



**Report
to
The LEGISLATIVE FINANCE COMMITTEE**



Corrections Department
Review of Facility Planning Efforts and Oversight of Private Prisons and Health Programs
May 23, 2007

Report #07-04

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May 23, 2007

Joe R. Williams, Cabinet Secretary
New Mexico Corrections Department
4337 NM 14
Santa Fe, New Mexico 87508

Dear Secretary ^{Joe} Williams:

On behalf of the Legislative Finance Committee (Committee), I am pleased to transmit *Corrections Department: Review of Facility Planning Efforts and Oversight of Private Prisons and Health Programs*.

The review team assessed the Corrections Department's oversight of basic medical, mental health, addictions and food services; the impact and costs of contracted (private) prison facilities; and the adequacy of facility planning. The report will be presented to the Committee on May 23, 2007. An exit conference was conducted on May 17, 2007 to discuss the contents of the report with you and your staff.

I believe this report addresses issues the Committee asked us to review and hope your respective agencies benefit from our efforts. We very much appreciate the cooperation and assistance we received from you and your staff.

Sincerely,

A handwritten signature in cursive script that reads "David Abbey".

David Abbey
Director

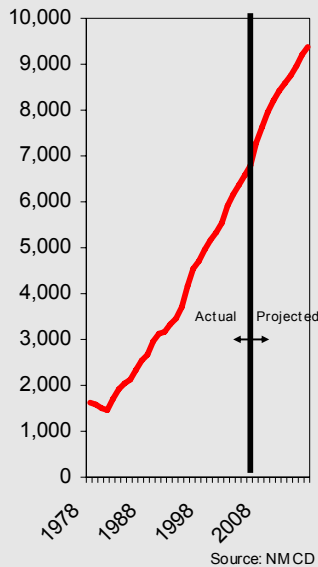
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Table of Contents

Page No.

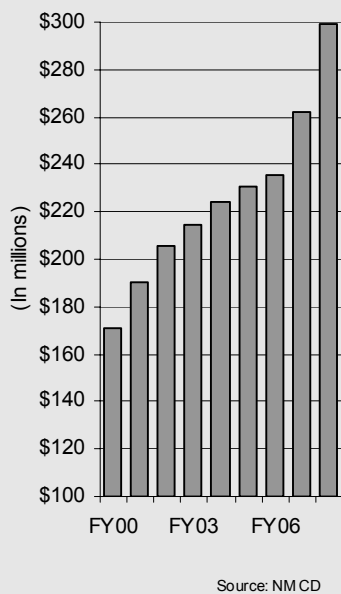
EXECUTIVE SUMMARY	1
BACKGROUND INFORMATION	7
FINDINGS AND RECOMMENDATIONS	15
NEW MEXICO'S PRIVATE PRISONS COST MORE THAN OTHER STATES, BUT IMPROVED CONTRACTS AND BETTER MONITORING COULD SAVE TAXPAYERS MILLIONS.....	15
NEW MEXICO'S APPROACH TO PRISON PLANNING AND CONSTRUCTION IS NOT IN THE TAXPAYERS' BEST INTEREST	26
THE DEPARTMENT NEEDS BETTER OVERSIGHT TO CONTAIN MEDICAL COSTS AND ENSURE THE PROVISION OF ADAQUATE CARE	33
MORE INFORMATION IS NEEDED TO DETERMINE BOTH THE QUALITY AND EFFECTIVENESS OF THE DEPARTMENT'S INPATIENT ADDICTIONS SERVICES	37
THE DEPARTMENT DOES NOT REGULARLY ASSESS THE IMPACT OF MENTAL HEALTH SERVICES ON INMATES' ABILITY TO FUNCTION IN A PRISON ENVIRONMENT OR SOCIETY UPON RELEASE	43
THE DEPARTMENT ENSURES BASIC COMPLIANCE WITH POLICIES BUT COULD IMPROVE PRISON OPERATIONS FURTHER BY INCREASING ITS FOCUS ON PERFORMANCE.....	47
IMPROVED MONITORING OF FOOD SERVICE CONTRACTS COULD REDUCE COSTS AND INCREASE DEMONSTRATED QUALITY.....	49
APPENDIX A	52
APPENDIX B	54
DEPARTMENT RESPONSES	

NMCD Inmate Population Growth 1978 - 2017



All NMCD facilities meet national standards.

Corrections Dept. Operating Budget FY00 - FY08



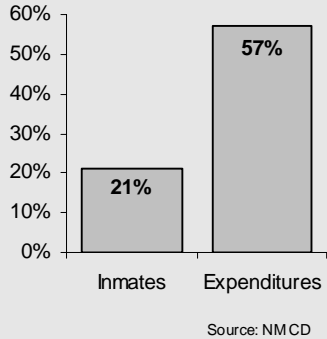
On February 2, 1980, inmates overpowered four correctional officers at the Penitentiary of New Mexico beginning what would become one of the nation’s bloodiest prison riots. Thirty-six hours later, 33 inmates were dead and another 90 were being treated for injuries. All 12 correctional officers held hostage survived the chaos. The results of an investigation by Attorney General Jeff Bingaman indicated that overcrowding, lack of trained security staff, inconsistent policy enforcement, a disciplinary system reliant on “snitches,” failure to separate predatory inmates from others and an overall lack of incentive programs, such as education, were conditions leading to the prison riot.

New Mexico began a long, expensive and massive prison construction process and expansion of services for inmates. The bloody riot and the *Duran* federal consent decree profoundly affected the design and cost of prison facilities and the services provided. Since 1980, the number of state inmates has increased over 440 percent to 6,574; the number of prisons has increased from one to 12, including six privately operated prison facilities; and corrections appropriations approach \$300 million going into FY08.

Today, the Corrections Department (department) operations and all facilities meet national standards; one of only six states receiving full accreditation by the American Correctional Association (ACA). Legislative Finance Committee (Committee) staff commends the department for this achievement. However, public concerns continue regarding the cost, quality, adequacy and effectiveness of New Mexico’s prison operations. The review assessed the department’s oversight of basic medical, mental health, addiction and food services to inmates; the impact and costs of contracted (private) prison facilities; and the adequacy of facility planning efforts in light of the projected 40 percent increase in the prison population over the next ten years.

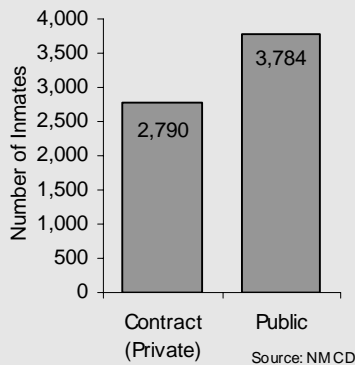
New Mexico’s inmate population resides in relatively safe, clean, professionally operated prisons and has access to expanded medical and behavioral health services. The department is well positioned to continue improving prison operations, but needs a more comprehensive approach to planning, oversight and evaluating not only the quality of prison services but their effectiveness. Historically, the department has not fared well negotiating cost-effective contracts for private prisons and medical services, nor has it provided strong monitoring. Overall, these deficiencies and a seemingly endless increase in prison population have resulted in unsustainable growth in costs to New Mexico taxpayers.

Percent Change in Prisoners and Expenditures at Private Prisons FY01 to FY06



The department pays significantly higher rates to house inmates in private prisons than other states.

NMCD Out-of-System Bed Use March 2007



The department's agreement with Clayton provides a model per diem structure.

Significant findings.

New Mexico's private prisons cost more than they should due to contract price increases. New Mexico houses 42 percent of its state inmates in private prisons which is the highest rate of private prison use in the nation.

- *State spending on private prison contracts has increased 57 percent since 2001, largely due to contract price increases. Private prison contracts provide an automatic price increase based on the Consumer Price Index (CPI) subject to a five-percent cap. Past adjustments to the structure of per diems by then Governor Johnson's administration have resulted in the department exceeding the contracts' five percent cap in some years.*
- *The department pays significantly higher rates to house inmates in private prisons than other states for similarly classified prisoners. Other state's per diem rates include medical costs. Neighboring states do not renew private facilities contracts based on CPI.*
- *Providing price increases on fixed private prison construction costs may result in New Mexico paying, at a minimum, an estimated \$34 million more than it should over twenty years to Lea and Guadalupe counties. In 2000, the Independent Board of Inquiry (IBI) review noted the contractual flaw of providing inflationary price increases on fixed construction costs. The department has not corrected these agreements. The department, nor the contract, ensures LCCF and GCCF use price increases only for operational costs.*

Restructuring agreements could lower private prison costs an estimated \$60 million during the next ten years without sacrificing quality and safety.

- *Restructure per diems to take advantage of economies of scale and separate facility use fees. The department's original agreements with Lea and Guadalupe counties appropriately considered economies of scale generated by filling facilities to 90 percent occupancy, but were changed in 2001. The department's agreement with Clayton provides a model per diem structure. The Clayton agreement includes a base operating fee, incremental per diem and a separate facility use per diem. Using this three-tier per diem model for Lea and Guadalupe county agreements could result in annual estimated savings of at least \$4.9 million or \$49 million over the next ten years. The department could save an additional estimated \$11 million over the next ten years by not increasing facility use per diems.*

The department lacks active long-term planning to accommodate inmate growth.

Contracting outside of the Procurement Code for private prisons puts the state in a poor negotiating position.

Current law limits the department's flexibility to obtain prison space at a more affordable price.

- *Require private prisons to justify annual price increases based on performance and improve management of savings created by staff vacancies at private facilities. Facilities often run high vacancy rates, which do not benefit the department programmatically or financially.*

New Mexico's approach to prison planning and construction is not in the taxpayers' best interest.

The department projects its inmate population will increase 37 percent by 2016, requiring bed space for an estimated 9,365 inmates. Despite additional facilities in Clayton, Springer and Albuquerque the department may face overcrowding between 2009 and 2011. The department lacks active long-term planning to accommodate inmate growth, leading to a disjointed approach to acquiring bed space that proves costly.

- *Rapid deterioration and an inefficient design make New Mexico's public prison facilities increasingly expensive to operate. The department may require an estimated \$100 million in capital outlay funding to repair public facilities statewide over the next five years. Upgrading these housing units may not make fiscal sense because of the higher costs to staff these small units.*
- *New Mexico's use of county jail statutes as the basis for building private state prisons results in the state paying for a prison it will never own, including prisons in Clayton, Lea and Guadalupe counties.*
- *Not using traditional state capital outlay financing for prison construction results in higher long-term costs for the state taxpayer. For example, the prison in Clayton will cost about \$61 million to construct but the department will pay \$132 million over twenty years for construction and financing charges through higher per diems rates, but it still will not own the facility.*
- *Contracting outside of the Procurement Code for both the use and operation of prison facilities puts the state in a poor negotiating position.*
- *Current law limits the department's flexibility to obtain prison space at a more affordable price. The law also does not require that private prison operations will cost less than if the department operated the same facility.*
- *Other alternatives exist to finance prison construction that would be more beneficial to the department and state taxpayer.*

The department needs better oversight to contain medical costs and ensure the provision of adequate care.

The department has not effectively monitored the cost of medical services and has struggled to enforce key contract provisions, such as staffing requirements, despite applying nearly \$90 thousand in financial penalties. Committee contract

The quality of medical care is inadequate.

More information is needed to determine the effectiveness of addiction services.

medical experts concluded that Wexford's health care staff includes many highly qualified professionals, but the quality of the care provided is inadequate. The quality of inmate care is hampered by deficiencies in staffing, policies, protocols, record keeping, data collection, and communication systems. In addition, the department's oversight and the quality improvement program have failed to identify problems in a timely fashion. At the time of this report, the department terminated its contract with Wexford and was in the process of soliciting bids for a new medical contract. Committee medical experts found the following.

- *Wexford's insufficient record-keeping, the lack of meaningful and consistent reports and poor communication between Wexford and the department has limited oversight of access to care, particularly for off-site specialty care.*
- *The department's lack of a medical director during part of 2006 greatly compromised its oversight responsibility for quality of care.*
- *The geriatric housing unit at the Central New Mexico Correctional Facility is counter-therapeutic.*
- *Wexford's chronic illness program fails to meet national standards, resulting in poor medical outcomes for inmates.*

Inmates generally have sufficient access to behavioral health services, but better monitoring is needed to ensure the effectiveness of services.

- *The department does not regularly assess the impact of mental health services on inmates' ability to function in a prison environment or society upon release.*
- *More information is needed to determine both the quality and effectiveness of the department's inpatient addiction services.*

The department ensures basic compliance with policies but could improve prison operations further by increasing its focus on performance.

- *The department does not measure or monitor performance in key aspects of prison operations such as its inmate classification system. ACA is moving towards performance-based accreditation that will require the department to demonstrate not only compliance but the performance of its prisons.*

Key Recommendations. Modify department agreements for private correctional facilities.

- *Restructure Lea and Guadalupe county rates using a three-tier per diem to include a base per diem (existing per diem less recalculated debt service), incremental per diem (about 30 percent of base per diem) and a separate debt service fee. Reduce past price increases in recalculating the debt service fee. This*

per diem will mirror the Clayton agreement and save an estimated \$4.9 million per year.

- Align incremental per diems for NMWCF and Camino Nuevo to eliminate cost increases associated with transferring inmates to Albuquerque.
- Withhold no less than five percent of the total estimated contract amount as a performance incentive for maintaining low vacancy rates. Automatically deduct penalty amount for unfilled security positions after 30 days. Require private prisons to justify annual price increases based on meeting performance measures.

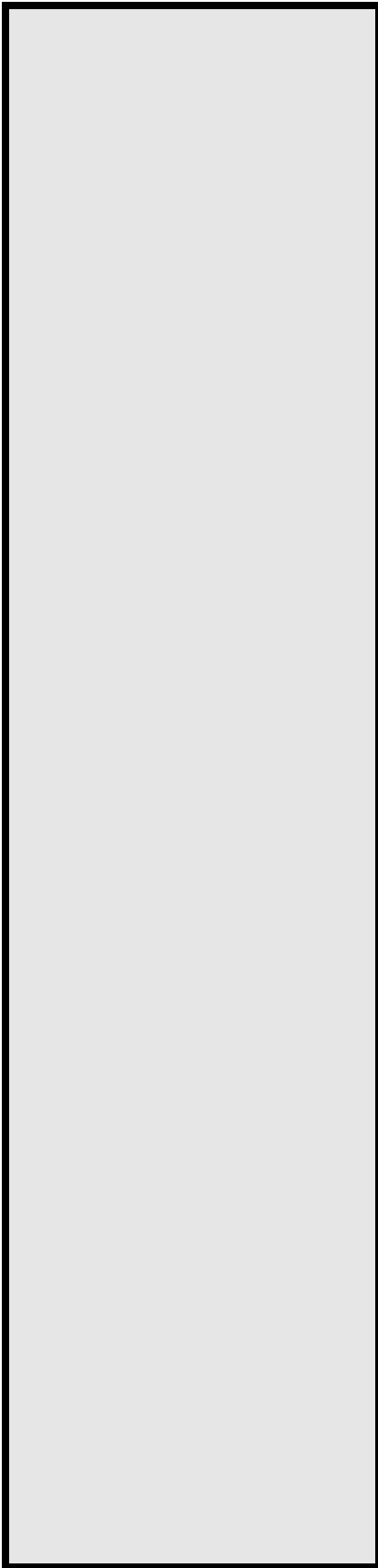
Committee staff proposes the following statutory changes.

