors interview staff, review documentation provided by the facility, and examine a sample of inmate medical records. NCCHC and ACA inspectors submit their findings to expert panels, who make the accreditation decisions.

One component of the quality improvement program required by both NCCHC and ACA is a grievance system that allows inmates an opportunity to question or complain about their care. Inmates at the Jail or the CTF who have concerns about medical services can complete a grievance form and submit it to the warden's office in their facility. The warden's staff records the grievance in their system and then forwards it to CCHPS. CCHPS's medical director and quality improvement coordinator review the grievance and work with the clinicians involved to determine if the inmate's complaint is valid and, if so, how it should be addressed. If it is determined that an inmate needs to receive care, CCHPS schedules an appointment. After CCHPS has reviewed the grievance, it sends a report to the warden, who then provides a response to the inmate.

In June 2000, we testified before the House Committee on Government Reform, Subcommittee on the District of Columbia, about the provision of medical services at the Jail.¹¹ We reported that the per inmate cost at the Jail was higher than those at the two other jurisdictions reviewed, and that services and staffing levels also exceeded those of the other jurisdictions.¹² We also found that there were no specific criteria that determine an acceptable level of medical service and staffing at a jail. Rather, the range of services was a function of many local factors, including the specific demands and constraints placed on the facility's service delivery system.

¹¹This testimony focused only on the medical services receivership and the contract with CCHPS as it pertained to the Jail, and did not consider any issues related to the CTF. See [GAO/T-GGD-00-173](#).

¹²We also reported that these services and staffing levels appeared to stem from court-ordered requirements.

CCHPS Provides a Range of Services to Inmates and Has Established Systems to Monitor Service Quality

As required by the contract, CCHPS provides a broad range of medical services to Jail and CTF inmates, and the types of services CCHPS provides at the Jail have not changed significantly over the life of the contract. In addition, CCHPS assists DoC in helping inmates obtain services beyond those included in CCHPS's contract, such as emergency and specialty care that cannot be provided at the Jail or the CTF. CCHPS also assists DoC in its efforts to work with other District of Columbia agencies and community providers to link soon-to-be-released inmates in need of medical services with services in the community. As part of its contract with DoC, CCHPS has also developed a system to monitor the quality of the medical services it provides to inmates. A key component of this program is quarterly analyses of random samples of inmate medical records to measure how consistently CCHPS delivers required services to inmates.

CCHPS Provides Screening and Treatment Services Required in Its Contract and Assists DoC in Obtaining Additional Services

As required by the contract, CCHPS provides a broad range of medical services to Jail and CTF inmates, including primary care services such as sick call¹³ and chronic care; mental health care; and specialty care, such as dental and orthopedic services. (See table 1 for a description of these services.) At intake, all inmates receive a health assessment—referred to as an intake screening—that screens for physical and mental health conditions. The inmates receive a physical examination and are asked about current and past health problems, substance abuse, and medication use. In addition, they receive a chest x-ray and skin test to identify possible tuberculosis.¹⁴ As part of the mental health screening, inmates are asked a series of questions.¹⁵ If inmates respond positively to any of these

¹³Sick call services consist of clinical services provided to inmates who have requested routine or nonemergency medical care. Inmates submit a form requesting to be seen during sick call and are scheduled to be seen by a nurse in sick call rooms located in the Jail's housing units. Inmates in the CTF are seen in a centralized location in the medical unit.

¹⁴Because tuberculosis occurs more frequently in correctional settings than in the general population and because of the ease with which it can be transmitted, it is considered a significant health issue for correctional facilities. Pregnant inmates and inmates who have been in the Jail or the CTF within the last 6 months and have a record of a normal chest x-ray do not receive a chest x-ray at intake. Similarly, inmates who have recently been in the facilities and received a skin test for tuberculosis with normal results are not required to have another. However, according to CCHPS officials, even if inmates have had a skin test within 3 to 4 weeks, they often perform another test to ensure that the inmate has not been exposed to tuberculosis while in the community.

¹⁵These pertain to whether the inmate currently uses or has ever used mental health services, has experienced a recent significant loss, has ever attempted suicide or self-injury, has a position of respect in the community, or is charged with a high-profile crime.

questions, or if they are a juvenile or in jail for the first time, they are referred for a comprehensive mental health assessment. Based on the findings of the intake screening, inmates in need of medical care may receive treatment in a chronic or specialty care clinic, receive therapy for mental health problems, or be placed in one of two specialized mental health units. According to CCHPS officials, in 2002 they conducted an average of 1,654 intake screenings each month. About 20 percent of these inmates were referred to a chronic care clinic, and about 34 percent were referred for further mental health assessment.

Table 1: Medical Services Provided by CCHPS to Inmates at the Jail and the CTF, March 2004

Service area	Type and description of service	Types of service providers
Intake services	Initial medical, mental health, and dental screening on admission to the Jail and referral for additional care if needed ^a	Physicians, physician assistants (PA), licensed practical nurses (LPN), phlebotomists ^b
Primary medical care	Sick call and primary care services: assessment of inmates requesting to be seen by a clinician and possible referral to a physician or specialty care clinic	Physicians, PAs, nurse practitioners (NP), registered nurses (RN)
	Chronic care services: ongoing management of chronic diseases, primarily asthma, diabetes, epilepsy and other seizure disorders, hypertension, and human immunodeficiency virus (HIV) and other infectious diseases	Physicians, NPs, PAs
	Halfway house services: assessment and coordination of care for inmates at one halfway house	NPs, RNs
Mental health services	“Outpatient” mental health services: services provided to inmates in the general housing population, including group therapy, one-on-one therapy, and medication management	Psychiatrists, psychologists, social workers, RNs, LPNs
	“Inpatient” mental health services: services provided in two specialized units of the Jail for inmates with acute or serious chronic mental health problems; inmates needing inpatient services are housed in these units ^c	Psychiatrists, social workers, RNs, LPNs; interdisciplinary team also includes corrections officers and classification and parole officers
Specialty care	Dental services: basic dental care, including routine and surgical extractions, fitting dentures, filling cavities, and oral hygiene and education	Dentists, dental assistants, dental hygienists
	On-site specialty services include cardiology, dermatology, gynecology, neurology, ophthalmology, orthopedics, general surgery, podiatry, and pulmonary clinics	Physicians, podiatrists
Infirmiry services	Short-term management of inmates requiring observation or a level of care that cannot be provided in the general population	Physicians, RNs
Ancillary services	Includes pharmacy services, laboratory services, and providing prostheses and glasses	Pharmacists, pharmacy technicians, radiology technicians, dieticians, off-site providers related to laboratory services, glasses, etc.

Source: GAO analysis of documents from the Center for Correctional Health and Policy Studies, Inc., and the District of Columbia Department of Corrections.

^aAll inmates are admitted to the Jail and the CTF through the Jail’s Receiving and Discharge Unit, so all intake screening takes place in the Jail.

^bPhlebotomists are medical technicians who collect blood.

^cThere are no inpatient mental health units in the CTF, so inmates in the CTF in need of inpatient services are transferred to the Jail’s inpatient units.

There have been no significant changes in the types of medical services provided by CCHPS since the start of its contract with DoC. However, there have been some minor changes, including modifications to on-site specialty clinics. For example, in 2001, the requirement for an oral surgery

clinic was deleted from the contract, and more recently CCHPS combined the ophthalmology and optometry clinics. In addition, CCHPS began offering endocrinology and infectious disease clinics on-site—even though they are not required by the contract—to improve inmates’ access to these services and continuity of care. CCHPS officials had expected the consolidation of medical services at the Jail and the CTF to result in some service efficiencies, such as combining the on-site specialty clinics offered at both facilities; however, CCHPS and DoC officials told us it has not been feasible to easily move inmates between facilities because of security issues. CCHPS therefore continues to offer all on-site specialty clinics at both facilities.

When inmates need medical services that cannot be provided at the Jail or the CTF, CCHPS refers them to providers in the community. These off-site services, including emergency care and certain specialty services, are not part of the CCHPS contract; instead, DoC has an agreement with the District of Columbia Department of Health (DoH) to provide services to inmates through Greater Southeast Community Hospital.¹⁶ When Greater Southeast is not able to provide the needed services, it in turn refers the inmates to other members of the DC Healthcare Alliance and other community providers.¹⁷ DoC pays for all off-site services through an interagency agreement with DoH;¹⁸ in 2003 there were 4,169 appointments for inmates off-site.

Although DoC’s contract with CCHPS does not specify that CCHPS provide discharge planning services to inmates,¹⁹ NCCHC accreditation

¹⁶Specialty services that are provided off-site include certain diagnostic tests and surgeries. While these services are not part of CCHPS’s contract, CCHPS has a utilization management nurse located at Greater Southeast to assist in managing off-site hospital and specialty services.

¹⁷Until 2001, medical services for certain District residents, including inmates, were offered through the not-for-profit Public Benefits Corporation and District of Columbia General Hospital. In 2001, the Public Benefits Corporation was abolished and most services at District of Columbia General Hospital were discontinued. The District and Greater Southeast entered into a contract to form the DC Healthcare Alliance to provide medical services to uninsured or underinsured District residents, as well as inmates. The Alliance, which is overseen by DoH, is composed of Greater Southeast and other local health care providers subcontracted to Greater Southeast.

¹⁸DoC transfers funds to DoH, which in turn arranges payment to service providers through its contract with Greater Southeast and the Alliance.

¹⁹Discharge planning refers to the process of providing soon-to-be-released inmates with medications and assistance in obtaining follow-up medical services when they are released.

standards include discharge planning activities. Both CCHPS and DoC have made efforts to plan for the release of inmates with medical conditions and to link them to community-based medical services.^{20,21} For example, CCHPS's policies require that inmates receive a 2-week supply of medications at the time of their release. In addition, CCHPS provides support to DoC's collaboration with the District of Columbia Department of Mental Health (DMH) to help Jail inmates²² obtain access to community mental health services when they are released.

CCHPS supports DoC's and DoH's discharge planning efforts to link inmates who have certain chronic and communicable diseases, such as tuberculosis, to community-based medical services. In addition, through a joint program of DoH's HIV/AIDS Administration and DoC, Family and Medical Counseling Services, Inc. (FMCS), a community-based provider, offers HIV testing and links HIV-positive inmates to services in the community when they are released.²³ CCHPS refers inmates requesting an HIV test to FMCS and provides FMCS with office space, computers, and access to the inmate's electronic medical record in the CCHPS system.²⁴

²⁰According to DoC officials, their concern about discharge planning has increased as a result of a July 2000 decision by the Supreme Court of New York. This decision held that each inmate receiving mental health services during incarceration in New York City was entitled to receive discharge planning services, so long as the services do not delay or postpone the inmate's release date. See *Brad H. v. City of New York*, 712 N.Y.S.2d 336 (Sup. Ct. 2000), *aff'd*, 176 N.Y.S2d 852 (App. Div. 2000).

²¹DoC and other District agencies bear the cost of these discharge planning services, although CCHPS provides some on-site support, including access to computers and office space.

²²A DMH staff member works on-site at the Jail to provide assistance to inmates. Because of resource limitations, this DMH staff member currently works only with Jail inmates unless contacted by CTF staff about a specific CTF inmate. However, DMH officials told us that they hope to eventually expand discharge planning services to CTF inmates with mental health problems.

²³FMCS also offers inmates pre- and post-test counseling and prevention information.

²⁴Under the Health Insurance Portability and Accountability Act privacy rule, CCHPS's disclosure of an inmate's personally identifiable health information to an outside health care provider is allowed where necessary for treatment, payment, or health care operations. See 45 C.F.R. §§ 164.502(a)(1)(ii) and 164.506 (2003).

CCHPS Developed a System to Monitor Its Medical Services

As part of its contract with DoC, CCHPS is responsible for monitoring the quality of the medical services it provides to Jail and CTF inmates, and CCHPS has established a quality improvement program to fulfill this responsibility. A key component of the program is a quarterly analysis of random samples of inmate medical records using standardized performance assessment instruments. These quarterly analyses provide CCHPS with quantitative data about its performance in certain areas. Each assessment instrument measures CCHPS's performance of a specific set of activities; these activities are generally more detailed than the requirements described in the contract.²⁵ (See app. III for a summary description of the instruments.) Using the samples of medical records and other documentation to complete the performance assessment instruments, CCHPS clinicians determine how consistently CCHPS delivers required services to inmates. Currently, there are 23 performance assessment instruments, 20 of which measure medical services provided to inmates in various service areas. For example, the intake services instrument includes a measurement of the percentage of inmates who received a chest x-ray for tuberculosis within 24 hours of admission. The remaining 3 instruments measure the extent to which CCHPS has conducted other components of its quality improvement program, such as validating that clinical staff are licensed.

In addition to these quarterly analyses of medical services, CCHPS's quality improvement program also includes other reviews, such as annual reviews of urgent care and radiological safety procedures, monthly reviews of inmate grievances and of any inmate deaths, and ongoing reviews of infection control activities. The program also requires CCHPS to conduct at least two in-depth studies a year, each of which focuses on a specific issue, such as a medical service problem that has been identified by the quarterly analyses.

²⁵As of May 2004, CCHPS and DoC were in the process of reviewing and revising these performance assessment instruments.

DoC Established Several Mechanisms to Oversee CCHPS's Delivery of Medical Services

DoC has developed several mechanisms to oversee CCHPS's delivery of medical services to inmates and enforce CCHPS's compliance with the contract. For example, DoC's contract with CCHPS gives DoC the authority to impose monetary damages if CCHPS fails to meet any of 12 requirements specified in the contract, most of which relate to CCHPS's performance in providing key medical services. For most of these requirements, the contract authorizes DoC to impose the damages if CCHPS fails to deliver the required service to a minimum percentage of inmates—for example if CCHPS does not conduct an intake screening within 24 hours for 95 percent of inmates. (See app. II for additional information on the contract requirements that are linked to monetary damages.) Some of the requirements relate to CCHPS's staff, including ensuring that staff have required licenses and credentials. In addition, the contract contains a requirement that CCHPS have an infection control program approved by DoC. DoC, or its designee, is responsible for determining CCHPS's compliance with these 12 contract requirements.

To further assist DoC in overseeing CCHPS's delivery of services, the contract also stipulates that CCHPS will submit quarterly and annual progress reports to DoC. These progress reports are to include a description of quality problems, such as those identified by CCHPS's quality improvement program or the independent reviewer, and actions taken to correct them. DoC also requires CCHPS to maintain accreditation of its services. In addition, DoC staff responsible for oversight of the contract are frequently on-site at the Jail and the CTF observing the contractor, and, as of May 2004, DoC had plans to begin jointly conducting the quarterly analyses of inmate medical records with CCHPS.²⁶

Furthermore, DoC's independent reviewer conducts quarterly reviews of CCHPS's activities. Each review consists of two principal components. First, the independent reviewer checks the accuracy of CCHPS's internal use of the standardized performance instruments. To do this, he uses the same performance assessment instruments that CCHPS uses in its quality improvement program to examine a sample of the analyses CCHPS has completed, and assesses whether CCHPS accurately characterized the

²⁶In the past, DoC conducted occasional reviews of CCHPS's services using the same performance assessment instruments as CCHPS.

medical records studied.²⁷ Second, in addition to validating CCHPS's analyses, the independent reviewer uses the performance instruments to independently assess the quality of CCHPS's services by analyzing a separate random sample of inmate medical records in selected service areas, such as mental health services.²⁸ While CCHPS uses the performance assessment instruments as a quality improvement vehicle, the independent reviewer's use of these instruments contributes to his assessment of whether CCHPS is meeting its contractual obligations. However, the independent reviewer does not specifically evaluate CCHPS's compliance with the contract requirements associated with monetary damages.

As part of his review, the independent reviewer also assesses other components of CCHPS's quality improvement program, visits the medical units at the Jail and the CTF, and interviews CCHPS staff. After conducting the review, the independent reviewer provides DoC with a written report describing his general findings, including service areas in which CCHPS excels or needs to improve. Since August 2000, the independent reviewer has conducted 14 quarterly on-site reviews of CCHPS.

CCHPS Generally Meets Contract Requirements, but DoC's Oversight of CCHPS Is Incomplete

Most available evidence indicates that CCHPS has generally complied with the contract, but DoC has not exercised sufficient oversight to be assured that problems are not occurring or are quickly corrected. The independent reviewer has reported that CCHPS's services meet the contract's requirements for access to care and quality. In addition, CCHPS has generally met the contract requirement that it implement a quality improvement program. However, in a few areas, CCHPS has not always met the contract's requirements, such as submitting required quarterly and annual progress reports describing quality problems and actions taken to correct them. Although the independent reviewer provides important information about CCHPS's performance, limitations in DoC's oversight of CCHPS may hinder the agency's ability to be assured of CCHPS's compliance with the contract. For example, DoC has not enforced the

²⁷His assessments cover a selection of service areas included in the 23 instruments. As he has become more confident of the accuracy of CCHPS's monitoring, he has reduced the number of service areas he includes in his reviews, and may validate only one or two areas during a review.

²⁸These service areas can be areas of his own choosing or areas DoC has asked him to review.

contract requirement that CCHPS provide it with quarterly and annual progress reports. Furthermore, although DoC has authority to impose monetary damages on CCHPS if it does not meet certain requirements included in the contract, DoC has not collected data needed to impose these damages or developed formal procedures for determining whether CCHPS has met these requirements and for imposing damages if CCHPS has not met them.

CCHPS Generally Provides Required Medical Services and Internal Monitoring, but a Few Gaps Remain

On the basis of his review, the independent reviewer has consistently reported that CCHPS's medical services meet the contract's requirements for access to care and quality. He has also reported that services meet the "required constitutional standards of care." In addition, he told us that, in his opinion, CCHPS is one of the best correctional health care providers in the country. According to the independent reviewer, some activities, such as documenting the administering of medication, have been performed consistently over the life of the contract. Other activities have improved over time. For example, in one report, the independent reviewer noted that CCHPS's chronic disease guidelines were outdated, but later reported that CCHPS had appropriately revised the guidelines.

In addition, CCHPS generally meets the contract requirement that it implement a quality improvement program. CCHPS has used the performance assessment instruments each quarter to monitor its services, and the independent reviewer has concluded that CCHPS accurately uses these instruments to assess its medical services. For example, based on data from its quarterly analyses, CCHPS identified problems in inmates' access to dental care. As a result, CCHPS conducted a study to identify ways to improve access to this service and eventually established a system that gave higher priority to care for inmates with more serious dental problems. CCHPS's subsequent review found that access had improved.