- Require the department to develop and implement a 10-year facility strategic plan and submit the plan to the Courts, Corrections and Justice Committee, the Legislative Finance Committee and the Department of Finance and Administration no later than November 1 of each even-numbered year.
- Amend state law to remove restrictions on the location or type of correctional facility for which the department may award a prison contract. Add provisions to prohibit the department from entering into agreements with a prison operator that also owns the facility. Require the department to demonstrate that private operation of the facility would cost at least ten percent less than if the department operated the facility (Section 33-1-17 NMSA 1978).
- Consolidate multiple prison construction funds into one New Mexico prison fund, remove restrictions that require use of revenue for prisons in certain locations or type of correctional facility and remove authority to use the fund proceeds for operating leases (Sections 33-1-18 and 33-1-19 NMSA 1978).
- Authorize the department to procure private or locally financed correctional facilities by entering into lease-purchase agreements, subject to legislative approval as provided by Laws 2007, Chapter 184 (H.B. 1022).

Throughout the interim, legislative committees could explore other alternatives for prison financing, including whether to grant specific revenue bond authority to the New Mexico Finance Authority for prisons or creating a public corporation to own any financed correctional facilities.

The department should:

- Implement recommendations from Committee medical experts included in Appendix B.
- Limit medical contract annual price increases to no more than the medical service CPI based on meeting certain performance



targets; withhold no less than five percent of the total estimated contract amount as a performance incentive for maintaining low vacancy rates; and include automatic financial penalties for excessive staff vacancies, particularly for critical professions such as physicians and dentists.

- Require the medical vendor to provide monthly reports on medical spending by defined expense categories and staff vacancies by type of staff. These should be submitted with invoices.
- Begin collecting and reporting program outcome and performance information for addictions and mental health services. The Committee and Legislature should reconsider funding increases for addictions services until the department completes and implements the recommendations related to addictions services.

AGENCY AT A GLANCE

The mission of the New Mexico Corrections Department (department) is to provide a balanced systems approach for corrections, from incarceration to community-based supervision. The department operates under six strategic goals, including the following.

- Provide a balanced system approach to all offenders.
- Optimize population control management.
- Provide a comprehensive approach to female offenders.
- Lower cost of corrections.
- Reduce exposure to litigation.
- Enhance public relations and education efforts.

FAST FACTS

Inmate Population & Growth – The department housed 5,945 male inmates and 629 female inmates as of March 2007. The male inmate population grew 10 percent during FY06, and the female population grew eight percent based on LFC budget analysis. The department projects the total inmate population will grow to over 9,300 by 2016.

Funding – The department operates on an FY07 budget of \$262 million with FY08 appropriations totaling \$299 million.

Prison Facilities – The department operates six public facilities located throughout the state. In January 2007, the department opened a public facility for level I and II male inmates at Springer Correctional Center, formerly the New Mexico Boys' School.

Private Prisons – Nationally, New Mexico places the highest percentage, about 42-44 percent, of inmates in private prisons. The national average is 6.5 percent.

HISTORY OF MAJOR EVENTS

1854	The Territorial Legislature authorized the construction of a Territorial Penitentiary on the site of the current federal courthouse in Santa Fe. The construction was halted due to citizen opposition to its location and a lack of funds.
1885	Penitentiary of New Mexico was completed at a cost of \$150,000 and included 104 cells. PNM was located in Santa Fe at Cordova and Penn Roads.
1897	Prison overcrowding required inmates to be housed in yard buildings.
1912	New cell house completed at PNM, but the state still faced overcrowding.
1939	Honor Farm, an unrestricted minimum security facility in Los Lunas, was built as a satellite of PNM and produced all inmate food. Pattern of overcrowding continues through the 1950s.

1953	Riot erupts at PNM, the fourth major violent incident in a year and prompted public outcry for a new penitentiary.
1956	New Penitentiary of New Mexico opened ten miles south of Santa Fe. At the time, the “new” PNM was considered one of the nation’s finest corrections structures and cost \$8 million to construct. The state closed the Main unit in 1998.
1958	PNM faced overcrowding. Between 1956 and 1969 eleven inmates escaped.
1969	Department of Corrections and Police Academy formed, combining PNM, the New Mexico Boys School, the Girls Welfare Home and the Board of Adult Probation and Parole into one organization.
1977	Inmate Dwight Duran filed a federal class action lawsuit on behalf of other inmates claiming unconstitutional living conditions. The state accepted a federal consent decree in 1979 that would govern much of the department’s operations for two decades.
1980	Riot at the Penitentiary of New Mexico resulted in the death of 33 inmates and injury to another 90. Twelve correctional officers taken hostage survive.
1980-2000	The state built three new correctional facilities in Los Lunas, Las Cruces and Grants, and expanded PNM. Private facilities were constructed in the 1990s in Torrance, Santa Fe, Lea and Guadalupe counties and the private women’s facility in Grants was expanded.
2001-2007	The department takes over juvenile facilities at Springer and Albuquerque from the Children, Youth and Families Department.
2008	The department will open a private facility in Clayton bringing the total number of facilities to 13.

Riot at the Penitentiary of New Mexico
February 2-3, 1980

Pre-Riot

The department had four Cabinet Secretaries from 1976-1980 and experienced significant overcrowding conditions. Correctional staff became more reliant on coercion as the primary method of inmate control as incentive programs were removed. In 1980, the Secretary of Corrections offered his resignation after eleven inmates escaped from PNM, but inmate unrest continued. Officials discussed intelligence revealing other planned escapes and race riot, and pinpointed Dormitory E-2 as a possible problem area due to the high number of requests for inmate transfers out of the housing unit.

Riot

In the early hours of Saturday, February 2, inmates overpowered four correctional officers in Dormitory E-2, beginning what would become one of the nation’s bloodiest prison riots. The inmates took keys from the officers and proceeded to open other housing units and eventually broke through newly installed shatter-proof security glass at PNM’s central control center. Inmates began destroying the prison through fire and floods and broke into the infirmary seeking drugs. Other inmates began searching for enemies and ended up opening other cellblocks, including cellblock 4 which housed the “snitches” and other inmates in protective

custody. Brutal violence ensued. Many inmates fled the violence by going outside. By 1:20 PM on February 3, State Police and the National Guard began to retake the badly damaged prison.

The takeover and riot lasted 36 hours. All 12 correctional officers held hostage survived the chaos. Thirteen officers were responsible for over 1,100 inmates that night. A total of 33 inmates were killed by fellow inmates; some were tortured and their bodies mutilated. Another 90 were treated for injuries from beatings, stabbings and rapes by other inmates.

Post-Riot

The results of an investigation by Attorney General Jeff Bingaman indicated that overcrowding, lack of trained security staff, inconsistent policy enforcement, a disciplinary system reliant on “snitches,” failure to separate predatory inmates from others and an overall lack of incentive programs, such as education, were conditions leading to the prison riot.

Extreme levels of violence continued after the riot. Two correctional officers and seven inmates were killed during the 18 months that followed the riot. Inmate disturbances, including fires and flooding, and attacks, beatings and stabbings continued on the regular basis both at PNM and at out-of-state prisons holding New Mexico inmates. Many of the attacks were in retaliation to the riot. PNM struggled to staff the facility due to high numbers of resignations and retirements. Some officers refused to go back inside PNM until the administration addressed grievances related to pay, understaffing and lack of supervision and training.

Source: NMCD and the Albuquerque Journal.

ORGANIZATION

Office of the Secretary. The Secretary of Corrections acts as the department’s chief executive and operations officer. The appointed Secretary serves at the pleasure of the Governor and must be confirmed by the Senate. The Secretary has authority to adopt necessary rules and regulations; appoint, with the governor’s consent, division directors; and carries out other duties needed to operate the department.

Staff. In FY07, the department had 2,467 authorized FTEs. Staff is located throughout the state in prison facilities, probation and parole offices and the Santa Fe central office.

Operations. The department consists of six divisions and numerous bureaus. State law provides for the following divisions: adult prisons, probation and parole, correctional industries, training academy, administrative services and information technology.

Inmate Management and Control. This budget program is the largest of the department’s programs, consisting of over 1,800 FTEs and an FY07 operating budget of over \$209 million. The program includes the Adult Prisons Division, which oversees over 6,600 inmates housed in twelve different facilities: six public prisons and six private facilities. The division ensures these facilities provide secure, safe, humane and cost-effective operations, including housing, food, health-related services and other quality of life services.

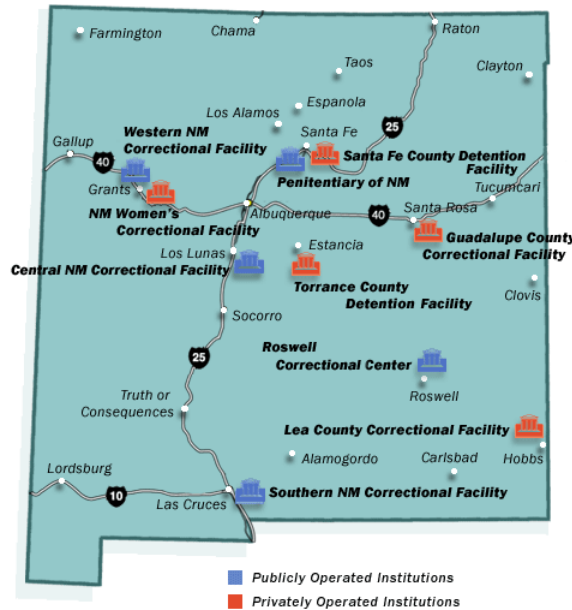
Table 1. Corrections Department Prison Facilities

Type of Correctional Facility	Inmate Classification	Bed Capacity	FY06 Avg. Daily Pop.
Public Facilities			
Penitentiary of New Mexico (PNM) - <i>Santa Fe</i>	II, V, VI	906	902
Central New Mexico Correctional Facility (CNMCF) - <i>Los Lunas</i>	I, II, III, IV	1382	1365
Southern New Mexico Correctional Facility (SNMCF) - <i>Las Cruces</i>	II, III, IV	810	835
Western New Mexico Correctional Facility (WNMCF) - <i>Grants</i>	II, III, IV	428	413
Roswell Correctional Center (Roswell)	II	340	336
Springer Correctional Center (Springer)*	II	264 [#]	NA
Private Facilities			
Camino Nuevo Correctional Center (CNCC) - <i>Albuquerque</i>	I, II	192	85
Lea County Correctional Facility (LCCF) - <i>Hobbs</i>	III	1264	1272
Guadalupe County Correctional Facility (GCCF) - <i>Santa Rosa</i>	III	601	603
Santa Fe County Detention Facility (SFCDF)	III	144	150
Torrance County Detention Facility (TCDF) - <i>Estancia</i>	III	213	212
NM Women's Correctional Facility (NMWCF) - <i>Grants</i>	I – VI	612	594
Northeastern New Mexico Detention Facility – <i>Clayton</i> *	III	600	NA

Source: NMCD

*Springer opened January 2007 and Clayton will open in 2008. # Bed space, but as of May 2007 operational capacity was 80.

**New Mexico Correctional Facilities' Locations*
As of December 2006**



Source: NMCD

*In 2006 the department expanded its capacity to one private facility in Albuquerque, in 2007 to one public facility in Springer; and in 2008, one private facility in Clayton. These facility locations are not reflected on the map above.

Health Services. The department contracts with Wexford to provide all medical, dental and psychiatric services to inmates throughout its prison system (public and private). Wexford provides onsite physician and nursing staffing and quality assurance management of health services. Wexford subcontracts for off-site care such as hospitalization and specialty consults with local providers. The FY07 contract is estimated at \$38 million.

Department central office staff conducts contract monitoring and quality assurance audits of Wexford. The department works with the University of New Mexico ECHO program to treat inmates with Hepatitis C. The department purchases its most expensive pharmaceutical drugs for inmates with Hepatitis C or HIV/AIDs through a discount program managed by the Department of Health.

Mental Health Services. The Mental Health Services Bureau provides and oversees all mental health services, except psychiatric care, for inmates. About 20 percent of department inmates receive some type of mental health service. The program operates on a \$4.1 million budget in FY07 and is staffed by 74 clinicians (counselors, social workers and psychologists). Psychiatrists and the provision of psychotropic drugs are delivered through the department’s medical vendor and overseen by a department psychiatrist in the Health Services Bureau. Mental health services at private facilities are carried out by the contractor, but the bureau is still responsible for ensuring quality of care.

All inmates entering the system are assessed for mental health disorders and have access to a range of mental health services. Mental health staff provides diagnostic assessment, basic therapy (individual and group), participates in medication management and conducts crisis interventions. The department operates a 104-bed inpatient acute care mental health unit and an alternative placement area unit for inmates that cannot function safely in general population. The Bureau is also responsible for sex offender treatment programs.

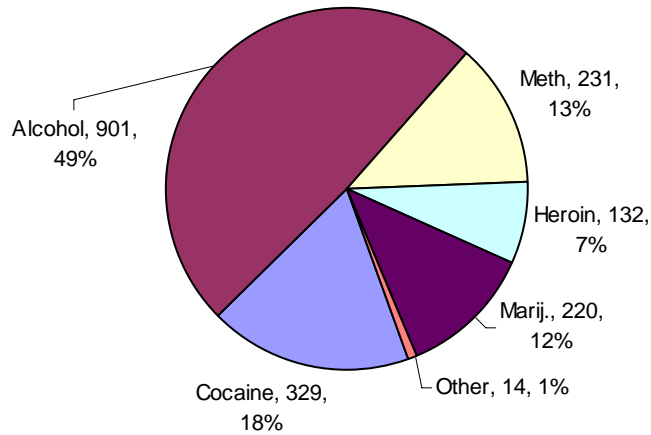
Table 2. Mental Health Services Statistics
4th Quarter – CY06

Number of Inmates System-wide	6,630
Mental Health Total Caseload (Individual, Group, and/or Medication)	1,419 (21.4%)
Individual & Group Treatment	514 (7.8%)
Psychotropic Medications	1,286 (19.4%)
Community Reintegration (Sex Offender Treatment)	132
Psycho-Educational Groups (Number of Inmates)	457
Number of Mental Health Contacts	35,028
Avg. Number of Contacts per Clinical Staff Member (Quarter)	459

Source: NMCD

Addiction Services. The department provides comprehensive substance abuse services, including outpatient counseling, self-help groups, and inpatient treatment called therapeutic communities (TC). Addictions Services employs 42 people and has an FY07 operational budget of about \$3.7 million. Comprehensive services are also provided in contracted private facilities but spending is imbedded into the overall contracted per diem rate. According to the department about 60-75 percent of its inmate population meets the criteria for substance dependence and about 85 percent have a history of substance abuse. Nationally, about 81 percent of state inmates’ criminal behavior revolved around drugs and alcohol in one way or another; either through use/abuse, sell/buy, drunk driving, etc, according to national studies.