While CCHPS's medical services and monitoring efforts generally meet the requirements of the contract, in a few areas CCHPS has not always met requirements. For example, the contract requires that CCHPS provide timely follow-up services to inmates with abnormal chest x-ray results.²⁹ Although CCHPS has recently improved its performance, the independent

²⁹The contract requires CCHPS to provide inmates with a chest x-ray at intake to screen for tuberculosis, to review the results of the x-ray within 72 hours, and to provide appropriate referral for follow-up or additional evaluation if needed.

reviewer had repeatedly found that CCHPS did not always provide timely follow-up services to these inmates. The independent reviewer also recently determined that CCHPS is not performing reviews of inmate deaths. This is an NCCHC requirement, and CCHPS's quality improvement program specifies that CCHPS should conduct such reviews monthly.

In addition, CCHPS has not regularly submitted the required quarterly and annual progress reports providing information on quality problems and its actions to correct them. CCHPS has never submitted quarterly reports, and submitted only one annual report. Furthermore, the annual progress report CCHPS did submit provided only limited information. For example, it did not discuss CCHPS's lack of timely follow-up on abnormal x-ray results, although the independent reviewer had repeatedly identified this as a problem.

Inmates have expressed concerns about other medical services required by the contract. Our analysis of a sample of the 369 inmate grievances submitted from April 2003 through October 2003 found that many complaints related to inmates' ability to gain access to requested sick call and primary care services and to the timely distribution of medications.³⁰ For example, some inmates complained that they had submitted multiple requests to be seen during sick call and had not yet been seen. CCHPS's internal monitoring has also identified problems related to sick call services, such as inconsistent use of the protocols developed to guide inmate health assessments.³¹ In addition, advocacy groups with whom we spoke expressed concern about distribution of medications on weekends and to newly admitted inmates.

DoC's Oversight Limitations Reduce Its Assurance That CCHPS Complies with Contract

Although the independent reviewer provides important information about CCHPS's services, DoC has other weaknesses in its oversight of CCHPS that reduce its ability to be assured that CCHPS is complying with the contract and that problems are not occurring. DoC has never used its authority to impose monetary damages on CCHPS for failing to meet certain contract requirements. This is in part because it lacks the

³⁰The 369 grievances represent individual grievances. In some instances inmates submitted multiple grievances. During this period, over 10,000 inmates were admitted to the Jail and the CTF, and the combined average daily population was 3,169.

³¹CCHPS has developed a set of nursing sick call protocols to guide nurses providing sick call services.

necessary data and a formal procedure for determining whether CCHPS has met the requirements; it also lacks a procedure for imposing damages if they are warranted. To evaluate CCHPS's compliance with many of the requirements that are linked to monetary damages, DoC needs data that indicate the percentage of inmates for whom CCHPS provided the required service. One potential source for such data is the performance assessment instruments used by CCHPS and the independent reviewer, which measure many of the activities included in these contract requirements.³² However, at present, DoC neither regularly collects data itself nor requires the independent reviewer or CCHPS to submit data they collect through their quarterly analyses of services.³³ DoC officials also were not able to provide any documents that articulated how, and how often, they would evaluate CCHPS's compliance with the contract requirements associated with monetary damages, and DoC has not provided CCHPS with information on the status of its compliance. Furthermore, if DoC were able to determine that CCHPS was not meeting a contract requirement, it has not determined whether it would immediately impose damages on CCHPS or first give CCHPS an opportunity to correct the problem.

In addition, DoC has generally not enforced the contract requirement that CCHPS submit quarterly and annual progress reports describing quality problems and actions taken to correct them. These reports would allow DoC to obtain information on how CCHPS is addressing compliance or other performance problems identified by CCHPS's own monitoring or the independent reviewer. For example, the independent reviewer has repeatedly reported that CCHPS did not consistently screen and treat female inmates for chlamydia and gonorrhea. In addition, while CCHPS usually responds to inmate grievances in a timely way,³⁴ the independent reviewer has reported on several occasions that CCHPS does not analyze

³²CCHPS's analyses produce data on its compliance with 9 of the 12 requirements linked with monetary damages—all those related to medical services. The independent reviewer's analyses do not necessarily produce data on all 9 because he does not specifically review these 9 service areas and does not review the same service areas during each review.

³³The independent reviewer provided DoC with the data from his quarterly reviews through March 2001. Since then, he has generally not provided data.

³⁴CCHPS's policies and procedures state that the elapsed time from when CCHPS receives a grievance to when it issues a written response should be 10 days or less. In almost three-fourths of the cases we reviewed, CCHPS met this standard. According to the written responses we reviewed, many inmates had already received care by the time CCHPS wrote its response.

grievances in a sufficiently thorough way to identify systemic problems in CCHPS's services. Enforcing the requirement that CCHPS submit regular progress reports would better enable DoC to ensure that CCHPS promptly corrects such problems.

An area where DoC has been slow to carry out its oversight responsibility relates to the contract requirement for an infection control plan. To maintain its NCCHC accreditation, CCHPS must have an infection control plan, and the April 2003 modification of the contract required that CCHPS's plan be approved by DoC. Although CCHPS submitted an infection control plan to DoC for approval in August 2003, DoC did not complete its review and approve the plan until June 2004.

In addition to having gaps in its oversight of services provided by CCHPS, DoC is not providing systematic oversight to ensure that, when CCHPS refers inmates to off-site services, inmates receive those services promptly. DoC officials believe the closure of District of Columbia General Hospital in 2001 and the shift of off-site services to Greater Southeast Community Hospital have resulted in delays in obtaining off-site care for inmates, particularly in certain specialty areas, such as orthopedics and dermatology. The independent reviewer and CCHPS have also expressed concerns about access to off-site services. CCHPS, which is responsible for arranging and monitoring off-site appointments, documented earlier delays in obtaining these appointments, but at the time of our review, it no longer possessed this documentation. Despite its concerns, DoC has not systematically documented more recent delays in obtaining off-site appointments for inmates, is not able to provide any data on the nature or length of delays, and has no plans to study this issue.³⁵

Average Per Inmate Medical Cost at Jail Has Decreased

From 2000 to 2003, DoC's average daily cost of providing medical services to an inmate at the Jail decreased by almost one-third. This resulted from a decrease in the total cost of providing medical services to inmates despite an increase in the inmate population. DoC and CCHPS officials told us they controlled costs in various ways, including reducing personnel expenditures. In 2003, DoC consolidated the services provided to inmates in the Jail and the CTF under one CCHPS contract and introduced a daily per inmate pricing structure, known as per diem pricing. The total cost to

³⁵DoC uses data provided by CCHPS to track utilization of off-site services, but does not obtain or collect information related to the timeliness of those services.

provide medical services to inmates at the Jail and the CTF in 2003 was about \$15.8 million, an average of \$13.28 per inmate.

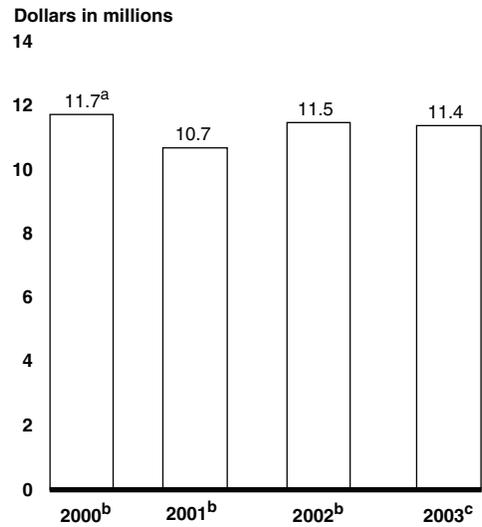
Cost of Medical Services at Jail Decreased, Despite Growth of Inmate Population

From initiation of the CCHPS contract in 2000 to 2003, the average daily per inmate cost of medical services at the Jail³⁶ decreased by almost one-third, from about \$19 a day to about \$13 a day. The average decrease resulted from a decline in the total cost of services, combined with a rise in the inmate population. During this period, the total cost of providing medical services at the Jail decreased from about \$11.7 million to about \$11.4 million,³⁷ about 3 percent. (See fig. 1.) At the same time, the average daily population in the Jail increased by about 680 inmates, about 41 percent. (See fig. 2.) In fiscal year 1999, the last full year in which the Receiver directly provided medical services at the Jail, the total cost was about \$12.6 million and the average per inmate cost was about \$21 a day.

³⁶Although DoC consolidated medical services for the Jail and the CTF under a single contract in April 2003, we were able to identify the cost attributable to the Jail for the entire year. See app. I for additional information on our cost and population calculations for each annual period.

³⁷Adjusted for medical inflation, the total cost would have decreased by about \$1.8 million from 2000 to 2003. Medical inflation adjustments were calculated using the medical care component of the Consumer Price Index for urban consumers.

Figure 1: Total Annual Cost of Medical Services at the District of Columbia Jail, 2000–2003



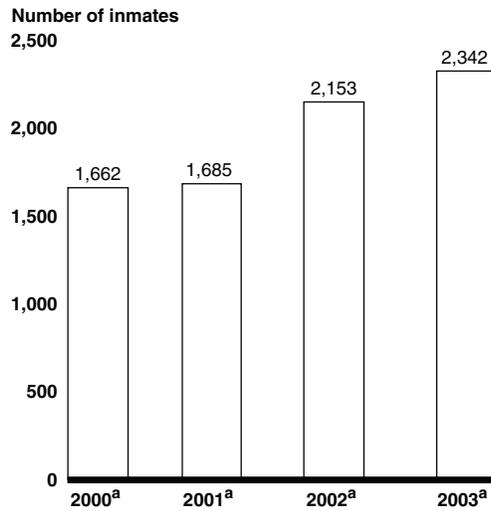
Sources: GAO analysis of data from the District of Columbia Department of Corrections, Department of Financial Operations and Systems, and the Center for Correctional Health and Policy Studies, Inc.

^aIf adjusted for medical inflation, the total cost for 2000 would have been about \$13.2 million. Medical inflation adjustments were calculated using the medical care component of the Consumer Price Index for urban consumers.

^bData for 2000, 2001, and 2002 are from March 12 of the year through March 11 of the following year, coinciding with the DoC-CCHPS contract year.

^cData for 2003 are from April 1, 2003, through March 31, 2004, approximating the DoC-CCHPS contract year and coinciding with the April 1, 2003, contract changes.

Figure 2: Average Daily Inmate Population at the District of Columbia Jail, 2000–2003



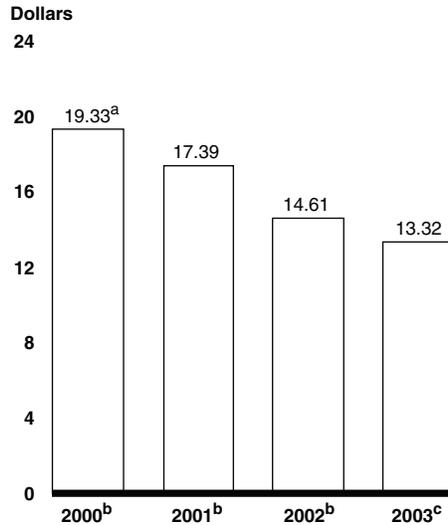
Source: GAO analysis of data from the District of Columbia Department of Corrections.

^aData for 2000, 2001, 2002, and 2003 are from April 1 of each year through March 31 of the following year, approximating the DoC-CCHPS contract year.

As a result of the combination of decreased cost and increased inmate population, DoC's average daily cost of providing medical services to an inmate at the Jail since CCHPS began providing services fell by almost one-third from 2000 to 2003.³⁸ (See fig. 3.)

³⁸We calculated the average daily cost per inmate by dividing the total cost for the period by the average inmate population for the period, and then dividing by the number of days in the period.

Figure 3: Average Daily Cost Per Inmate of Medical Services at the District of Columbia Jail, 2000–2003



Sources: GAO analysis of data from the District of Columbia Department of Corrections, Department of Financial Operations and Systems, and the Center for Correctional Health and Policy Studies, Inc.

Note: Average daily cost per inmate is calculated by dividing the total cost for the period by the average inmate population for the period, and then dividing by the number of days in the period.

^aIf adjusted for medical inflation, the total cost for 2000 would have been about \$13.2 million, resulting in an average daily cost per inmate for 2000 of about \$22. Medical inflation adjustments were calculated using the medical care component of the Consumer Price Index for urban consumers.

^bAverage daily cost per inmate for 2000, 2001, and 2002 is based on population data from April 1 of each year through March 31 of the following year, approximating the DoC-CCHPS contract year. It is also based on total cost data from March 12 of each year through March 11 of the following year, coinciding with the DoC-CCHPS contract year.

^cAverage daily cost per inmate for 2003 is based on total cost and population data from April 1, 2003, through March 31, 2004, approximating the DoC-CCHPS contract year.

DoC and CCHPS officials told us that they were able to reduce the total cost of providing medical services at the Jail through various means. For example, in 2003, DoC officials stopped paying CCHPS a management fee. DoC also negotiated with CCHPS officials to reduce employee salaries and fringe benefits, and CCHPS made more efficient use of its staff.³⁹ For example, CCHPS was able to eliminate unnecessary testing done at intake, such as conducting repeat chest x-rays for recently returned inmates, which allowed CCHPS to increase staff time available for providing other

³⁹Personnel expenditures represent about three-fourths of CCHPS's costs.

services. In addition, CCHPS officials told us they have selectively replaced higher salaried staff with lower salaried staff; in one case they changed a vacated pharmacist position to a pharmacy technician position.

CCHPS also controlled personnel expenditures by reducing the overall number of staff at the Jail, while still meeting NCCHC standards for physician staffing levels. When the contract began in March 2000, CCHPS had about 125 full-time equivalent (FTE) positions at the Jail,⁴⁰ and there were about 18 Jail inmates for each clinical staff member. As of April 2003, CCHPS's FTEs at the Jail had decreased to about 114, and the number of inmates for each clinical staff member had risen to about 27.⁴¹ NCCHC requires jails to maintain one physician on-site for 3.5 hours a week for every 100 inmates, and as of April 2003, CCHPS exceeded this standard by having one physician on-site for about 4.3 hours a week for every 100 inmates.⁴² Until April 2003, DoC established required staffing levels for CCHPS as a part of its contract, but the contract now allows CCHPS, with DoC's approval, to adjust staffing levels in response to inmate population changes.

Cost in 2003 Reflected Addition of the CTF and Change to a Per Diem Pricing Structure

In 2003, the total cost for medical services in the Jail and the CTF was about \$15.8 million;⁴³ over the course of that year 17,431 inmates were admitted to both facilities.⁴⁴ In the same year, DoC consolidated medical services for CTF inmates into the contract for services for Jail inmates. It also introduced a daily per inmate pricing structure—known as per diem pricing—to calculate the rates paid to CCHPS. This pricing structure uses

⁴⁰In March 2000, CCHPS was required by the contract to have 125.2 FTE positions at the Jail. By April 2003, the contract no longer specified the number of FTE positions CCHPS had to have.

⁴¹In April 2003, there were also 51.7 FTEs at the CTF.

⁴²At the time of the transition from the receivership to the CCHPS contract, members of Congress expressed concern that CCHPS's staffing level was very high; however, there is no single standard for an acceptable level of medical staffing at a jail. NCCHC's most recent standards indicate that, despite the general expectation for physician staffing ratios, the number and type of health care professionals required depends on a variety of factors.

⁴³Cost data for 2003 are from April 1, 2003, through March 31, 2004, approximating the DoC-CCHPS contract year.

⁴⁴In 2003, the combined average daily population of the Jail and the CTF was 3,257. These data are from April 1, 2003, through March 31, 2004, approximating the DoC-CCHPS contract year.

a per diem rate schedule, which is a sliding scale of prices that declines slightly as the combined inmate population increases. The schedule starts at \$14.75 per inmate when the inmate population is below 2,200, and incrementally falls to \$13.00 per inmate when the population exceeds 3,200. For example, if the combined population on a particular day were 2,000 inmates, the per diem rate would be \$14.75 and the total cost to DoC for that day would be \$29,500. According to DoC officials, the per diem rate declines when the inmate population rises to reflect economies of scale. Over the course of 2003, the per diem rate charged to DoC for services at the jail and the CTF averaged \$13.28 per inmate.

The per diem pricing structure has simplified DoC's contract administration by generally eliminating the need for a reconciliation process. Prior to April 2003, the contract required that DoC and CCHPS complete quarterly reconciliations to determine the difference between CCHPS's expected staff costs at the beginning of the contract year and CCHPS's actual staff costs during the year.⁴⁵ These differences resulted primarily from inmate population changes. However, as DoC and CCHPS negotiated the final amount of each reconciliation, the process became increasingly lengthy and several unresolved reconciliations accumulated. Over the first 3 years of the contract, for example, DoC completed only 4 of the 12 scheduled reconciliations. When the per diem pricing structure was implemented in 2003, all incomplete reconciliations were resolved in a final reconciliation settlement.

Conclusions

DoC has provided a broad range of medical services to inmates at the Jail and the CTF since the receivership ended in September 2000. CCHPS's medical services have generally met the contract's requirements for access to care and quality, and CCHPS has demonstrated a commitment to providing inmates with the services they need by adding on-site specialty clinics to improve access and continuity of care. CCHPS also regularly and accurately monitors its services to ensure that it is providing appropriate care. However, CCHPS has not always met all contract requirements for service delivery and quality improvement activities.

Although DoC has taken an important step toward ensuring the quality of services that CCHPS provides to inmates by retaining the independent

⁴⁵The new per diem pricing system retains two reconciliations each year for pharmaceutical supplies due to the high variability of pharmaceutical costs.

reviewer, it has not taken several other actions that would help it better oversee the care that inmates receive. For example, DoC has limited its ability to hold CCHPS accountable for meeting the contract requirements that are linked to monetary damages. For monetary damages to be a viable oversight and contract enforcement mechanism, DoC would need to obtain data that demonstrate whether CCHPS is providing required services to the minimum percentage of the inmate population stipulated by the contract. However, DoC has not collected these data. DoC would also need to develop formal procedures for assessing CCHPS's compliance with the requirements and for imposing monetary damages if they are warranted.