**Chart 1. Therapeutic Community Participant
Drug of Choice - 2004**



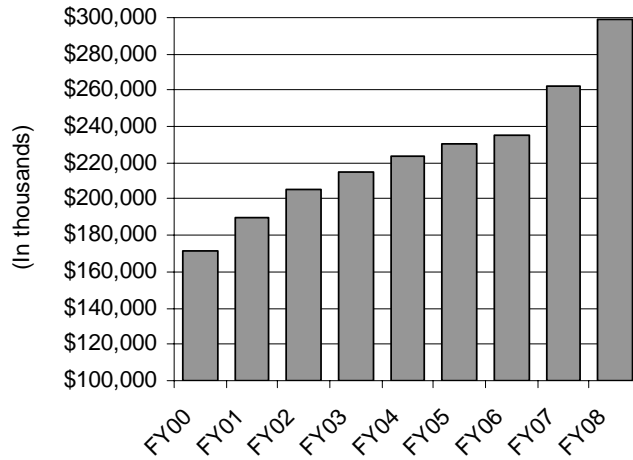
Source: NMCD

In 1994, Congress funded Residential Substance Abuse Treatment (RSAT) grants for intensive residential substance abuse programs at state prisons to address the increasing numbers of offenders with substance abuse problems. A federal RSAT evaluation noted that funds were used to dramatically expand the number of inmates receiving services, but expressed concern over the structure of many programs. However, according to the federal Office of Management and Budget, “evaluations of prison-based treatment programs show that drug dependent inmates who complete treatment are significantly less likely to return to drugs and crime following release, compared to inmates who receive no treatment.”

FUNDING

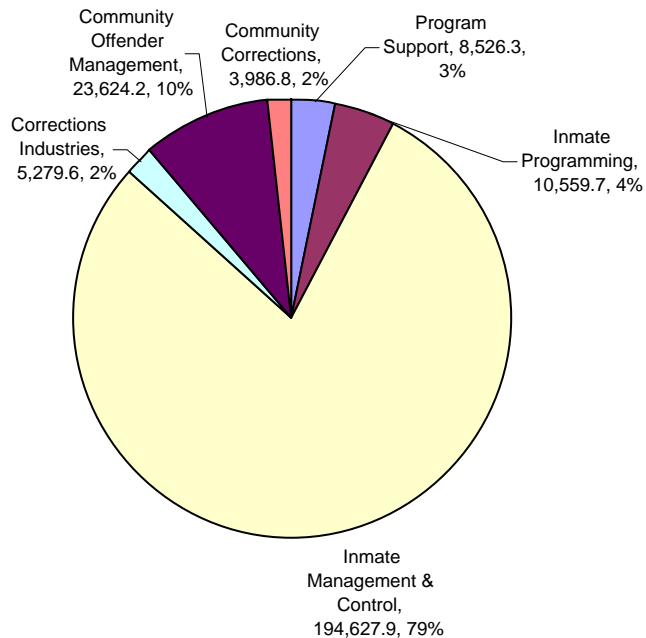
Fiscal year 2008 appropriations total about \$299 million in general fund revenue and other sources, such as income from the permanent land grant fund, up from \$262 million for FY07. The department has five budget programs, with Inmate Management and Control accounting for 82 percent of all expenditures in FY06.

**Chart 2. Corrections Department
Operating Budget
Fiscal Years 2000 - 2008**



Source: NMCD

**Chart 3. Corrections Department
Expenditures by Program - FY06**



Source: NMCD

Review Objectives.

- Review the department’s oversight of costs and the provision of basic medical, mental health, addiction and food services to inmates. The food service contract for the Training Academy was reviewed at the request of the department.
- Assess the impact of contracted facilities on department operations and costs.

- Determine the accuracy of prison population projections and adequacy of the department's facility and program planning efforts.

Review Activities (Scope and Methodology).

- Reviewed and analyzed statutes, laws, administrative rules and department policies.
- Conduct field visits to department correctional facilities, including PNM, SNMCF, WNMCF, CNMCF, NMWCF, GCCF, LCCF and SFCDC.
- Interviewed staff from the department, its contractors and other states' correctional departments; General Services Department and New Mexico Finance Authority. Interviewed state inmates.
- Conducted research on best practices and other states' prison systems.
- Reviewed contracts, performance measures, data, budgets, state plans, and reports provided by the department, other state and federal entities and LFC documents dating back to 1980.

Review Authority. The Committee has authority under Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political sub-divisions, the effect of laws on the proper functioning of these government units, and the policies and costs of government. Pursuant to its statutory authority, the Committee may conduct performance reviews and inquiries into specific transactions affecting the operating policies and costs of governmental units and their compliance with state law.

Review Team.

Manu Patel, Deputy Director for Performance Audits
Charles Sallee, Performance Auditor
Usha Shannon, Performance Auditor
Bobby Greigo, Performance Auditor
Dr. Steven Spencer, Contract Medical Expert
Dr. Jaye Anno, Contract Medical Expert

Exit Conference. The contents of this report were discussed with Secretary Joe Williams and senior Corrections Department staff on May 17, 2007.

Report Distribution. This report is intended for the information of the Office of the Governor, the Corrections Department, the Department of Finance and Administration, the Office of the State Auditor, the Courts, Corrections and Justice Committee and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report which is a matter of public record.



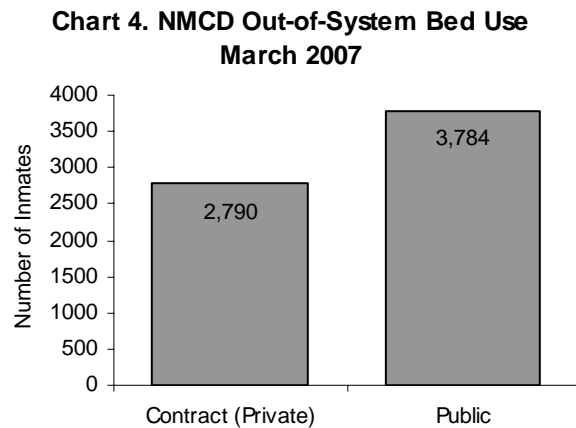
Manu Patel
Deputy Director for Performance Audits

FINDINGS AND RECOMMENDATIONS

NEW MEXICO'S PRIVATE PRISONS COST MORE THAN OTHER STATES, BUT IMPROVED CONTRACTS AND BETTER MONITORING COULD SAVE TAXPAYERS MILLIONS.

Currently, New Mexico houses 42 percent of its state inmates in private prisons, which is the highest rate of private prison use in the nation. In 2005, five states had at least 25 percent of their prison population housed in private prisons, led by New Mexico (43 percent), Wyoming (41 percent), Hawaii (31 percent), Alaska (28 percent), and Montana (26 percent), according to the U.S. Bureau of Justice Statistics.

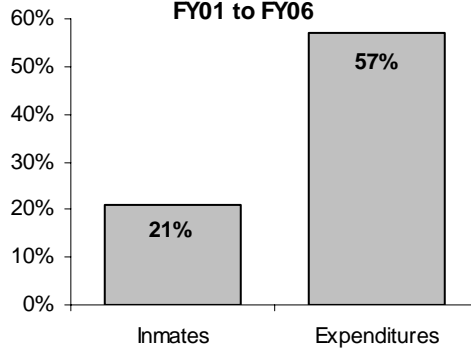
As of March 2007, the department housed 2,790 or 42 percent of its state inmates in local jails or private facilities, also called out-of-system beds.



Source: NMCD

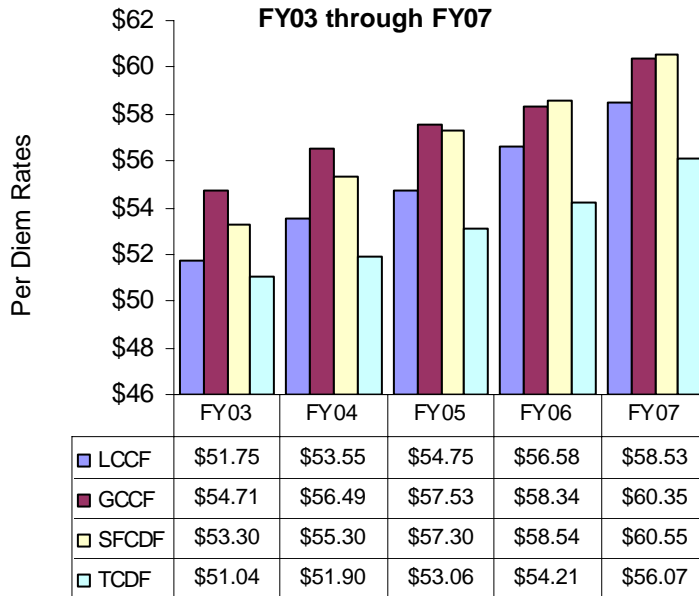
State spending on private prison contracts has increased 57 percent since 2001, largely due to automatic contract price increases. Spending on private prisons has outpaced the number of inmates housed in private prisons. Between FY01 and FY06 annual spending on private prisons increased 57 percent from \$34 million to \$54 million. However, the number of inmates only increased 21 percent, from 2,348 to 2,840, during the same time period, as shown in Chart 5. Increases in private prison per diem rates for FY03-FY07 are shown in Chart 6.

Chart 5. Percent Change in Prisoners and Expenditures at Private Prisons FY01 to FY06



Source: NMCD

Chart 6. Private Prison Per Diem Rate Comparison FY03 through FY07



Source: NMCD

Automatic contract price increases limit the department's ability to control cost increases. The department annually increases prison contracts by an amount equal to 80 percent of the consumer price index (CPI) or other increase up to a five percent cap. Department staff asserts that using 80 percent of CPI was its attempt to avoid providing price increases on construction costs, but could not provide supporting documentation. The CPI calculation only provides the basis for determining the amount of the price increase, not how the increased payments will be applied. The contracts are silent on this issue. As such, the department has increased the entire price of the contract amount. The department does not monitor the contractor's expenditures to ensure these increases are applied to operational costs (non-debt service) and do not provide excessive price increases. The CPI measures changes in the average price of consumer goods and services

purchased by wage earners in urban areas. In addition to a cost-of-living index the CPI is used to measure the rate of inflation.

The department has not always correctly applied price increases based on the contract. During our review, we noted that the department used the wrong CPI for two years, FY05 and FY06. For FY05, the department under paid by using an incorrect CPI of 2.3 percent instead of 3.3 percent. The department overpaid in FY06 by using 2.7 percent as the CPI instead of the correct 2.5 percent.

The department did not use the same base year to calculate CPI increases, resulting in some facilities getting a bigger increase than others. The department used the state fiscal year as the basis for determining CPI, but used calendar year for GCCF until 2005. The department tried to align all facilities' contracts to the same year, but ended up granting GCCF two price increases in one year. On January 1, 2005, the GCCF contract price was increased from \$56.49 to \$57.53 and then again on July 1, 2005, from \$57.53 to \$58.34. As a result, the department paid about 81 cents more in per diem than it should, which costs the state about \$89 thousand extra, based on an average of 600 inmates.

Adjustments to the structure of per diems have resulted in the department exceeding the contract's five-percent cap in some years. Under Governor Johnson's administration, the department provided price increases that exceeded the contracts' maximum five-percent annual renewal per diem rate. Table 3 shows per diem rates of LCCF and GCCF from the inception of the contracts.

Table 3. Per Diems - FY98 to FY06

	LCCF	GCCF
Contractor	GEO	GEO
Level of Security	III	III
Inmates	1200	600
FY98	1-1140 @ \$42.5 >60 @ \$12.5	NA
FY99	1-1080 @ \$44.15 1081-1140 @ \$42.50 >1141 @ \$12.50	NA
FY00	1-1080 @ \$46.36 1081-1140 @ \$44.71 >1141 @ \$13.12	1-570 @ \$47.5 571-600 @ \$15.00
FY01	1-1080 @ 48.68 1081-1140 @ \$47.03 >1141 @ \$13.78	\$53.00
FY02	\$51.30	\$53.68
FY03	\$51.75	\$54.71
FY04	\$53.55	\$56.49
FY05	\$54.75	\$57.53
FY06	\$56.58	\$58.34

Source: NMCD

NA = Not applicable because the facility became operational in FY99.
Note: NMCD used July CPI to renew LCCF per diem and January CPI to renew GCCF per diem during FY05 and prior years.

In FY02, the department changed multiple per diem rates for housing inmates at LCCF to a single per diem rate, resulting in an almost 13 percent increase. The department adjusted the GCCF per diem rate in a similar fashion in FY01, resulting in more than a 15 percent increase in per diem rate. The department indicates these changes were necessary to pay for facility upgrades and additional security staff after the riot and inmate disturbances.

No other neighboring states renew private facilities' contracts based on CPI. Contracts between private prison operators and the states of Colorado, Montana, Texas, Idaho, and Oklahoma do not include automatic price increases tied to CPI. Instead, either the contracts are subject to direct legislative appropriations for price increases, or price increases are fixed and established at the beginning of the contract term. This approach has held down price increases for these other states or actually resulted in decreased per diem rates. For example, Colorado decreased its per diem for one facility from \$54.66 in FY03 to \$50.28 in FY06. Other states have experienced minimum per diem increases as shown in Table 4 below.

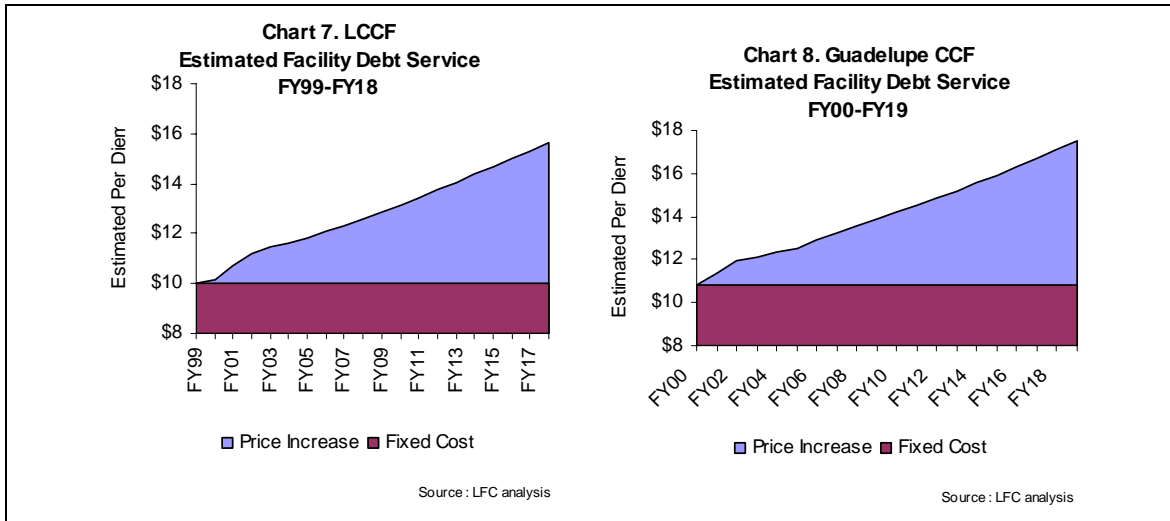
Business decisions across two administrations may result in New Mexico paying an estimated \$34 million more than it should for private prison construction costs. To date the department has paid, at a minimum, an estimated \$5.7 million more than it should have for private prison construction costs at LCCF and GCCF.