Furthermore, DoC has not enforced the requirement that CCHPS regularly submit progress reports describing how it is correcting problems identified through performance monitoring, including any problems that may place CCHPS out of compliance with the contract. If CCHPS provided this information, DoC could ensure that CCHPS promptly took corrective action to respond to problems identified by the independent reviewer or CCHPS's own monitoring, such as CCHPS's failure to promptly follow up on abnormal chest x-ray results. Having the capacity to enforce the contract requirements linked with monetary damages and requiring CCHPS to submit regular progress reports would strengthen DoC's ability to ensure that CCHPS provides important medical services to inmates.

Recommendations for Executive Action

To help ensure that CCHPS provides required medical services to inmates of the District of Columbia Jail and the CTF, we recommend that the Mayor require the Director of DoC to take the following two actions:

- Develop formal procedures—including collection of needed data—to regularly assess whether CCHPS's performance meets the contract requirements that are linked to monetary damages and to impose these damages.
- Ensure that CCHPS submits to DoC the required quarterly and annual progress reports, which should describe identified problems and the actions CCHPS has taken to correct them.

Agency Comments and Our Evaluation

We provided a draft of this report to DoC for comment. In its response DoC did not comment on our recommendations, but provided additional information about its contract with CCHPS and medical services for inmates of the Jail and the CTF. In addition, DoC elaborated on its oversight of medical services provided by CCHPS. (DoC's comments are reprinted in app. IV.)

DoC emphasized in its comments that the independent reviewer acts at the request and on behalf of the agency. We noted in the draft report that DoC's hiring of the independent reviewer was an important step toward ensuring the quality of CCHPS's services and described the independent reviewer's role in DoC's oversight of CCHPS. DoC expressed concern that the issues discussed in the independent reviewer's reports are intended to identify opportunities for CCHPS to improve, but that the draft report portrayed them as problems or deficiencies. While some issues raised by the independent reviewer could be characterized as opportunities for service improvement, we found that others indicated performance shortfalls related to specific contract requirements.

In its comments, DoC discussed our finding that CCHPS has not regularly submitted the quarterly and annual reports required by the contract; these reports are to provide DoC with information on problems identified by CCHPS's performance monitoring or by the independent reviewer and on CCHPS's corrective actions. DoC stated that instead of the quarterly reports, it relies on certain monthly reports and regular verbal communication. DoC's comments describe two types of monthly reports, one providing various data on off-site services and the other relating to two performance measures reported to the Office of the Mayor. However, undocumented verbal communications and these narrowly focused monthly reports are not a substitute for the quarterly progress reports called for in the contract and do not enable DoC to ensure that CCHPS is addressing identified problems. DoC's comments acknowledge that CCHPS has not submitted all required annual reports. We do not agree that the information provided in the December 2002 report on the reconciliation of CCHPS's expected and actual costs, which DoC cites in its comments, provided DoC with the type of information required in the annual progress reports. For example, this report contains no information about how CCHPS planned to improve its performance in screening and treating female inmates for chlamydia and gonorrhea.

DoC highlighted its role in reducing the cost of medical services provided to inmates by CCHPS. In the final report we provided additional information on DoC's role. DoC also noted that the average daily cost of services decreased from about \$19 to about \$13, which we stated in our draft report, and that this will result in savings over the remaining life of the contract. However, while the average daily cost per inmate in 2003 was \$13.32, under the current rate schedule, daily per inmate costs may range from \$13.00 when the combined Jail and CTF population exceeds 3,200 to \$14.75 when the inmate population is below 2,200. Therefore, costs over the remaining life of the contract will depend largely on the inmate population.

In response to DoC's comments, we replaced the term "financial penalties" with "monetary damages." While the comments state that DoC has other remedies for contract nonperformance, we believe that the authority to impose monetary damages is also a useful means of ensuring CCHPS's compliance with the contract.

In its comments, DoC described changes in the District's health care system that have affected the provision of off-site medical services for inmates. Because the focus of our report was on services provided by CCHPS through its contract with DoC, a detailed discussion of these developments was not within the scope of the report. DoC also stated that there was a past study on delays in obtaining off-site appointments for inmates and that there is no need to conduct an additional study. The draft report did not recommend that DoC conduct an additional study, but reported that DoC and the independent reviewer have identified problems with access to off-site services and that DoC has not collected data on delays.

We incorporated other information provided by DoC in its comments on our draft report where appropriate.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the DoC Director, interested congressional committees, and other parties. We will also make copies available to others on request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>. If you

or your staff have any questions about this report, please call me at (202) 512-7119. Another contact and key contributors are listed in appendix V.

Sincerely yours,

A handwritten signature in black ink that reads "Marcia Crosse". The signature is written in a cursive style with a long horizontal flourish at the end.

Marcia Crosse
Director, Health Care—Public Health
and Military Health Care Issues

Appendix I: Scope and Methodology

We examined the medical services provided by the Center for Correctional Health and Policy Studies, Inc. (CCHPS) to inmates at the Jail and the Correctional Treatment Facility (CTF), including CCHPS's internal monitoring; the District of Columbia Department of Corrections' (DoC) oversight of those services; CCHPS's contract compliance; and the cost of services under the contract. To provide information on CCHPS's and DoC's activities, we reviewed documents and interviewed officials from those two organizations. DoC documents we reviewed included contracting documents such as the original request for proposals and subsequent modifications, reports of inmate population volume, and specialty clinic utilization statistics. In reviewing DoC's activities, we assessed DoC's internal controls related to the contract with CCHPS. CCHPS documents we reviewed included policies and procedures, staffing plans, annual progress reports, and quarterly performance analyses. We also interviewed the independent reviewer hired by DoC and analyzed the reviewer's quarterly reports to examine CCHPS's medical services and CCHPS's quality improvement activities. In addition, we analyzed documents and interviewed officials from the National Commission on Correctional Health Care and the American Correctional Association to obtain information on their correctional health care accreditation standards, their accreditation review processes, and their findings on DoC facilities. We also reviewed our previous work on medical services at the Jail. We reviewed issues related to medical services provided to CTF inmates only since April 2003, when DoC expanded its contract with CCHPS to include medical services for inmates at that facility.

To obtain information on inmate complaints about medical services the contract requires CCHPS to provide and on CCHPS's responses to these complaints, we conducted an independent analysis of randomly selected samples of grievances submitted by inmates at the Jail and the CTF. Of the 201 grievances at the Jail and the 168 grievances at the CTF during the period April 1, 2003, through October 31, 2003, we randomly selected 75 grievances for each analysis, for a total sample size of 150. DoC was able to provide us with the detailed information needed for our analysis on 72 of the 75 grievances selected from the Jail and on 72 of the 75 grievances selected from the CTF. Grievances for which DoC could not provide the requested information were excluded from each analysis. For both the Jail and the CTF samples of inmate grievances, we analyzed the timeliness of CCHPS's response, the subject of the grievance, and the extent to which CCHPS's response addressed the principal areas of concerns cited in the complaint. The final sample size of 144 grievances produced estimates about types of grievances and timeliness of responses with a margin of error of plus or minus 5.0 percent at the 95-percent confidence level.

Although we focused principally on medical services provided by CCHPS under its contract with DoC, we also obtained information about inmate services that are not part of the CCHPS contract—such as off-site services—by reviewing documents and interviewing officials from CCHPS, DoC, and the District of Columbia Department of Health (DoH). Documents we reviewed included contracts between DoH and community providers and utilization data on off-site services provided to inmates. We also interviewed officials from the District of Columbia Department of Mental Health, a community health care provider, and groups providing legal services to inmates.

To calculate the total annual and average per inmate costs of the medical services that CCHPS provided, we reviewed documents such as DoC's budget records, purchase order summaries, contract pricing modifications, and CCHPS invoices. We interviewed officials from the District of Columbia Office of Contracting and Procurement; DoC, including its Office of the Chief Financial Officer; and CCHPS. We also examined independently audited accounting data from the District of Columbia Office of Financial Operations and Systems. We determined that the medical services cost information we reviewed was reliable, based on documentation provided by the District of Columbia Office of Financial Operations and Systems stating that the source of the data was the System of Accounting and Reporting, the District of Columbia's official accounting records, which is subject to an independent audit each year. We made certain assumptions to define four comparable 12-month periods that approximated the DoC-CCHPS contract year. Although there are slight differences between the time periods defined for total costs and inmate population averages, the length of each period was 1 year. Total cost data for 2000, 2001, and 2002 are from March 12 of each year through March 11 of the following year, coinciding with the DoC-CCHPS contract year, while inmate population data for 2000, 2001, and 2002 are from April 1 of each year through March 31 of the following year, approximating the DoC-CCHPS contract year. Total cost and inmate population data for 2003 are from April 1, 2003, through March 31, 2004, approximating the DoC-CCHPS contract year. We calculated the average daily inmate population for each annual period by first calculating an average daily population for each of the 12 months within the period, and then averaging the monthly averages.

We applied an accrual methodology to calculate the total costs associated with each annual period. The DoC-CCHPS contract during the years 2000 through 2002 specified a fixed contract price at the beginning of each year, subject to reconciliations during the year. Reconciliations conducted

during contract years often resulted in adjustments to DoC payments in a subsequent contract year. By applying an accrual method, we attributed reconciliation costs to the years from which they originated rather than the years in which they were paid. We performed our work from August 2003 through June 2004 in accordance with generally accepted government auditing standards.