The department's contracts with Lea and Guadalupe counties do not include a separate per diem for facility debt service or lease costs. In the late 1990s, Wackenhut (now GEO, Inc.) privately financed the construction of prisons in Lea and Guadalupe Counties, after failed attempts to use county-issued revenue bonds. The state had an opportunity to purchase these facilities in the late 1990s, but the Legislature and Governor Johnson could not come to an agreement over the direction of prison privatization.

The costs of construction, private capital and GEO's return on its investment are captured in the overall per diem rate (we use debt service to explain construction and return on investment). According to GEO, the company reported about \$27 million constructing GCCF and \$50 million constructing LCCF as of 2001. Separating these costs is not necessary for the Torrance and Santa Fe County agreements because those facilities are multi-jurisdictional facilities, housing jail inmates as well as federal inmates. In addition, the department does not use the vast majority of bed space in those facilities as it does at LCCF and GCCF.

Since the department has not segregated the facility per diem, it has ended up providing a price increase on what should have been fixed costs. Again, the contract does not require the contractor to spend revenue from price increases on operational costs. As a result, the state has been providing price increases on estimated fixed costs of \$10.04 for LCCF and \$10.85 for GCCF. Through FY06, the difference between the estimated debt service and the price increases is \$4.4 million for LCCF and \$1.3 million for GCCF. We calculated the fixed cost based on a minimum of 540 inmates at GCCF and 1,080 inmates at LCCF because the state has committed at the inception of the contracts to use a minimum of 90 percent of bed space. The application of price increases on the debt service may cost state an additional \$21.9 million dollars for LCCF and \$12.1 million for GCCF over twenty years from the inception of the contracts. These figures include five percent return on investment or finance charges. See Appendix A for additional information on methodology and assumptions used for estimates. Charts 7 and 8 show the actual

facility debt service per diem the department should pay for versus what it has and will pay due to price increases. The figures do not include additional overpayments as a result of the department paying the same amount in per diem for inmates above and beyond the 90 percent threshold necessary to cover the costs of debt service. The department should not pay as much for these inmates because, presumably, the contractor’s construction costs are covered in the first 540 and 1,080 inmates at each facility.



In 2000, the Independent Board of Inquiry (IBI) review noted the contractual flaw of providing inflationary price increases on facility debt service and construction costs. However, the department has not amended existing agreements with GCCF and LCCF to create a separate facility use per diem for construction and return on investment costs.

The department has addressed this problem in its new agreement with the town of Clayton. In that agreement, the department will pay a separate facility use fee equal to the debt service costs the town has incurred to construct and finance a new prison.

The department pays significantly higher rates to house inmates in private prisons than other states do for similarly classified prisoners. Tables 4 and 5 compare per diem rates and inmate-to-staff ratios of New Mexico’s two largest male private facilities (LCCF and GCCF) with other states. The five comparison states include: Colorado, Montana, Texas, Idaho, and Oklahoma.

**Table 4. New Mexico and Other States' Per Diem Rates
FY02 through FY06**

		LCCF ¹	Idaho ²	Oklahoma ³	Texas ⁴	GCCF ¹	Colorado ⁵	Montana ⁶
	# of Inmates	1200	1250	1918	1100	600	500	500
	Level of Security	III	III	III	III	III	III	III
FY02	Operational Cost	51.30	37.62	40.82		53.68		42.45
	Health Services Cost	9.99	0	0		9.99		0.97
	Building Use Fee	0	0	0		0		9.14
	Total	61.29	37.62	40.82	na	63.67	na	52.56
FY03	Operational Cost	51.75	38.71	40.82		54.71	54.66	43.6
	Health Services Cost	6.19	0	0		6.9	0	0.97
	Building Use Fee	0	0	0		0	0	9.14
	Total	57.94	38.71	40.82	na	61.61	54.66	53.71
FY04	Operational Cost	53.55	39.87	40.42		56.49	50.37	43.6
	Health Services Cost	5.90	0	0		5.90	0	0.97
	Building Use Fee	0	0	0		0	0	9.14
	Total	59.45	39.87	40.42	na	62.39	50.37	53.71
FY05	Operational Cost	54.75	41.07	40.42	26.46	57.53	49.56	43.6
	Health Services Cost	6.97	0	0	7.49	6.97	0	0.97
	Building Use Fee	0	0	0	0	0	0	9.14
	Total	61.72	41.07	40.42	33.95	64.5	49.56	53.71
FY06	Operational Cost	56.58	42.30	41.23	27.00	58.34	50.28	44.47
	Health Services Cost	12.28	0	0	7.66	12.27	0	0.97
	Building Use Fee	0	0	0	0	0	0	9.14
	Total	68.86	42.30	41.23	34.66	70.61	50.28	54.58

Source: NMCD and other states' corrections departments

na = not available because facility did not entered into contract as yet.

¹ = Lea County Correctional Facility (LCCF) and Guadalupe County Correctional Facility (GCCF) are operated by the private contractor, GEO. It houses >1200 and > 600 inmates respectively in each facility. Health care services is contracted to another contract. ² = The per diem rate includes health care services cost. The facility is the only state-owned, privately run facility. The facility is built on state property by the contractor, and the does not pay for debt service because the state owns the facility. ³ = Total per diem rate includes 39.84 (base) +0.56 (protective custody) + .42 (therapeutic community) - \$0.40 if monthly average inmates per day is at least 1,875. Protective custody rate is spread out over the whole population at the facility. The contractor agrees to a per diem reduction of \$0.40 per inmate a day across the entire population based on a monthly average daily population of 1875 inmates as measured from the first day of the month to the last day of the month. The department has an option to purchase at the fair market value before the renewal of the contract every year. The department did not raise per diem rate in FY05. In FY07, legislators gave 5% raise to the contractor. The department advances six months of the first year operating per diem in the amount of \$3,622,500. ⁴ = per diem rate includes \$7.49 and \$7.66 per inmate for health care cost for FY05 and FY06 respectively. The per diem rate does not include building use fee because the facility is owned by the state. ⁵ = The state uses one per diem rate for all private facilities. The state does not guarantee minimum number of offenders to be assigned to contractor's facility, but the state agrees to house up to 700 offenders at any time. The per diem rate includes health care services cost. ⁶ = Montana pays for health care services over and above \$1000 deductible, through a separate. It comes to an average of \$0.97 per inmate a day. Montana pays \$9.14 is paid for building use fee per inmate. The use fee stays the same for the life of the contract with the expectation being after 20 years the facility is paid for by Montana and it has an option to obtain possession.

Other states' private prisons provide similar services and, even after adjusting for medical services, still have lower costs than New Mexico. Colorado, Oklahoma, Montana and Idaho private facilities per diem rates, in Table 4, include medical services. The Texas per diem rate in Table 4 includes medical services costs provided by the state's medical vendor. New Mexico's medical services are provided by a separate medical vendor, but for comparison purposes included in the per diem rates on Table 4. All facilities provide standard services, including food, education and recreation as show in Appendix A.

New Mexico's private facilities are more staff intensive, which could result in higher cost services. Table 5 shows the total staff required to operate private facilities in New Mexico and private facilities in five other states. New Mexico facilities appear to use more administrative and support program staff than other states. Uniform staff includes security supervisor/unit management and security/correctional officers.

Table 5. Comparison of Private Facilities' Staffing Requirements

	LCCF	Idaho	Oklahoma	Texas	GCCF	Colorado	Montana
No. of Inmates	1200	1454	1918	1000	600	724	500
Total Administration	25	19	20	16.5	18	7	10
Total Security Supervisor/Unit Management	42.8	106	46	15.0	25.4	68	40
Total Security Officers	168.4	91	226	129.2	96.8	60	70
Total Unit Support/Programs	74	27	50.05	21.4	37.6	17	21
Total Education ³	22	19	27	16.0	13	8	13
Health Care	na	27	26.6	na	na	16 ²	8 ¹
Total	321.2	289	395.65	198.1	190.8	160	162
Inmate to correction officer ratio	5.7	7.4	7.1	6.9	4.9	5.7	4.5
Inmate to staff ratio	3.7	5.0	4.8	5.0	3.1	4.5	3.1
Inmate to education staff ratio	54.55	76.53	71.04	62.50	46.15	90.50	38.46

Source: NMCD and other states' corrections departments

na = not applicable because health care services are subcontracted to another private contractor. Idaho staffing requirements are based on twelve hour shifts for uniformed staff. ¹ = Dentist, physician, dental hygienist, psychiatrist, optometrist are sub-contractors hired by private prison contractor. ² = Physician, dentist, dental assistant, psychiatrist, optometrist are subcontractors hired by private contractor. ³ = Education staff includes library staff, education and vocational staff.

The department paid for services it may not have received. On September 21, 2004, the department entered into an agreement with LCCF to provide a 116-bed residential sex offender program and agreed to pay \$304,160 annually. To provide services, LCCF was required to hire four masters' level licensed mental health providers within 60 days of the effective date of the agreement. The facility did not hire four additional mental health staff even though it billed for services, based on a review of LCCF personnel documents. LCCF instead moved four existing mental health staff to the sex offender program but did not fill the newly created vacant mental health positions caused by the move. LCCF did not hire a new staff member until April 2005 to provide the services. In August 2006, the department reduced the contract amount in half because LCCF was unable to provide services to all the inmates. Table 6 shows the mental health FTE, sex offender treatment program FTE and actual positions filled.

Table 6. Comparison of Mental Health FTE, Sex Offender Treatment Program FTE and Positions Filled

	MH	SOTP	Total	Filled
10/1/04	8	0	8	7
11/1/04	9	4	13	7
4/1/05	9	4	13	8
8/1/06	9	2	11	10

Source : NMCD and LCCF

MH = Mental health FTE
SOTP = Sex offender treatment program

Restructured agreements could lower private prison costs by at least \$60 million during the next ten years without sacrificing quality and safety. While private facilities clearly cost the department less on a per-inmate basis, and should, a more aggressive cost containment strategy could yield further savings from privatization.

Restructure per diems to take advantage of economies of scale and separate facility use fees. The department's original agreements with LCCF and GCCF appropriately considered economies of scale generated by filling facilities to 90 percent occupancy, but were changed in 2001. The department's agreement with Clayton provides a model per diem structure for a facility the department intends to nearly fully occupy with state inmates. That agreement includes a base operating fee, incremental per diem and a separate facility use per diem. The base and incremental per diems demonstrate that the department recognizes the prison operator will only have marginal cost increases for housing inmates beyond 90 percent capacity. Adjusting LCCF and GCCF per diems using Clayton as a model could save the department an estimated \$4.9 million annually. Using a separate facility use per diem for debt services helps ensure the department does not provide price increases on fixed facility costs.

The incremental per diem does not make as much sense for overflow facilities at Torrance and SFCDC since the department houses so few inmates.

**Table 7. Annual Savings from Restructuring LCCF Per Diem
FY06**

		No. of Inmates	Annual Cost
Estimated Operations Cost	\$44.51	1268 ¹	\$20,600,118.20
Estimated Debt Service	\$12.07	1268	\$5,586,237.40
FY06 Actual Per Diem	\$56.58	1268	\$26,186,355.60
Recommended Tiered Per Diem			
Base Operations Cost	\$44.51	1080 ²	\$17,545,842.00
Incremental Operations Cost	\$13.35	>1080	\$828,553.65
Total Operations Cost			\$18,374,395.65
Historical Debt Service	10.04	1080	\$3,957,768.00
Total Cost			\$22,332,163.65
Total Savings			\$3,854,191.95

Source : NMCD and LFC Analysis

¹ = Number of inmates at LCCF on June 30, 2006.

² = NMCD committed 90% of 1200 inmates, 1080, at inception of the contract.

³ = Assume 188 inmates (1268-1080=188)

**Table 8. Annual Savings from Restructuring GCCF Per Diem
FY06**

		No. of Inmates	Annual Cost
Estimated Operations Cost	\$44.28	591 ¹	\$9,551,860.20
Estimated Debt Service	\$12.30	591	\$2,653,294.50
FY06 Actual Per Diem	\$56.58	591	\$12,205,154.70
Recommended Tiered Per Diem			
Base Operations Cost	\$44.28	540 ²	\$8,727,588.00
Incremental Operations Cost	\$13.28	>540	\$247,281.66
Total Operations Cost			\$8,974,869.66
Historical Debt Service	\$10.85	540	\$2,138,535.00
Total Cost			\$11,113,404.66
Total Savings			\$1,091,750.04

Source : NMCD and LFC analysis

¹ = Number of inmates at GCCF on June 30, 2006.

² = NMCD committed 90% of 600 inmates, 540, at inception of the contract.

³ = Assume 50 inmates (591-541=50)

The per diem structure for operational agreements for NMWCF and Camino Nuevo women's facilities also need restructuring. The department does not have sufficient flexibility to place female inmates in locations that best suit their programming and security needs at no extra cost. Currently, the department has significant excess capacity to house women. As of March 2007, female inmates accounted for 78 percent of available female bed space capacity, including 570 inmates at Grants and only 52 at Camino Nuevo. Camino Nuevo is a 192 bed facility. However, moving any women from NMWCF to Camino Nuevo would result in a cost increase due to the structure of each facility per diem. For example, the department will pay \$38,106 per month, or \$457,000 per year, more in per diem costs to transfer just 48 women from Grants to Camino Nuevo. Moving the women will require the department to pay a \$40 per diem at Camino Nuevo as opposed to a \$13.90 per diem at NMWCF.

**Table 9. Women's Facilities Population and Per diem Rates
March 2007**

	March 2007 Actual Inmate Population	Number of Inmates	Per diem
NMWCF	322	1-322	\$62.06
	193	323-516	53.83
	54	>516	\$13.90
Camino Nuevo	48	1-48	\$163
	4	49-96	\$40
	0	97-144	\$19
	0	145-192	\$17

Source: NMCD

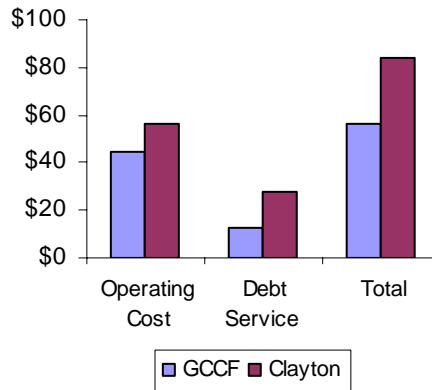
Better management of savings created by staff vacancies at private facilities. As noted above, New Mexico pays for a relatively expensive staffing pattern for its private facilities, particularly for inmate programming. However, the facilities often run high vacancy rates which do not benefit the department programmatically or financially. For example, as of April 2007 LCCF reported a 37 percent vacancy rate for security posts. The department is paying for a full complement of staff and the services that they are supposed to deliver. The contracts do not anticipate routine staff vacancy savings common to any organization, including state government, and as a result the private operator, not the state, benefits financially.