Appendix II: Requirements Linked to Monetary Damages Provisions in the CCHPS Contract

The contract between DoC and CCHPS contains certain requirements that CCHPS must meet. If these requirements are not met, DoC has the authority to impose specified monetary damages on CCHPS. Table 2 summarizes the requirements linked with monetary damages.

Table 2: Summary of Contract Requirements with Monetary Damages Provisions

	Monetary damages may be imposed if:	Damages calculation method
Medical services	Less than 95 percent of Jail intake health screenings are completed within 24 hours.	\$200 times the number of occurrences during the period being measured ^a
	Less than 95 percent of eligible inmates' tuberculosis skin tests are placed and read within the prescribed time frame. For this item "eligible inmates" are inmates in the Jail or the CTF more than 96 hours.	\$200 times the number of occurrences during the period being measured ^a
	Less than 95 percent of eligible inmates with positive tuberculosis skin tests receive timely follow-up. For this item "eligible inmates" are inmates in the Jail or the CTF more than 30 days.	\$100 times the number of occurrences during the period being measured ^a
	More than 10 percent of the eligible inmates known to have an abnormal blood pressure do not have a plan to control blood pressure levels documented in the medical record within 14 days. For this item "eligible inmates" are inmates in the Jail or the CTF more than 15 days.	\$100 times the number of occurrences above the 10-percent threshold during the period being measured ^a
	More than 15 percent of the eligible inmates known to have human immunodeficiency virus (HIV) have a clinical status warranting treatment for prevention of pneumonia, and are not receiving it within 2 weeks of identification of the need for treatment. For this item "eligible inmates" are inmates in the Jail or the CTF more than 15 days.	\$100 times the number of occurrences above the 15-percent threshold during the period being measured ^a
	More than 15 percent of the eligible diabetics tested as part of an audit are found to have a Hemoglobin A1c ^b level greater than 7 percent and there is no documented clinical strategy to improve the outcome. For this item "eligible inmates" are inmates in the Jail or the CTF more than 15 days who are known to have diabetes.	\$100 times the number of occurrences above the 15-percent threshold during the period being measured ^a
	Less than 95 percent of eligible inmates with chronic illness (hypertension, diabetes, HIV, asthma, seizures) are followed clinically according to the chronic care guidelines and seen at least every 90 days.	\$100 times the number of days for each inmate not followed in the chronic care clinic
	Infection control	The contractor does not maintain a DoC-approved infection control plan within 1 month of the contract award.

**Appendix II: Requirements Linked to
Monetary Damages Provisions in the CCHPS
Contract**

	Monetary damages may be imposed if:	Damages calculation method
Staffing	The contractor does not maintain valid and current licenses and certifications as required for all health care providers.	\$500 times the number of occurrences per day for each healthcare provider, calculated from the date of the finding
	The contractor does not have evidence of annual tuberculosis screening and hepatitis B immunization for all health care staff. The contractor's direct patient care personnel fail to maintain current cardiopulmonary resuscitation certification.	None identified
	The contractor leaves vacant a principal leadership position ^c for greater than 60 days. If a qualified individual is performing the functions of a principal leadership position, this position is not considered vacant.	One and one-half the salary rate per hour plus fringe hourly rate defined in the contract ^d times the number of required hours the position is left vacant after 60 days
	The contractor leaves vacant any required position as accepted by DoC in the contract for greater than 120 days.	One and one-half the salary rate per hour plus fringe hourly rate defined in the contract ^d times the number of required hours the position is left vacant after 120 days

Source: GAO analysis of the District of Columbia Department of Corrections documents.

^aThe contract states that these damages will not exceed a 30-day period. However, DoC officials were not able to explain whether this means that the period being measured is not to exceed 30 days or that the damages cannot be imposed for a period exceeding 30 days.

^bHemoglobin A1c is a blood sugar average used to determine how well diabetes is being controlled. The contract defines a normal hemoglobin A1c level as less than 6.8 percent.

^cPrincipal leadership position is defined as the medical director, mental health director, health services administrator, executive administrator, or director of nursing.

^dAccording to DoC officials, the hourly rates are defined using the most recent wage rates specified in the contract.

Appendix III: Performance Assessment Instruments Used to Monitor Services Provided by CCHPS

In 2000, DoC, CCHPS, and the independent reviewer hired by DoC to monitor CCHPS's medical services developed performance assessment instruments to allow them to determine how consistently CCHPS delivered required medical services to inmates and whether it conducted activities included in its quality improvement program.¹ Table 3 describes the measures included in the performance assessment instruments, as well as the samples measured and the sources of the samples. When reviewing services, the person conducting the assessment determines whether each bulleted measure has been met.

¹As of May 2004, CCHPS and DoC were in the process of reviewing and revising these performance assessment instruments.

**Appendix III: Performance Assessment
Instruments Used to Monitor Services
Provided by CCHPS**

Table 3: Information on Performance Assessment Instruments Used to Monitor CCHPS's Services

Service area/type	Measure	Sample used	Source of sample
Intake services			
Intake evaluation	<ul style="list-style-type: none"> Performed complete health assessment by licensed physician, physician assistant (PA), or nurse practitioner (NP) at intake to the Jail, including a physical and oral examination and review of bodily systems, such as the cardiovascular system; a medical and substance abuse history; check of vital signs (breathing rate, pulse, temperature); and analysis of a urine sample Placed tuberculosis skin test, if applicable, and read within 48-72 hours; performed chest x-ray, if applicable, within 24 hours Documented syphilis lab test result Conducted further mental health evaluation within 24 hours, if indicated by positive response to screening questions asked at intake 	20 randomly selected inmate medical records ^a	General inmate population
	<ul style="list-style-type: none"> Performed pregnancy test 	10 randomly selected inmate medical records	Female inmate population
Primary medical care			
Asthma care	<ul style="list-style-type: none"> At intake or within the past 3 months, conducted measurement of the amount of air an inmate can push out of his/her lungs 	10 randomly selected inmate medical records ^b	Inmates with asthma
	<ul style="list-style-type: none"> Followed chronic disease guideline; assessment included degree to which disease has been controlled and strategy to improve outcome if degree of control is fair or poor or if patient's status has worsened^c 	First 5 of the 10 randomly selected inmate medical records reviewed above	
Diabetes care	<ul style="list-style-type: none"> Measured blood sugar levels on intake 	10 randomly selected inmate medical records ^b	General inmate population
	<ul style="list-style-type: none"> Performed blood test that measures average blood sugar over a period of time (Hemoglobin A1c), and if test indicated diabetes, a clinical strategy for treating the inmate was documented in medical record within 40 days of admission to facility or within past 3 months 	10 randomly selected diabetic inmate medical records	Inmates with diabetes
	<ul style="list-style-type: none"> Followed chronic disease guideline; assessment included degree to which disease has been controlled and strategy to improve outcome if degree of control is fair or poor or if patient's status has worsened^c 	First 5 of the 10 randomly selected diabetic inmate medical records reviewed above	

**Appendix III: Performance Assessment
Instruments Used to Monitor Services
Provided by CCHPS**

Service area/type	Measure	Sample used	Source of sample
Human Immunodeficiency Virus (HIV) care	<ul style="list-style-type: none"> • Tested for level of certain white blood cells with CD4 marker^d and HIV viral count within 40 days or within the past 3 months • Offered treatment for prevention of pneumonia within 2 weeks if level of certain white blood cells with CD4 marker is low • Considered or ordered anti-HIV drugs within 2 weeks if level of certain white blood cells with CD4 marker is moderately low • Followed chronic disease guideline; assessment included degree to which disease has been controlled and strategy to improve outcome if degree of control is fair or poor or if patient's status has worsened^e • Vaccinated against pneumococcal infection including pneumonia • Administered influenza vaccine during flu season, October – February. 	10 randomly selected inmate medical records ^b	Inmates with HIV
Hypertension care	• Noted blood pressure reading at intake	10 randomly selected inmate medical records ^b	General inmate population
	• Initiated treatment, or plan to treat, within 14 days of identification of high blood pressure	10 randomly selected medical records of inmates with high blood pressure	Inmates with high blood pressure
	• Followed chronic disease guideline; assessment included degree to which disease has been controlled and strategy to improve outcome if degree of control is fair or poor or if patient's status has worsened ^e	First 5 of the 10 randomly selected medical records of inmates with high blood pressure reviewed above	
Positive tuberculosis skin test cases	• Clinical evaluation of inmate and treatment decision made within 14 days ^c	10 randomly selected inmate medical records ^e	Inmates with positive tuberculosis skin tests
Nursing sick call performance	<ul style="list-style-type: none"> • Assessment of inmate's condition appropriate to chief complaint^f • Recorded relevant vital signs, such as breathing rate, pulse, and temperature^f • Treatment plan appropriate to condition^f 	2 inmate medical records from each of 18 inmate housing units ^g	Sick call requests from inmates
Mental Health Services			
Chronic mental health care	<ul style="list-style-type: none"> • Psychiatric progress evaluations conducted by psychiatrist every 2 weeks • Inmate's interdisciplinary treatment plan reviewed by staff within 4 weeks 	10 randomly selected inmate medical records	Inmates in male inpatient mental health housing units