The department's contracts provide penalties for any unfilled positions after 30 days, not just mandatory security positions. This contract provision is discretionary, rarely enforced and applies to individual positions. For example, GCCF had 17 vacant security positions for more than 30 days in June 2006. But the department did not enforce any penalties. In addition, the private operator could meet the 30-day requirement through changing staff assignments, but due to high turnover of staff still maintain unsatisfactory vacancy rates. If the facilities' operational quality is not hampered due to high vacancy rates, then the department may be paying for staff that isn't needed.

Require private prisons to justify annual price increases based on performance. The department misses an opportunity to use positive financial rewards based on performance. The department's private prisons are long-term agreements with little practical opportunity for changing vendors for non-performance. One option for extracting better performance could be by only giving price increases to facilities that demonstrate superior performance. This approach would assure that only high-performing facilities receive price increases and serve as an incentive to others.

The base per diem for the Clayton prison appears higher than its comparison facility in Guadalupe County. As a result, Clayton's operating cost is \$2.5 million higher than GCCF based on housing 540 inmates. According to GEO, the Clayton operating costs are based on costs at GCCF. However, GCCF per diem includes debt service costs. The department did not account for this difference by reducing the GCCF per diem to near actual operating costs in order to compare the two facilities' operational per diems. Clayton per diem excludes additional debt service cost included in GCCF per diem.

Chart 9. Per Diem Rate and Debt Service Rate Comparison



Source: NMCD

Recommendations. The department should seek to modify its agreements with counties and private contractors to do the following.

Restructure per diems to take advantage of economies of scale and separate facility use fees. At a minimum, the agreements for LCCF and GCCF should be structured using a three tier per diem structure similar to Clayton. This would include a base per diem (existing per diem less recalculated debt service), incremental per diem (about 30 percent of base per diem) and a separate debt service fee. In recalculating the debt service fee the department should reduce past price increases. Work with private vendor to include total financing costs in the facility debt fee. We conservatively estimate the department could save about \$4.9 million per year and \$49 million over the next 10 years by only paying the variable cost, such as food and clothing, of housing inmates above 90 percent capacity and not overpaying for debt service. Separating construction costs will allow the department to identify how much the per diem should drop in ten to twelve years as the facilities are paid off and not provide inflation adjusted price increases on fixed costs.

Do not apply price increases to the separate debt service fee. This change could save an estimated \$11 million over the next ten years. Maintenance costs are already included in the base operating per diem.

The per diem structure for operational agreements for the women's facilities in Grants (NMWCF) and Camino Nuevo in Albuquerque needs restructuring as well to, at a minimum, allow the department to transfer another 40-50 inmates at no extra cost. This could help the department avoid an estimated \$457,000 per year as Camino's population ramps up.

At a minimum, withhold five percent of the total estimated contract amount to better manage savings created by staff vacancies at private facilities. Set vacancy rate target at a reasonable level (10 percent) for contractor to earn the five percent back. Modify contracts to automatically deduct the amount for at least unfilled security positions after 30 days. Require contractors to provide detailed invoices. For example, invoices should include the current month's number of education classes conducted, and number of classes cancelled and the reasons for cancellation.

Require private prisons to justify annual price increases based on meeting performance measures. The department should also measure public facilities performance on an expanded number of measures listed throughout this report.

Reevaluate the base per diem costs for the Clayton facility and consider bringing it more line with GCCF.

Require contractors to submit prior year actual expenditures and financial audits, a balance sheet, statement of income and expenditures, and statement of cash flow for each facility.

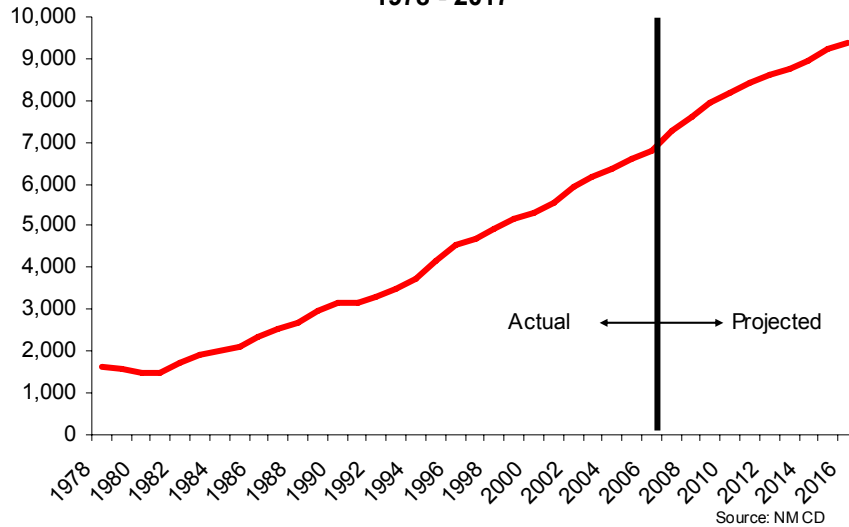
Require LCCF to refund \$456,239.88 to the state for non-performance of the sex offender treatment program.

NEW MEXICO'S APPROACH TO PRISON PLANNING AND CONSTRUCTION IS NOT IN THE TAXPAYERS' BEST INTEREST.

The department projects its inmate population will increase 37 percent by 2016, requiring bed space for an estimated 9,365 inmates. Over the past 28 years, the department's budget has increased over 1,495 percent from \$20 million in 1980 to \$299 million in 2008. The number of inmates has increased 442 percent from 1980 through March 2007.

According to the Legislative Council Service, "sentencing policy changes in the 1980s and 1990s, which were gaining wide support both in New Mexico and nationally, contributed to faster-growing prison populations. The changes included mandatory prison sentences for selected crimes (including drug offenses), longer sentences for some offenses and limitations on the early release of inmates." For example, current truth in sentencing laws require New Mexico inmates to serve 75-80 percent of their sentences as opposed to the former good time provisions that allowed inmates to serve 55-60 percent of sentences, according to the department.

**Chart 10. NMCD Inmate Population Growth
1978 - 2017**



Historically, the department's population projections have been generally accurate. Projections are based on the current law at the time of the projection. Changes in laws, policies and sentencing practices of judges, among others, can impact the accuracy of long-term projections. However, ten-year projections are useful for long-term planning and assessing the costs of incarceration. Long-term planning helps refocus the department from the yearly fluctuations that can occur in prison populations and evaluate the need for future prison space.

The department regularly monitors JFA & Associates' population projections. The department considers +/- 3 percent as an accurate projection and tracks this data monthly. The projections are generally accurate, running about 2 percent higher than actual inmate population over a 12 month period. However, as of March 2007 the projection was eight percent higher than the actual population. In comparison, a year ago the department was facing overcrowding in its prisons and quickly running out of bed space.

Despite the additional prisons in Springer, Clayton and Albuquerque, the department may require additional bed space within two to four years. The department has or will increase its bed space capacity to 7,755 by 2008 by adding beds at Springer and Clayton. According to JFA the department will run out of capacity in 2009, however internally the department projects it will exceed capacity in 2011.

Rapid deterioration and an inefficient design make New Mexico's public prison facilities increasingly expensive to operate. Two key factors contribute to inefficient prison designs of New Mexico's public facilities. The 1980 riot at PNM demonstrated that inmates could quickly overtake an entire facility. According to the department, the state's response to increased need for inmate control was to design smaller 48-cell housing units spread across a campus separate from programming and central control complexes. The *Duran* consent decree required the state to house medium security prisoners, which makes up the bulk of inmates, in single-man cells. At the time these designs and agreements may have made sense, but over time have proved extremely costly. For example, one public correctional officer oversees each 48-cell housing

unit control center versus one private correctional officer that can oversee 160 inmates due to facility design.

Public prisons also house high security inmates and have become increasingly specialized. For example, CNMCF includes the mental health and long-term care treatment units. High security and specialized units are more staff intensive or require addition higher cost professional personnel, which contributes to higher operational costs.

The department may require an estimated \$100 million in capital outlay funding to repair public facilities statewide over the next five years. The Property Control Division (PCD) at the General Services Department (GSD) provides repair and replacement estimates for state owned facilities. The estimates are based on the facility condition index, which reflects the costs of repairing a building divided by the cost of replacement. Buildings with an index rating of 60 – 70 percent should be considered for replacement, rather than repair. Most of the assessed costs relate to mechanical, electrical, plumbing, floors, walls, doors, and site renovations. Few of the department's buildings require full replacement today; however, without repair many may require replacement sooner than later.

Twenty housing units, 960 cells, at SNMCF and CNMCF need about \$26.8 million in repairs to extend their usefulness. These housing units were built in 1983 and 1981, respectively, and need repairs to plumbing, heating and cooling systems, new roofs and some electrical. Plumbing has never been upgraded and is past its 20-year life cycle at each facility. Ductwork at CNMCF is crushed due to foundation problems and the SNMCF cooling system fails during the hot Las Cruces summer months. Maintaining decent living conditions in prison housing units helps reduce unrest among inmates, according to staff.

WCNMF has some of the most serious facility problems, based on LFC staff observations and interviews. One housing unit is sinking and separating from an attached structure, and the plumbing across the facility is corroding as quickly as it is repaired due to the hard water in Grants. Modular units housing low-security inmates appear in disrepair. PCD is currently in the process of updating the estimated repair/replacement costs for WNMCF – meaning the current repairs totaling \$19.3 million may increase significantly in the near future.

Continued increases in inmate population mean that New Mexico cannot afford to reduce the life of existing prison buildings due to deferred maintenance. Many state prison buildings will reach their estimated life cycle during the next ten years, requiring decisions on whether to continue using the buildings or replacing them. Entire complexes may not require replacement, but housing units constructed in the early 1980s may need either continued upgrades or replacement. Significant capital investments in these housing units may not make fiscal sense because of the higher costs to staff and operate these small units. For example, in FY05 WNMCF was the second most expensive facility to house an inmate at \$102 per day.

New Mexico's use of county jail statutes as the basis for building private state prisons results in the state paying for a prison it will never own. The effect of decisions to alternatively finance prison construction and the 1989 *Montano* Supreme Court decision barring lease-purchase agreements will result in the department paying for three prisons it will never

own: Clayton, LCCF and GCCF. The department sold its equity interest in the NMWCF in 1999 for \$3.5 million and does not fully use county jail space in Torrance and Santa Fe.

Since the mid-1990s, New Mexico has expanded the financing of prison construction from using traditional public capital outlay funding to private or local financing. This approach shifts prison construction costs to the department's operational budget through higher private prison per diems. In many cases, these costs are even hidden within the per diem as demonstrated in other sections of this report. The shift in costs results in higher department operational budgets. The NMWCF was the first privately financed facility in 1988. This practice became more widely accepted as the state needed more prison space.

The 1989 Montano Supreme Court decision barred the state from entering into certain lease-purchase agreements because they violated the constitution's restrictions on state debt. Essentially the decision said lease-purchase arrangements, which allowed government entities to possess assets after making specified lease payments, constituted debt that requires voter approval. The practical effect of the decision on the department was that it would pay for a private or locally financed prison facility through higher per diems but never have an equity interest or clear ownership right after the facility debt was paid off.

Not using traditional state capital outlay financing for prison construction results in higher long-term costs for the state taxpayer. This alternative financing approach has freed-up the state's bonding capacity and one-time funding for use on public capital outlay projects other than prison construction. However, fully financing a prison costs more than if the state used one-time capital outlay funds to pay cash or partially pay for construction. For example, the prison in Clayton will cost about \$61 million to construct. However, the department will pay \$132 million over twenty years for construction and financing charges through higher per diems rates.

Construction of prisons in Lea and Guadalupe counties were financed by the private contractor. The state should be able to secure tax-exempt financing at cheaper prices than private prison operators, which would have significantly reduced borrowing costs. The private prison's higher borrowing or financing charges are presumably built into New Mexico's higher per diem rates by the department. The state has no legal ownership interest in these facilities even though in practice it will pay the full cost for construction.

The department did not anticipate the opportunity to use a lease-purchase agreement for the Clayton prison that may prove costly. In 2005, the Legislature passed HJR 9 that proposed a constitutional amendment allowing state agencies to enter into lease-purchase arrangements originally banned by the *Montano* decision. The agreement with Clayton did not anticipate possible voter approval of the constitutional amendment, which would provide the opportunity for the department to own the Clayton facility after 20 years. The department finalized the agreement in September and the voters approved the amendment in November 2006. The state has the option to purchase the Clayton facility, but without consideration of intervening lease payments. As a result, Committee staff considers the contract's purchase option clause to mean that the state would have to purchase the prison at market value because the state and Clayton would negotiate a price or the state would have to match a third-party price offer.

State use of existing local jail statutes also allows the department to bypass an important cost containment provision provided by the Procurement Code. As a result, the department does not benefit from the competitive requirements that force down contract prices. Because the local jails (prisons) are both owned and operated by the same company, the department is forced to negotiate contract prices in a non-competitive and monopolistic environment.

Local government contracts with a private independent contractor for the operation, or provision and operation, of a jail are exempt from the Procurement Code (Section 13-1-98 (M) NMSA 1978). A 1987 Attorney General opinion concluded that the design and construction of jails were also exempt from the Procurement Code. The department has statutory authority to contract with county jails to house state inmates (Section 31-20-2(G) NMSA 1978). Presumably this authority was granted to ease overcrowding at state prisons and does not contemplate the department using an entire jail for state inmates. Since contracts with counties are considered intergovernmental agreements they too are not subject to the Procurement Code. The Committee and other lawmakers questioned this tactic, but according a letter from then-Attorney General Madrid's office in 2005 the practice is perfectly legal under state law.

Contracting for both the use and operation of prison facilities puts the state at a poor negotiating position to obtain low cost, high quality prison services. Using an owner-operator contract model outside a competitive process further reduces the advantages of privatization. These advantages include demonstrated lower prices and higher quality normally produced through competition, ability to change vendors and the flexibility offered by reducing long-term obligations.

The department contracts for almost half of its total bed space and will continue to need contracted bed space in the foreseeable future. Three department agreements, in particular, put the state in a less-than-ideal negotiation position for prison services because the private provider both owns and operates the facility. These include LCCF (1,250 beds), GCCF (600 beds) and NMWCF (600 beds). The department has few practical alternatives for housing this many inmates if it cannot afford, or is unhappy, with the prison contractors' service. Prisons are expensive to build and operate; resulting in a very tight marketplace and few options in terms of alternative prisons to place inmates.