**Appendix III: Performance Assessment
Instruments Used to Monitor Services
Provided by CCHPS**

Service area/type	Measure	Sample used	Source of sample
Acute mental health care	<ul style="list-style-type: none"> Initial mental health assessment done by clinical staff within 7 working days Initial psychiatric evaluation done by psychiatrist within 24 hours Subsequent psychiatric progress evaluations by psychiatrist every week Developed interdisciplinary treatment plan within 5 working days Inmate's interdisciplinary treatment plan reviewed within 4 weeks 	10 randomly selected inmate medical records	Inmates in male inpatient mental health housing units
Abnormal Involuntary Movement Scale (AIMS) testing	<ul style="list-style-type: none"> Documented testing (AIMS test) to determine possible side effects of antipsychotic drugs within 30 days of intake or within past 6 months 	10 inmate records from male inpatient mental health housing unit and 10 inmate medical records from general population	Pharmacy list of inmates taking antipsychotic drugs
Appropriate medication for mental health treatment	<ul style="list-style-type: none"> Diagnosis consistent with use of medication^h 	10 randomly selected inmate medical records	Pharmacy list of inmates taking certain medications, e.g., for schizophrenia
Level of certain drugs for bipolar disorder (depakote and lithium)	<ul style="list-style-type: none"> Reported level of medications every 3 months Physician review of medication levels with appropriate response noted in medical records^h 	10 randomly selected inmate medical records	Pharmacy list of inmates receiving depakote and lithium
Specialty care			
Urgent care performance	<ul style="list-style-type: none"> Care timely^f Documented appropriate vital signs, such as breathing rate, pulse, and temperature^f Appropriate assessment of condition and plan to treat^f 	10 urgent care visits ⁱ	Inmates seen in urgent care
Specialty clinic services	<ul style="list-style-type: none"> Progress note in medical record reflects need for consultation Consultation ordered by physician, PA, or NP Consultation accomplished within 30 days of order Documentation of appropriate follow-up consistent with consultant's recommendation or rationale for not following consultant's recommendation 	5 randomly selected inmate medical records from each specialty clinic ^j	Inmates seen in specialty clinic
Communicable disease treatment	<ul style="list-style-type: none"> Screened female inmates for gonorrhea and chlamydia within 14 days of admission to the facility 	10 randomly selected inmate medical records	General inmate population
	<ul style="list-style-type: none"> Patients with positive test for syphilis received appropriate treatment (based on federal guidelines) within 5 days of receiving laboratory report^c 	10 randomly selected inmate medical records for each disease	Inmates identified as positive for gonorrhea, chlamydia, or syphilis
	<ul style="list-style-type: none"> Patients with positive test for gonorrhea received appropriate treatment (based on federal guidelines) within 3 days of receiving laboratory report^c 		
	<ul style="list-style-type: none"> Patients with positive test for chlamydia received appropriate treatment (based on federal guidelines) within 3 days of receiving laboratory report^c 		

**Appendix III: Performance Assessment
Instruments Used to Monitor Services
Provided by CCHPS**

Service area/type	Measure	Sample used	Source of sample
Dental care	<ul style="list-style-type: none"> Timeliness of treatment appropriate to condition: Trauma/symptoms of infection or intense pain – within 24 hours Any other acute condition – within 7 days Documentation that oral health education materials were provided to patients Clear and complete documentation of visits and procedures, including medical history 	10 randomly selected inmate medical records	Inmates seen in dental clinic
Ancillary services			
Chest X-ray reporting and follow-up	<ul style="list-style-type: none"> Timely reporting of chest x-ray results, appropriate clinician acknowledgment of results, and appropriate follow-up of abnormal chest x-ray results within 48 hours^c 	10 randomly selected inmate medical records	Log of all x-rays taken
Nonchest X-ray reporting and follow-up	<ul style="list-style-type: none"> Timely reporting of x-ray results, appropriate clinician acknowledgment of results, and appropriate follow-up of abnormal x-ray results within 48 hours of when the x-ray is performed^c 	10 randomly selected inmate medical records	Log of all x-rays taken
Laboratory services ^k	<ul style="list-style-type: none"> Report laboratory results within 24 hours, as appropriate Clinical acknowledgment of laboratory results and appropriate clinical response^c 	10 randomly selected inmate medical records	No source identified in performance assessment instruments
Medication administration records (MAR) ^l	<ul style="list-style-type: none"> Number of omissions in inmate records in the medication administration books Number of cases in which inmates refused medications on three consecutive occasions noted in the medication administration books Number of cases in which inmates who refused medications on three consecutive occasions received appropriate follow-up^m 	5 MARs books	MARs books
Quality improvement activities			
Credentialing	<ul style="list-style-type: none"> Validated current license for physician, PA, and NP staff and U.S. Drug Enforcement Administration registration for physician and NP staff Validated current license – nursing staff Validated current license – dental staff Validated current license – mental health staff 	10 randomly selected clinician files from each provider type, and from the combined physician/PA/NP staff	Nursing files, dental files, mental health files, and combined physician/PA/NP files
Complaints and grievances	<ul style="list-style-type: none"> Analyzed trends in terms of numbers and category distribution of complaints and grievances Percentage of complaints and grievances appropriately addressed within 14 days 	All medical grievances	CCHPS log of inmate grievances

**Appendix III: Performance Assessment
Instruments Used to Monitor Services
Provided by CCHPS**

Service area/type	Measure	Sample used	Source of sample
Quality improvement program	<ul style="list-style-type: none"> Annual work plan Activities reviewed include management of communicable diseases, pharmacy and therapeutics, reviews of inmate deaths, clinical guidelines, and adherence to standards. In addition, there is regular performance measurement of access to and availability, continuity, and coordination of care; complaints about care; and acute, chronic, and communicable disease care. Focus studies should be performed where problems exist. Barriers to care should be identified and interventions should be designed to reduce the barriers. Remeasurement should occur to document meaningful improvement. 	Not applicable	Not applicable

Source: GAO analysis of the Center for Correctional Health and Policy Studies, Inc. information.

^aThis sample is limited to the first eight if all eight have been done appropriately. The sample is chosen from the 2-week period beginning 4 weeks prior to the review.

^bThe sample is chosen from the inmates seen within the 3 months prior to the review.

^cPerformance assessment requires clinical judgment by physician, PA, or NP.

^dCD4 cells are a type of white blood cell that fights infection. HIV destroys CD4 cells, which weakens the immune system.

^eThe sample is chosen from the inmates seen within the month prior to the review.

^fPerformance assessment requires clinical judgment by physician, PA, NP, or registered nurse (RN).

^gThe sample covers 3 days within the 2-week period prior to the review.

^hPerformance assessment requires clinical judgment by physician.

The sample is chosen from 3 days within the 3-week period prior to the review.

ⁱThis sample is composed of five records from each specialty clinic within the 3 months prior to the review. The specialty clinics are the cardiology, dermatology, eye, gynecology, neurology, orthopedics, podiatry, and pulmonary clinics.

^jBecause of problems, such as difficulty linking CCHPS's computerized inmate medical records to laboratory results, these measures have not been used in recent reviews, and are being reviewed.

MARs are written records of medications ordered for and distributed to inmates. MARs for each inmate are placed in larger "books," separated by housing unit and organized alphabetically by inmate, which are then taken to the housing units when medications are distributed. RNs distributing medications to inmates are required to note on the MAR that the inmate received the medication, or to provide information on why the medication was not given to the inmate.

^mInmates who refuse three or more consecutive doses of medication or refuse to take medications consistently are referred to their primary provider for evaluation.

Appendix IV: Comments from the District of Columbia Department of Corrections

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF CORRECTIONS

Office of the Director



June 22, 2004

Ms. Marcia Crosse, Director
Health Care · Public Health
and Military Health Care Issues
U.S. General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Ms. Crosse:

Enclosed please find the Department of Corrections' comments to the General Accounting Office Draft Report on Medical Services at the Central Detention Facility. As requested, we have reviewed the draft report and are providing supplemental information relating to medical services.

We appreciate the efforts of your staff while conducting the study. We look forward to continuing our cooperative relationship regarding any concerns relating to medical services at the Central Detention Facility. If you have questions or need any additional information, please contact me at (202) 671-2128 or Brenda Baldwin-White, Deputy General Counsel at (202) 671-2042.

Sincerely,



Odie Washington
Director

OW/ls

Enclosure

1923 Vermont Avenue, N.W. Washington, D.C. 20001 (202) 673-7316

RESPONSE
TO THE GENERAL ACCOUNTING OFFICE (GAO)
REPORT ON MEDICAL SERVICES AT THE DISTRICT OF COLUMBIA
CENTRAL DETENTION FACILITY

The D. C. Department of Corrections (DOC) welcomes the opportunity to respond to and supplement the findings in the Draft Report on Medical Services at the Central Detention Facility. The primary findings were based on the Contract, which is the original Request for Proposal (RFP) developed by the Court Appointed Receiver in 1999. The Center for Correctional Health and Policy Studies, Inc., (CCHPS), a District of Columbia not-for-profit corporation, made the Best and Final Offer. The provision of medical and mental health services, by CCHPS commenced on March 12, 2000 at the CDF. The GAO Draft Report also focused on the quarterly reports of the Department of Corrections' medical expert consultant. Therefore and accordingly, the following responses are offered.