Executive policy combined with the department's lack of active long-term planning to accommodate inmate growth has led to a disjointed and costly approach to acquire needed bed space. The department lacks concrete policies to guide site selection and decision making for adding bed space. The department has attempted to implement the Governor's policy of not using state capital outlay funds for building prisons. From FY03 to FY06, the department experienced a nearly 15 percent population growth (630 inmates) and crowded prisons. The department developed short-term goals to accommodate a growing prison population that put the department in a reactive, rather than proactive, position to acquire bed space at a low cost. Despite the no new prisons policy, the administration and department agreed to finance the cost of a new prison in the town of Clayton, as discussed above, and take over two existing juvenile facilities vacated by the Children, Youth and Families Department (CYFD). The facilities in Clayton, Springer and Albuquerque will be some of the most expensive to operate in the state. This approach lacks consideration of the following.

- **Short and long-term cost.** The department avoided the need for capital outlay funding to construct facilities by taking over Springer, Camino Nuevo and contracting with Clayton but will pay higher long-term costs as a result. For example, Springer will cost an estimated \$120 per day for 260 low-security inmates. This per-inmate cost is similar or higher than what the department must incur to house maximum security inmates. As pointed out above, the state will pay \$132 million over twenty years for a \$61 million dollar facility in Clayton that the state will never own.
- **Impact on operations.** Contemporary prison operations rely more heavily on licensed professionals for medical, mental health, education and substance abuse services. However, the department's ability to hire professional staff in remote and rural areas may prove difficult. In addition, adding more facilities in different areas of the state reduces economies of scale that can be achieved from adding bed space to existing facilities and increases other costs such as construction and inmate transportation.

Current law limits the department's flexibility to add bed space or replace existing prisons at a more affordable price. State law allows the department to contract for the operation of a prison with a private vendor through a competitive process (Section 33-1-17 NMSA 1978). However, the law restricts department flexibility by only authorizing private prisons in certain counties or only for women's facilities. Without support for public prison construction, the department is left with using intergovernmental agreements with counties to house state inmates to meet space needs. These agreements lack controls needed to ensure lower-cost services because they are non-competitive.

The law does not require the department to ensure that private prison operations will cost less than if the department operated the same facility. According to a Moss Adams study, GEO's proposed wage costs for the Clayton facility were 16 percent less than the average wages for similar positions based on U.S. Bureau of Labor Statistics for New Mexico. However, compared with state employee wages, GEO's costs were only 1.5 percent less.

Other states statutorily require that private prisons cost less than if the state were to operate the facility. This approach ensures the state receives savings associated with privatizing prison operations.

Other alternatives exist to finance prison construction that would be more beneficial to the department and state taxpayer. The state has many options to finance prison construction ranging from purely state capital outlay to wholly privately financed prisons. The least expensive options require use of the state's general obligation or severance tax bond capacity or one-time general revenue funding. The next best options include the following.

- *Dedicate income from the permanent land grant fund to finance prison construction as authorized by current state law (Section 33-1-18 NMSA 1978).* Currently, the Legislature appropriates land income for the penitentiary of New Mexico to the department for operational expenses. This income could be used to pay debt service on bonds issued for the department by the Board of Finance. Diverting this revenue to the prison fund would require a replacement or reduction by the same amount of general fund revenue for the department's operating budget. Adding or replacing prisons will require a net increase to the state no matter what. The department would need additional flexibility to procure a

- prison because current law restricts the use of the prison fund to certain counties or type of building.
- *Authorize the New Mexico Finance Authority to issue revenue bonds for prison construction and use lease payments from the department to repay the bonds.* The state could designate GSD or create a public corporation as the owner of the facility. This option would mirror the arrangement currently used in the Clayton agreement, but ownership of the facility would be in the hands of a state, not a local or private, entity. This option better protects the state's long-term financial interests.
 - *Clarify state law to authorize the department to procure privately financed prisons through a lease-purchase agreement.* In 2007, the enactment of House Bill 1022 provided an enabling statute and criteria for lease-purchase financing of state buildings, including requiring legislative approval of any agreements. For the department, the statute should protect the state's interests by prohibiting a private owner-operator model. Current agreements would have to be exempt. This approach would also allow the department to decide whether to procure a private vendor to operate the facility or whether it could operate the facility at a similar or lower price. In addition, the approach would not lock the department into long-term operational contracts that limit its negotiating power.

Recommendations. Committee staff proposes the following statutory changes.

- Require the department to develop and implement a 10-year facility strategic plan. At a minimum, the plan should forecast projected growth in the inmate population; provide information, in coordination with the New Mexico Sentencing Commission, concerning impacts on the inmate population caused by changes in sentencing policies and law enforcement policies; prioritize projects to repair or replace existing correctional facilities, including analyzing the need for future construction of additional correctional facilities, and estimated costs; if necessary, prepare proposed legislation to further the implementation of cost-effective correctional facilities; and ensure recommendations consider public safety concerns. The department should be required to update the plan every two years and submit the plan, including any legislative proposals, to the interim Courts, Corrections and Justice Committee; the Legislative Finance Committee; and the Department of Finance and Administration no later than November 1 of each even numbered year. The plan should form the basis for capital outlay spending.
- Amend Section 33-1-17 NMSA 1978 to remove restrictions on the location or type of correctional facility for which the department may award a contract. Amend the section by including provisions to prohibit the department from entering into agreements with an operator who also owns the facility and requiring the department to demonstrate that operation of the facility would cost, at minimum, 10 percent less than if the department operated the facility.
- Amend Section 33-1-18 NMSA 1978 to authorize establishment of only the New Mexico prison fund by repealing references to the corrections department building fund and Guadalupe county prison fund. These other funds are no longer necessary.
- Amend Section 33-1-19 NMSA 1978 to remove restrictions on the location or type of correctional facility for which the department may use proceeds from the New Mexico prison fund and remove authority to use the fund proceeds for operating lease agreements.

- Authorize the department to procure private or locally financed correctional facilities by entering into lease-purchase agreements, subject to the provisions of Laws 2007, Chapter 184 (H.B. 1022).

Throughout the interim, legislative committees could explore other alternatives for prison financing, including whether to grant specific revenue bond authority to the New Mexico Finance Authority for prisons or creating a public corporation to own any financed correctional facilities.

The department should modify the Clayton agreement by adding a lease-purchase clause to ensure the state, if it chooses, will own the facility after twenty years or may purchase the facility at any time. The purchase price should take into consideration past lease payments.

THE DEPARTMENT NEEDS BETTER OVERSIGHT TO CONTAIN MEDICAL COSTS AND ENSURE THE PROVISION OF ADEQUATE CARE.

The quality of inmate medical care varies by facility, however, the department has failed to systematically ensure Wexford delivers adequate medical services. Committee staff contracted with two nationally renowned medical experts, Dr Steven Spencer and Dr. Jaye Anno (LFC medical experts), to conduct an in-depth evaluation of the department's medical services. Their full report is included in Appendix B and their major findings are incorporated below. Overall, LFC-contracted medical experts found that health care staff at the facilities includes many qualified professionals, but system-wide the quality of care provided is inadequate. At the time of this report, the department terminated its contract with Wexford and was in the process of soliciting bids for a new medical contract.

Improved monitoring of inmate's access to care and addressing complaints is needed. Wexford's insufficient record-keeping, the lack of meaningful and consistent reports and poor communication between Wexford and the department has limited oversight of access to care, particularly for off-site specialty care. LFC medical experts could not conclude whether inmates received timely off-site care because of a lack of information on inmates' cases where a final decision was deferred to a later date. For example at LCCF, of the 40 cases presented between November 2006 and January 2007, only 15 (37 percent) were approved by Wexford. However, without a department physician reviewing the cases that were deferred, it is impossible to know whether those decisions were medically appropriate.

LFC medical experts questioned the effectiveness of the grievance system. Many facilities reviewed had very few inmate grievances, in some cases representing only one percent or less of a facility's inmate population. The department does not track or analyze informal complaints made at the unit level regarding medical care. This approach could be more illustrative of the effectiveness or problems with the medical system. For example, inmates may complain at high rates over access to care issues but not file formal grievances, or units may effectively remedy the problem and thus avoid a formal grievance.

Corrections Department oversight and the quality improvement program have failed to identify problems in a timely fashion. The department's lack of a medical director during part of 2006 greatly compromised its oversight responsibility for quality of care. For example, 14 inmates

died in department facilities in 2006, but the department had not completed the necessary reviews of these deaths as of April 2007. In addition, Wexford did not complete its portion of these mortality reviews timely. As a result, the department does not know whether lack of adequate care lead to these deaths.

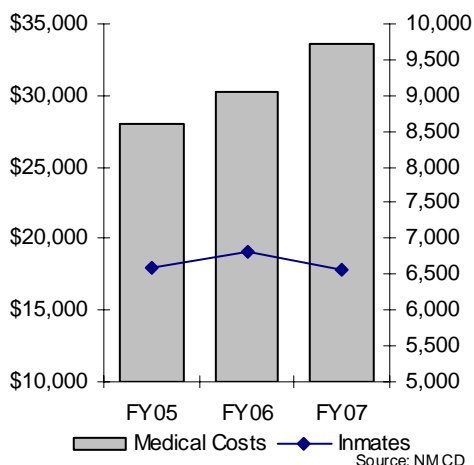
The department relies too heavily on Wexford self-monitoring and other external accrediting agencies to assess the quality of care delivered to inmates. Also, the department and Wexford lack an adequate continuous quality improvement program to ensure effective and efficient inmate medical care, according to LFC medical experts.

The geriatric housing unit at the Central New Mexico Correctional Facility is counter-therapeutic, according to LFC medical experts. There is a small geriatric population at CNMCF housed in three modular units, or trailers, with a total of 42 beds. The modular units need repairs and other modifications to improve living conditions, according to LFC medical experts. The quarters are cramped and there is barely enough room for wheelchairs to pass down the aisle. The floors are rotting and some of the plumbing does not work.

Wexford's chronic illness program fails to meet national standards, resulting in poor medical outcomes for inmates according to LFC medical experts. LFC medical experts reviewed a sample of records for inmates receiving care for chronic conditions such as diabetes, asthma, and hypertension. Evidence revealed that Wexford staff failed to follow nationally accepted guidelines for providing care in numerous cases and found examples of erroneous diagnosis of inmate's health conditions. Inmate health outcomes suffered as a result. Overall, the chronic care program has poor record keeping and uses inadequate medical forms. The department does not gather performance information system-wide on adherence to national treatment guidelines.

The department has not effectively monitored the cost of medical services or enforced key contract provisions such as staffing requirements. Contract costs for medical services have increased almost 59 percent since FY03 and more than doubled in the past ten years. The department sought to contain these increases through the state's SaveSmart initiative when it contracted with Wexford. A 2005 Committee performance audit of SaveSmart indicated the department estimated saving about \$800 thousand. In FY07, the department expects to pay about \$34 million for medical services. Chart 11 shows the cost of the Wexford contract and inmates.

**Chart 11. Medical Costs
FY05-FY07**



The contract with Wexford provides for an automatic price increase, regardless of performance or justification for increased medical costs. The Wexford contract lacks specific performance measures, such as timely access to offsite care and adherence to clinical treatment guidelines, to assess the results and outcomes of services delivered.

The department does not regularly obtain information about Wexford medical spending to ensure the adequacy of the contract amount and prevent inappropriate cost-containment that could impact inmate care. The department lacks sufficient information showing the health status of its inmate population and use of services needed to approve an effective staffing pattern or ensure an appropriate contract price for medical services. Some of this information is maintained by Wexford at each site per department policy, but the department’s central office staff has not received system-wide reports or reports from individual facilities on a routine basis. During this review, the department’s central office began compiling monthly statistics regarding use of health services.

The contract requires that Wexford will assume full risk and liability for cost overruns, which provides a strong incentive for the company to contain costs. However, the department lacks needed oversight mechanisms to ensure Wexford does not inappropriately cut or restrain care. These oversight mechanisms include tracking, timely access to expensive treatments – which the department has not done – and treatments that on aggregate are costly, such as prescription drugs. The department has not routinely received this type of information, even though the contract provides for it. During this review the department did obtain some aggregate data. Other systems, Medicaid for example, require limits on the amount of funds that managed care companies can use for administration, overhead and profit. The department’s contract does not require such a spending test.

Inadequate or nonexistent medical staffing limits inmates’ access to care. The department has struggled to enforce staffing requirements and lacks information needed to easily monitor vacancies. Without aggressive monitoring and enforcement of staffing requirements, Wexford can generate vacancy savings and inmates do not receive appropriate medical care. The

department has imposed about \$90 thousand in financial penalties for staffing vacancies over the term of the contract.

According to LFC medical experts, the present contract does not provide adequate authorized staffing positions or hours of services. The contract includes insufficient physician staffing at LCCF and WNMCF, insufficient dental staffing at LCCF, PNM, NMWCF and CNMCF, insufficient optometry staffing at CNMCF and PNM, insufficient clerical staffing at all facilities, and insufficient nursing (particularly RN) at all facilities.

Wexford's vacancy rates and turnover have compounded the inadequacy of authorized positions. For example, review of the physician staffing at LCCF shows that a physician was on site 21 days in September, 22 days in October, and 20 days in November. However, the physician resigned in December. After the physician left, inmates only had access to a doctor 16 days in December and seven days in January.

Some facilities have serious backlogs for access to dental care. A dentist was on site at LCCF five days in September, nine in October, six in November, eight in December, and only three in January. PNM had 89 inmates on dental wait lists and the NMWCF had approximately 130, down from over 200 last year. At one facility our medical experts found that inmates no longer submit any sick call requests for dental care unless they have a very serious problem or a toothache, since they know that the chances are they will not be seen for many months.

The department has allowed Wexford to by-pass using local medical providers in some areas, such as Hobbs, which results in increased security and transportation costs for off-site care. The medical contract requires Wexford to consolidate the scheduling of appointments and services for inmates with community physicians, hospitals and other providers and services to minimize the impact upon security staff and available vehicles. However, Wexford uses a provider in Albuquerque for its off-site consultations, which is about a six-hour drive from Hobbs. This not only places a burden on security staff and vehicles, but it serves as a disincentive for inmates to complete their appointments, because they have to go to Albuquerque and back the same day.

The department lacks adequate staff to oversee a complex and expensive medical system that serves over 6,500 inmates across ten facilities. Currently, the department has an acting Bureau Chief, a vacant quality management position, a 30-hour per week clinical psychiatrist, a state-wide director of nursing, a state medical records manager, and an administrative assistant. The acting Bureau Chief held the quality management position until recently. The department plans to hire a clinical physician sometime soon.

LFC medical experts report that the Bureau of Health Services staff audits the Wexford facilities at least annually. However, their auditing tools are designed more to determine the extent of the facilities' compliance with national standards rather than compliance with specific terms of Wexford's contract. The current contract provides for numerous financial penalties to be assessed if Wexford violates specific terms. However, these areas are not all regularly monitored by the Bureau of Health Services. On the medical side, Wexford has refused to provide staffing vacancies until recently, according to the acting Bureau Chief. The last two quarters, Wexford

has reported aggregate staffing levels, but not site-specific information. This should be a requirement of the new contract.

Recommendations. Ensure the department's new medical contract does the following.

- Limit annual price increases to no more than the medical service CPI for western states based on meeting certain performance targets. These performance measures and targets should include, at a minimum, those related to timely access to care; quality of care, such as adherence to clinical treatment guidelines; low staff turnover, vacancies and use of contract nurses; and meeting reporting requirements.
- Withhold no less than five percent of the total estimated contract amount as a performance incentive for maintaining low vacancy rates. Ensure the next medical contract includes automatic financial penalties for excessive staff vacancies, particularly for critical professions such as physicians and dentists.
- Continue to use an "at-risk" contract approach, but require a direct services spending test of no less than 90 percent of total contract amount. This will limit indirect spending on administration, corporate overhead and excess revenue.
- Require the medical vendor to provide monthly reports on medical spending by defined expense categories and staff vacancies by type of staff. These should be submitted with invoices.

Conduct a cost-benefit analysis before allowing vendor to centralize off-site medical care by factoring the costs of security and transportation prior to approving the use of non-local off-site medical service.

Request a health services monitor position in the FY09 budget request. The monitor should be responsible for, at a minimum, day-to-day contract management, including ensuring financial, performance and clinical information is gathered in a timely and useful format.

Fill the department's medical director position with a permanent physician as soon as possible.

Begin addressing deficiencies in the CNMCF Geriatric housing unit immediately and develop a long-term housing plan for these inmates that meet their therapeutic and medical needs.

Track both informal medical complaints and formal grievances in a format that allows comparative analysis of nature of complaints, by facility and system-wide. The format should also compare previous quarters, months, years or annual targets as determined by the department.

Implement remaining recommendations from LFC medical experts included in Appendix B.

MORE INFORMATION IS NEEDED TO DETERMINE BOTH THE QUALITY AND EFFECTIVENESS OF THE DEPARTMENT'S INPATIENT ADDICTIONS SERVICES.

The department allocates about 700 beds to therapeutic communities (TC), which serve as residential substance abuse rehabilitation programs. The department has a goal of ensuring 90 percent of its TC bed space is used by active TC participants. Contract beds (CB) account for about 12 percent of total bed capacity in TC units.

According to the department, therapeutic communities (TCs) are voluntary one year-long residential treatment programs for inmates with drug or alcohol addictions. TC units exist in all department public and private facilities, except Santa Fe County Detention Facility and the Torrance County Detention Facility. TCs generally are supposed to operate in separate housing units apart from general population inmates and provide a daily regimen of substance abuse and criminal behavior therapy within a structured living environment. Department policy encourages TCs to operate as a “self sustaining sub-culture responsible for its own administration in order to facilitate desirable pro-social functioning” (CD-185200 (I)). The program is divided into four separate stages: I – entry into TC; II – Skills Development; III – Re-entry planning; and IV – Relapse Prevention.

All inmates are given the opportunity to participate in addictions services. However, TCs target inmates with diagnosed substance addictions, inmates with two years or less left on their sentences and inmates dually diagnosed with a mental and substance abuse disorder. Inmates also must agree to random drug urinalysis testing.

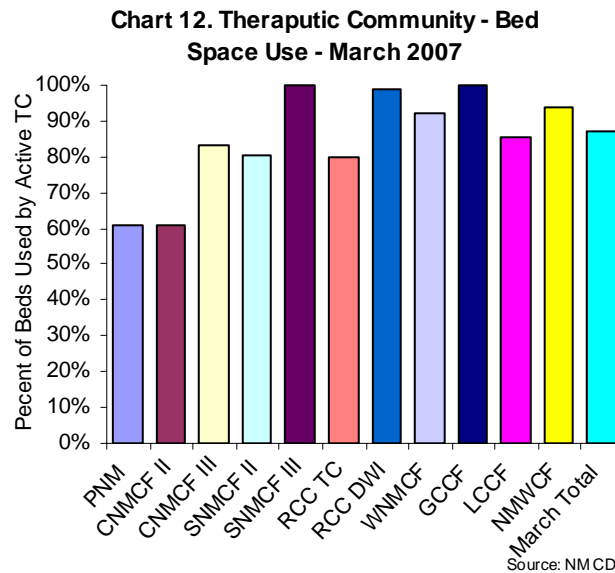
New Mexico’s prison population continues to increase and most of the state’s inmates have a substance abuse problem. According to the department about 60-75 percent of its inmate population meets the criteria for substance dependence and about 85 percent have a history of substance abuse. Research indicates a strong link between substance abuse and criminal behavior. Nationally, 51 percent of surveyed inmates reported the use of alcohol or drugs while committing their offense and “while only 20 percent of state prisoners are drug offenders, 57 percent were using drugs in the month before their offense, and 37 percent were drinking at the time of their offense,” according to the 1997 Survey of Inmates in State and Federal Correctional Facilities.

National evaluations demonstrate that in-prison therapeutic communities can significantly reduce recidivism based on meeting certain program standards. Model TC programs can significantly reduce recidivism, according to research summarized by the Institute of Behavioral Research at Texas Christian University and the Washington State Institute for Public Policy. On average, TC programs can reduce recidivism by 5.3 to 6.9 percent. Effective TC programs operate intensively for six to 12 months in a segregated housing unit; engage offenders in transitional and aftercare services; target certain high-problem offenders and use risk assessments to screen inappropriate placements; and use induction strategies to raise inmates’ engagement in treatment.

The department’s TC program meets many, but not all, national standards, but the lack of coordinated aftercare programs and other deficiencies may severely limit its overall effectiveness. The New Mexico TC program lacks the following components.

Lack of totally separate housing unit. About 12 percent of the department’s TC bed space is allocated for non-TC inmates. As of March 2007, 82 percent of available bed space was used by TC participants, with the remaining filled with non-TC inmates or unfilled. The department does not feel this arrangement violates program standards as non-TC inmates must agree to “random urinalysis testing, participate in dorm meetings and agree to support the goals of drug/alcohol free living.”

However, a 2002 evaluation of the TC unit at SNMCF noted that the program conditions were violated due to housing non-TC inmates in the same housing unit. The department still faces this problem due to the design of many New Mexico’s minimum security Level II prisons resulting in lack of totally separate housing arrangements. For example, only 40 percent of inmates living in PNM and CNMCF’s Level II units are actively participating in the TC program and about 50 percent are participants at SNMCF and WNMCF.



Mixing treatment methodology. The TC program primarily uses a mix of TC programming, cognitive-behavior therapy, and self-help 12-step groups. A federal evaluation of TC programs expressed concern over the mixing of different treatment methods – therapeutic community, 12-step program, and cognitive-behavioral therapy. The evaluation noted that “combination treatments have not been fully evaluated and that many combinations may result in watered-down components, leading to less effective treatment.” These treatment approaches are based on different theories and practices. For example, 12-step programs are spiritually-based and rely on non-professionals and recovering addicts for service delivery and support, which is different from professional therapy.

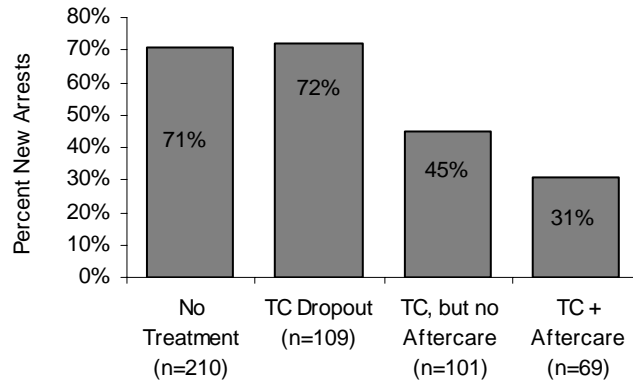
Lack of routinely paroling/discharging inmates near or at TC graduation. The department does not track the percentage of TC participants that parole/discharge at or near their graduation date. Department policy sets a guideline that inmates must be within two years of release to gain admittance to a TC program. However, many inmates begin treatment in Level III prisons. Starting TC at higher security levels may result in many inmates participating in TC who may not be within two years of release, according to department staff.

Transfers among facilities impact inmates’ therapeutic progress and may reduce the TC program’s overall effectiveness. The department has allocated about 60 percent of its overall TC and contract bed space to Level III prisons. LCCF accounts for 301 beds, or 37 percent of all TC and contract bed space system-wide. As many of these inmates participate in TC programming, their security level may be lowered for good behavior resulting in a move to a different facility. In addition, the percentage of graduates and the number who complete the full TC program at

one location are severely diminished. The Addictions Bureau “views these transfers as having a critical impact on recidivism rates.” However, the department has not studied how many inmates transfer, and how often, while participating TC programming to determine the extent of the problem. TC continuity of care could be compromised due to transfers either because an inmate is transferred to a unit without a TC or will have to integrate into a different group therapy arrangement.

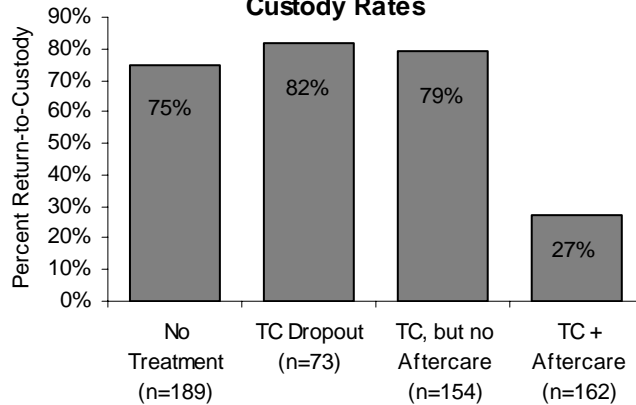
Lack of formal aftercare services. Well-designed programs include comprehensive reentry and aftercare services, from pre-release planning to strong linkages with community substance abuse treatment providers and other supportive services. A federal RSAT evaluation found that strong aftercare programs to help prisoners transition back into their communities drug-free were lacking nationwide, partly due to lack of funding. According to the evaluators, outcome studies show that aftercare programs further reduce recidivism and are critical for overall program effectiveness. For example, an evaluation of California’s Amity program showed that offenders who completed the program but did not participate in aftercare returned to prison at higher rates than prisoners that did not participate in Amity altogether.

**Chart 13. Delaware/Crest Program
3-Year Re-arrest Rates**



Source: TCU - 1999

Chart 14. California 3-Year Return-to-Custody Rates



Source: TCU, 1999

The department has not regularly evaluated the quality of services delivered, and its recent attempt at quality assurance needs improvements to make reports more useful.

The department has participated in one in-depth evaluation of a TC program at SNMCF in 2002. The evaluation assessed the program's compliance with national standards, of which there were deficiencies that have not been resolved and are discussed below, and of the quality of programming. In 2006, the Addictions Services Bureau began conducting site visits as part of a developing continuous quality improvement (CQI) process. The CQI audit primarily consists of a file/document compliance review but does have limited performance (timely treatment plans) and quality (treatment goals relate to problems to be addressed) criteria. The onsite review also includes qualitative information obtained from inmate participants. The CQI audit tool and report format could be improved through the following.

- *Data Accuracy.* The CQI process does not assess data accuracy. The bureau needs to use data and performance information to evaluate program success, manage the program and improve performance. To accomplish these tasks management has to rely on the data produced by individual programs at each facility. The CQI process could help ensure data received by central office either through monthly reports or CMIS is accurate.
- *CQI Report Format.* The report is presented in a narrative format that does not allow management outside of the bureau to easily understand or obtain the results of CQI audit scores. The CQI audit results in an aggregate compliance score as well as compliance scores for each of the major areas reviewed, including admissions, file completeness, urinalysis, treatment plans and discharge plans.
- *Performance Information.* CQI audits do test two items that could be used to assess program performance: timely treatment plans and percent of TC participants with a substance abuse diagnosis. Results of these and possible other items of importance are not broken out for the reader to ascertain whether the facility's program completes treatment plans on a timely basis or admits a high percentage with an actual substance abuse clinical diagnosis.

Addictions services does not track the most basic information needed to assess program effectiveness, such as the percentage of inmates completing the inpatient program.

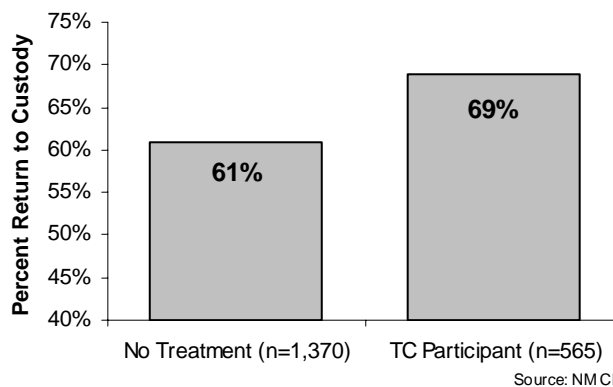
Department policy requires the Addiction Services Bureau to maintain data, evaluations, and information regarding measures of treatment outcome success (CD-185200 (Q)). The department does track some data, such as how many inmates are participating in TC programs each month and use of bed space. However, the department does not regularly compile outcome information that shows the program's effectiveness, including the following.

- *Percentage of TC participants testing positive for alcohol/drug use.* TC participants are supposed to abide by a no-drugs policy. Each facility TC program randomly tests TC participants each month but does not compile or report the aggregate results of these tests to central office. As a result, the department lacks information needed to assess whether the overall program is operating relatively drug free. Individuals caught using drugs can be expelled from the program.
- *Percentage of TC participants expelled from the program for non-compliance.* Again, the department tracks the number of individuals expelled, but without additional information this data is meaningless.
- *Percentage of TC participants successfully completing treatment within 12 months.* The department does not track the percentage of inmates that complete TC successfully or in a useful format to determine completion rates. The TC program is supposed to take about

12 months to complete. The department can and does track the raw number of inmates successfully completing the program, but does not compare this number to the overall number participating. As a result, the department cannot assess whether the resources and activity carried out by the program results in high or low percentages of inmates successfully completing treatment. Lower percentages may indicate a problem with program operations.

- *Average cost per TC participant.* The department does not routinely examine the average cost per inmate per day to provide TC services, whether in a public or private facility.
- *Recidivism rates for all TC participants and for TC graduates.* The department has taken steps to measure these outcomes, but not for graduates. The Addictions Bureau recently evaluated recidivism rates for TC participants as compared to all inmates released in 2001. The results indicate that 61 percent of all inmates released in 2001 returned to prison within five years but that a higher percentage, 69 percent, of TC participants returned. While these are disheartening results, they may not accurately reflect the effectiveness of the TC program as it operates today or even two years ago. In 2001, the TC program was still in its infancy according to department staff. A better approach could be to align TC recidivism data with the department-wide recidivism data efforts that measure return rates at 12, 24 and 36 months. The department should also separate TC participant rates from TC graduation rates to fully evaluate whether TC graduates return to prison at lower rates than TC participants and all other inmates.

Chart 15. N.M. 5-Year Recidivism Rates
Therapeutic Community Participants and
Inmates Released in 2001



Recommendations. Work with research experts in the field of correctional substance abuse treatment to assess the potential impact of program design deficiencies on the overall TC program's effectiveness, including mixing of TC inmates with non-TC inmates; mixing of treatment approaches and not discharging inmates from TC near parole dates.