1. The Contract, based on the 1999 RFP

The entire landscape for accessing medical care changed in the early summer of 2001, when DCGH, the public hospital closed and medical care was privatized for the residents of the District of Columbia. Oversight needs shifted with the paradigm. DOC made a management decision to have CCHPS make monthly reports in lieu of quarterly reports. There was a critical need to revamp the reporting requirements of the 1999 RFP to successfully meet the new demands of the Memorandum of Understanding with the Department of Health/Health Care Safety Net Administration and their contract with Greater Southeast Community Hospital, (GSCH), the prime vendor. The D. C. DOC was placed in the role as the intermediary in arranging for all hospital and other medical services.

Clearly, the RFP never anticipated the closure of the District of Columbia General Hospital (DCGH) when it was developed. The closure of the DCGH and the new methodology for payment dictated that new and immediate solutions be identified and implemented to ensure continuity of care for the inmate population of the DOC, as well as, employing mechanisms and measures for operation within the new system. DCGH was the designated facility for external medical care for primary, secondary, tertiary and specialized care, and was also conveniently located on the same campus. Part and parcel to the specialized care was a twenty (20) bed Locked Ward for inpatient care. Transporting inmate patients to DCGH did not present many public safety challenges or overtime expenditures, and its proximity to the Central Detention Facility made it immediately accessible for emergent, urgent and routine ambulatory visit.

As part of the new reporting requirements implemented, a Utilization Management Nurse was stationed on-site at Greater Southeast Community Hospital (GSCH) to provide a gatepost for inmate in and outpatient activities. In lieu of written quarterly reports, daily patient summaries, monthly hospital

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discharges, (by facility), monthly surgical procedures, rank order of diagnoses were all gathered and tabulated monthly and forwarded to the DOC. DOC representatives met with the CCHPS staff regularly and conversed by telephone daily, sometimes two (2) and three (3) times per day, as dictated by the new and different health care issues that surfaced, as the new privatized system evolved. Many of the meetings and telephone calls also included, but were not limited to representatives from the DOH/HCSNA, GSCH and Chartered Health Care (the administrative service organization).

As a result of the above utilization management efforts instituted by DOC, the agency remained below the pre-established contractual benchmarks for inpatient and outpatient activity, thus resulting in savings of \$1,000,698 for Reconciliation of Contract Year One of the DOH/HCSNA contract with GSCH. These savings, paid by GSCH, were passed directly from DOC, into the District of Columbia coffers to help to offset the deficit in fiscal year 2003.

Additional monthly reporting by CCHPS included two (2) performance measures. These performance measures went to the Mayor and Deputy Mayor for Public Safety and Justice through the Director of DOC. One of the performance measures was to maintain accreditation in the National Commission on Correctional Health Care (NCCHC) and the other was to conduct medical screenings or comprehensive medical evaluations on 100% of all intakes within 36 hours.

The DOC, as an organization, met the challenges presented by the new privatized system with the development and implementation of new reporting requirements for successful operation in the new privatized health care system.

2. **The Quarterly Reports of the DOC's Expert Medical Consultant/Oversight -**
The expert medical consultant provided clinical oversight and direction for medical and mental health services at the Central Detention Facility, and when medical services were consolidated, the Correctional Treatment Facility. These services were provided at the request of DOC and on behalf of DOC. These quarterly reports gave a status report of medical and mental health care received by the inmate population. In addition, the findings of the expert medical consultant were further discussed and hammered out in the CCHPS Quarterly Quality Council meetings. DOC representatives were present at Quarterly Quality Council meetings.

The DOC relied heavily on the reports of the expert medical consultant and reviewed each report with the Medical Director of CCHPS. There is a perceived disagreement between the expert medical consultant and the Medical Director of CCHPS, due in part to the difference in management styles and diverse medical backgrounds. This is an acceptable professional difference. Each may address a medical service problem differently and this has been recognized by the DOC staff. During the continual monitoring process DOC weighed both opinions and

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directed CCHPS to proceed on a consensus direction for the self-improvement recommendation. However, even with keeping these differences in mind, the DOC has periodically requested and received abatement plans from CCHPS. It should be further noted that the Medical Director sits on the DOC executive/senior staff and attends all meetings. During these meetings the Medical Director has raised issues and concerns to the executive staff that have been addressed by DOC management and vice-versa.

The expert medical consultant was, and currently remains, a significant partner for the clinical oversight function for the DOC. The quarterly clinical quality feedback that he provided is an integral part of the DOC's continuous quality assurance and self-improvement efforts to identify opportunities for self-improvement in health and medical services within the Department of Corrections, as explained in a September 5, 2003 letter to the GAO from the DOC. (See Attached Letter, Subject: Expert Medical Consultant's Reports.) The key points of the letter are quoted below.

“As we provide these reports to you, we note that areas identified for improvement are often seen as problems by those not familiar with the tenets of quality assurance, monitoring and auditing. In deed, there are those who would readily seek to exploit Dr. Greifinger's findings and recommendations for personal gain by initiating lawsuits based solely on those findings and recommendations without proof of any demonstrated harm to any inmates. Such lawsuits are often later declared frivolous, but nevertheless prove to be distracting and costly during their pendency. Moreover, misuse of reports such as these undermines their value as a management and quality assurance tool.”

It appears that the opportunities identified for self-improvement listed in the reports were perceived as problems or deficiencies. This revelation is unfortunate for all involved in this process.

In addition to the new monthly reports that were requested and discussed under the section on the contract on page one of this report, quarterly reporting by CCHPS to DOC was made either verbally or through the quarterly reconciliation meetings. There were also a myriad of other meetings called by DOC.

Quarterly contract monitoring and auditing were also completed, as evidenced by the November 25, 2003 letter submitted to the General Accounting Office. (See attached letter, Subject: Contract Monitoring of Medical Services.) The letter clearly defines the following:

- The expert medical consultant's role is clearly established as oversight by and for DOC;
- The DOC provided the momentum and was the driving force

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in establishing the overall direction for the expert medical consultant; and

- The monitoring of services conducted by DOC.

3. **Annual Reporting** – There appears to have been some confusion in regard to the timing and submission of annual reports. There was no annual report for the base year of the contract. The base year of the contract was March 12, 2000 through March 11, 2001. The annual report dated July 18, 2002, which was submitted to the DOC and subsequently to the General Accounting Office, was for Option Year One, March 12, 2001 through March 11, 2002. The annual report for Option Year 2, March 12, 2002 through March 11, 2003, was partially covered in Option Year 2 Reconciliation Issues. Option Year 3, March 12, 2003 through March 11, 2004, is now due and has a due date of June 15, 2004. All future annual reports will be completed.

4. **Cost Containment Efforts** – The DOC and CCHPS have embarked upon projects to contain costs throughout the life of the contract. The following examples include, but are not limited to the highlights noted below.

The consolidation of the medical contracts at the Central Detention Facility and Correctional Treatment Facility was a colossal task for all those involved in this process. DOC made diligent efforts to have one medical care provider at the two (2) facilities for seamless medical care. In early 2002 this process was begun and in September 2002, CCHPS became the provider for medical and mental health services at the Correctional Treatment Facility, contracting with the Corrections Corporation of America (CCA). The total consolidation of the contract was achieved in April 2003. The culmination of these diligent efforts changed the method of payment from one based on staffing to one based upon a per diem, according to inmate population. In essence, the average daily cost went from \$19.00 per day to \$13.00 per day, which over the remaining life of the contract will result in substantial savings.

The Medical Director of CCHPS conducted a study which showed a delay in obtaining some specialty clinic appointments. From the day-to-day operations, DOC was aware of the delay and moved swiftly to obtain action in obtaining medical services for the inmate population. There is no need to conduct another study at this time. In another effort to establish quicker access to specialty medical care for the inmate population, to contain costs and in the interest of public safety, CCHPS' leadership staff identified medical services which had been curtailed by GSCH, DCGH and/or other providers and implemented in-house services, e. g., dermatology, endocrine, infectious disease and obstetrics/gynecology.

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While CCHPS was a partner in controlling costs, primarily through reducing personnel expenditures, in large part, cost reduction was due to DOC's continuous review of the staffing and approving the staffing requirements. In addition, DOC reduced management costs to CCHPS by withdrawing the \$400,000 annual management fee that was previously awarded to CCHPS. Other reductions were achieved by reviews of CCHPS' budgets that were presented to the DOC during renegotiations. Several items in the budget were disapproved by DOC, as the items did not benefit the cost objective (contract). Further, pharmacy costs were set aside for reconciliation on a six (6) months basis. Due to the surge in population, the DOC recognized that the contractor could not predict pharmacy costs and elected to treat this cost separately and not on a fixed fee basis.

Costs were decreased by and through the oversight provided by DOC.

5. Liquidated Damages

The District of Columbia as a matter of policy does not impose penalties via the Liquidated Damages Clause, but attempts to recover costs the District would incur should the contractor not perform. For this reason the clause states "in place of actual damages" the District would access its estimated actual damages as specified in the contract. This is not a penalty but a cost recovery mechanism for the District, should the contractor not perform to the standard. The District has other remedies for non-performance such as termination for default.

6. Infection Control Plan

The Infection Control Plan was initially reviewed and approved by the DOC. However, in the interest of obtaining clinical input, the plan was referred to the expert medical consultant for his input. The Infection Control Plan has now been fully approved and is currently being finalized for publication and distribution.

Thank you for the opportunity to respond to the Draft Report.

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Helene F. Toiv, (202) 512-7162

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In addition to the person named above, key contributors to this report were Emily Gamble Gardiner, Marc Feuerberg, Krister Friday, and Anne Montgomery.

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