Complete a plan for including a formal aftercare component to the TC program no later than July 2008. The plan should include how the department will use existing resources as a first option by coordinating with the NMCD Community Corrections program and the state's behavioral health entity, ValueOptions, to provide services to TC graduates. The plan should also include a method for tracking how many TC graduates end up using community-based substance abuse services.

Conduct a CQI study in coordination with the Classification Bureau to identify how often TC participants are transferred during their treatment. Compare transfer rates of inmates from one security level to another and transfer of Level II inmates to other Level II facilities during treatment. Also, identify the number of inmates transferred who do not continue treatment as a result of the transfer. Report the results to the Cabinet Secretary and Committee staff no later than November 2007.

Enhance regular CQI audits by including a review of data accuracy as part of the audit and improving the report format by summarizing audit scores and performance scores at the beginning of each report.

Begin collecting and reporting TC program performance information including the following: percent of TC participants testing positive for substance use (monthly); percent of TC participants expelled for non-compliance (quarterly); percent of TC participants completing treatment within 12 months (quarterly); average cost per TC participant (quarterly); recidivism rates for TC participants at 12, 24, and 36 months (quarterly); recidivism rates for TC graduates at 12, 24, and 36 months (quarterly). Include the data above in an annual report to the Committee and report progress to Committee staff on a quarterly basis during FY08.

The Committee and Legislature should reconsider increased funding for addictions services until the department completes and implements the recommendations above.

THE DEPARTMENT DOES NOT REGULARLY ASSESS THE IMPACT OF MENTAL HEALTH SERVICES ON INMATES' ABILITY TO FUNCTION IN A PRISON ENVIRONMENT OR SOCIETY UPON RELEASE.

About 20 percent of all department inmates receive some type of mental health service.

Nearly forty percent of female inmates actively receive mental health services. According to the department, female offenders are more likely to have issues requiring services than males. National estimates indicate that about 20 percent of offenders in jails and prisons have a serious mental illness, according to the American Psychiatry Association.

Prison mental health services focus extensively on medication management, crisis intervention and limited counseling services to address psychosocial and criminal behavior. About 17 percent of inmates receive psychotropic medications for their mental illness and six percent participate in therapy.

The department collects quarterly data on the amount and type of mental health services provided to inmates. The department also requires its facilities to conduct extensive quality assurance self-audits for all aspects of care on a quarterly basis. The data and quality assurance audits were implemented as part of the *Duran* federal consent decree.

The department's extensive mental health quality assurance activities focus on compliance with policies and are not used by management to monitor performance. The quality assurance (QA) program evaluates quality, timeliness and documentation of clinical services. The QA self-audits cover high risk items and standards required by department policy, ACA or NCCHC accreditation standards.

Many facilities routinely report 100 percent compliance for the 96-item self-audits indicating that either the facilities are operating at high-performing levels or there are problems with data integrity. The self-audit tool includes 96 questions. If not meaningful or accurate, these items end up serving as filler questions that raise the overall compliance scores for each facility and the department. Total compliance on a routine basis may require the department to reassess whether to continue tracking this information on a quarterly basis and instead review annually. The department has not implemented on-site annual compliance audits to test data validity. The department does conduct peer reviews to ensure clinically appropriate care but the results are not subject to public disclosure.

Data is not summarized in a manner useful to management and does not include some outcome information needed to assess effectiveness. Some of the QA items are more important than others, such as timely access to care. However the format of the report obscures these areas in different rubrics such as “clinical assessments” and “treatment plans.” As such, certain really key questions such as timely assessments are hidden in the QA report’s summary of results and appear to distort, or hide, potential problem areas. For example, the FY06 4th quarter report shows the SNMCF overall score for clinical assessments is 95.6 percent. But SNMCF appears to have a significant problem conducting assessments on time, scoring only 56.4 percent. The facility reported 100-percent compliance on the rest of the section’s questions raising the facilities overall results.

The department does not use the results of self-audits to adjust how it develops training for staff or focus additional oversight and resources to either problem facilities or poor performing services. For example, facilities struggling with quarterly self-audits or data problems could receive additional on-site reviews from central office. This risk-based approach to using central office resources would allow all facilities to receive an on-site review but target additional assistance to facilities that are not performing at acceptable levels. The department could integrate continuous quality improvement (CQI) studies into its central office oversight to identify process problems or show patient outcomes on hard-to-measure items.

Mental health and psychiatry do not regularly coordinate quality assurance activities to ensure effective coordination of services. The department’s psychiatrist performs regular quality assurance audits of the department’s medical contractor, which is responsible for psychiatric care. The Mental Health Bureau has not been conducting on-site quality assurance audits of facilities. Effective mental health services require close coordination between psychiatrists and other mental health providers.

The department lacks meaningful performance and outcome data to ensure mental health services. The department’s quarterly performance measures for mental health services are targeted towards the reception and diagnostic central intake, other non-core duties, or do not demonstrate the results of services provided. Many of the mental health policies and services are designed to assist inmates, particularly those with severe mental illness, to live safely in a prison environment. An outcome from these efforts is reduced suicides and suicide attempts, which are not regularly measured by the department.

The following are other critical outcome areas for mental health services that lack meaningful performance information or regular monitoring.

Aftercare. Mental health staff participates in reentry planning for inmates using services including making referrals to community mental health providers. However, the department lacks data or other information to assess how often inmates actually connect and use community-based services upon release from prison. For many former inmates this connection is vital in order to continue receiving psychotropic drugs that help stabilize mental health conditions. The Behavioral Health Collaborative's creation of a single entity to coordinate community mental health services provides an opportunity for the department to better ensure continuity of care for former inmates.

Acute and residential care. The department runs a 104-bed mental health treatment center (MHTC). The center serves as the system's acute care mental health hospital and, as space allows, provides long-term intensive services for inmates. Acute care services seek to stabilize inmates' conditions to the point they may safely reside in either an alternative placement area or general population housing units. The department has not historically measured the effectiveness of this unit, such as how often inmates return to the MHTC. Community mental health systems measure the effectiveness of acute care hospitals in this way.

Improved inmate functioning. Mental health services seek to not only stabilize mental health conditions but to help people lead more productive lives. This is also true for prison systems, in terms of helping inmates reduce periodic acute conditions as well as live safely and productively in general population. Measuring these effects has proved elusive for community mental health services as well. The state's Behavioral Health Collaborative is developing methods to measure improved consumer outcomes as a result of mental health services. The department's participation with the Collaborative should provide an opportunity to expand this type of measurement to the prison population as well.

The department lacks needed bed space for acute mental health care for female inmates. Currently the department sets aside minimal bed space for females at MHTC. However, MHTC is not designed to safely accommodate both male and female inmates since there is not a fully separate housing unit. The department has attempted to work with NMWCF to create a small MHTC unit but the department has historically struggled to obtain professional mental health services in rural areas. The MHTC could be expanded, but this cost does not appear warranted at this time. Instead, the newly opened Camino Nuevo facility in Albuquerque may provide the necessary separate bed space and access to a wider pool of professionals to serve female inmates.

State law requires the department to perform diagnostic evaluations of county jail inmates, taking up valuable bed space for unknown results. New Mexico sentencing laws allow judges to commit, for not longer than 60-days, a felon to the department for a diagnostic and evaluation (D&E) to assist in determining the sentence disposition: prison, deferred or suspended sentence or probation (Section 31-20-3 NMSA 1978). The department must evaluate the prisoner and make a recommendation to the court. In CY06, the department admitted 302 males and 94 females for diagnostic evaluations at an estimated cost of \$2.1 million.

The diagnostic evaluation process has required the department to set aside an entire housing unit at CNMCF that could otherwise be used for needed medium security bed space. The department cannot allow mixing of D&E inmates with other committed inmates and must maintain totally separate housing arrangements for the protection of both inmates and staff. As of FY05, the state incurred an estimated \$97 per day per male D&E inmate and in FY06, an estimated \$62.06 for females at NMWCF.

The continuing need for the department to perform diagnostic evaluations, rather than county jails, is unclear. The department has not studied how often judges use department recommendations in determining whether or not to commit an inmate to a prison sentence. At the time of the statute's creation, county jails may not have had the professional expertise to perform D&Es. Modern jails now have the same type of mental health staff who can perform D&Es as the department.

Having the department make recommendations on whether to commit a person to a department or contracted prison may be a conflict of interest. Staff who performs D&Es at CNMCF and NMWCF cannot then treat or evaluate the same inmate if they return to the department's custody.

Recommendations. Examine whether to modify, including reducing the number of areas or questions that appear on quarterly QA self-auditing tools. Some of these items may be more appropriate to track on an annual basis.

Identify key measures out of the total number of QA compliance measures being tracked. These should be reviewed and discussed with wardens and central office management at internal performance meetings. For access to care, include measures related to timely assessments and timely discharge plans. For quality of care, include measures related to clinical appropriateness. For documentation, include signed consents.

Begin collecting and reporting the following system-wide outcome measures:

- Suicide rate.
- Rate of suicide attempts resulting in serious injuries.
- Percent of inmates discharged from MHTC who do not require crisis intervention services within six months.
- Percent of inmates discharged from MHTC who return within six months.

Work with the Behavioral Health Collaborative and experts in New Mexico or nationally to develop a methodology for demonstrating whether inmates receiving mental health services show improved functioning. At a minimum, the department should consider targeting those inmates with characteristics needing more intensive services/or potential for causing self-harm or misconduct within a general population setting (high risk/high need inmates); and determine whether a DSM-IV GAF score methodology for a prison setting or other assessment could be used to measure "improved functioning."

Identify mutual areas of concern for both mental health and psychiatry services, ensure existing quality assurance audit tools capture information to monitor these areas and consider conducting joint on-site annual QA visits to facilities.

Seek outside training to assist the Mental Health Bureau develop continuous quality improvement studies and quality assurance best practices for a prison setting. The department continues to rely heavily on *Duran* consent decree requirements for QA, which may not meet current best practices.

Explore further whether the department should set aside a housing unit at Camino Nuevo as a mental health treatment unit for female inmates and report the decision no later than December 1, 2007, to the Legislative Finance Committee.

Study, in coordination with the New Mexico Sentencing Commission (NMSC) the continuing need for NMCD to perform diagnostic evaluations, including an assessment of the results of existing evaluations; actual costs incurred by the department; other financing options; and alternative settings for the evaluation, such as county detention facilities. Report the results of the study and any recommendations to the appropriate interim legislative committees and the Legislative Finance Committee no later than December 1, 2007.

THE DEPARTMENT ENSURES BASIC COMPLIANCE WITH POLICIES BUT COULD IMPROVE PRISON OPERATIONS FURTHER BY INCREASING ITS FOCUS ON PERFORMANCE.

The department has implemented an extensive quality assurance (QA) process to ensure basic compliance with policy and the American Correctional Association (ACA) accrediting standards. This approach grew largely out of years of litigation related to the federal *Duran* consent decree. The current administration has focused resources on achieving ACA accreditation for its entire prison system. In 2007, the department received ACA's Eagle Award for having all applicable areas of department operations accredited. Only five other states have received this award. Accreditation signifies that the department's policies and compliance meet national standards. Committee staff commends the department for its efforts.

Central office does not always use QA information to improve compliance or monitor performance of public and private prisons. For example, each facility conducts regular file and compliance audits of their classification system. The facility forwards this report to central office QA Bureau. However, the results of the audits are not shared with the Classification Bureau which is responsible for overseeing the classification system at the state level, including providing training to facility staff. Without this information Classification cannot effectively help address deficiencies before they result in bigger problems or tailor training to areas or facilities that need it the most.

The department could increase efficiencies by integrating contract monitoring criteria with key compliance audits of private prisons. Currently, the department duplicate's private prison operator efforts to monitor compliance with department policy and ACA standards through quarterly audits. The department has a state employee on site at each private facility who in many cases, carries out the same or similar compliance audits as the private prison's QA manager. The contract monitor could instead focus time and resources on other activities related to performance and adherence to key aspects of the contract, such as staffing requirements, inmate grievances and classification and re-entry process.

The QA process does not ensure the accuracy of data submitted by facilities. This data for existing performance measures is supposed to be used to determine the performance of private prisons per the contract. The data is also used by the Legislature to determine the department's performance.

The department does not measure or monitor performance in key aspects of prison operations. ACA is moving towards performance-based accreditation that will require the department to demonstrate not only compliance but the performance of its prisons. As other portions of this report have indicated the department lacks needed performance measures to assess program effectiveness for medical and behavioral health services. The department does not regularly measure performance of its classification system to ensure inmates are appropriately classified and released from prison on-time. The Committee report regarding the Parole Board indicates serious problems with New Mexico's re-entry process and the timely release of inmates.

The department collects extensive data from facilities on other operational issues, such as grievances, non-serious inmate assaults, staff vacancies and turnover. In fact, the department compiles an excellent performance scorecard containing numerous performance measures. However, management does not use this information to assess whether the prison system is meeting long-term goals, such as a reduction in low-level violence. The performance score-card also contains numerous outdated performance measures that may not reflect the department's current strategic objectives.

Recommendations. Develop procedures to validate information provided by the facilities to ensure reliability of the information.

Require private facilities' contractors to conduct ACA compliance audits to ensure that facilities are ACA accredited and submit a copy of audit to the department.

Require private facilities' contract monitors to conduct contract compliance audits to ensure that contracts are in compliance with current contracts and provide services as required by the contract. Create a deficiency and corrective action plan database to analyze types of deficiencies reported on a regular basis and impact of corrective action plan on the facilities performance.

Conduct yearly independent quality assurance audits and follow-up audits of all facilities to ensure that all facilities are in compliance with standards and private facilities maintain contract compliance at all times.

Provide results of quality assurance audits and ACA compliance audits to other divisions or bureaus within the department to address training or other needs of the facilities to address deficiencies at the facilities.

IMPROVED MONITORING OF FOOD SERVICE CONTRACTS COULD REDUCE COSTS AND INCREASE DEMONSTRATED QUALITY.

The Aramark contract provisions are generally structured in the best interest of the department. The contract includes performance measures and sanctions/penalties associated with each measure. The larger areas of concern for the department are the execution, monitoring, reporting and enforcement of the food service contract provisions. Site visits and document review indicated that many of the food service contract terms were not being executed, properly monitored and reported and subsequently not enforced by the department. These findings in effect made the structure of the contract and presence of performance measures and sanctions clauses irrelevant unless proper departmental oversight was in place.

The department meals call for 3,400 calories per day for an inmate, which is more than comparable entities and results in more expensive meals. Table 12 shows the department pays more per meal served than private prisons do in New Mexico and requires higher calories for its inmates. The department's contract with Aramark was part of the SaveSmart initiative. Despite paying higher meal costs than comparable entities, the state paid the SaveSmart vendor about \$300 thousand for estimated savings to the food contract.

Table 10. Unit Cost, Daily Calorie Amount and Number of Meals Served Comparison

Public Correctional Facilities	Unit cost	Daily Required Calories
Aramark	\$1.51	3,400
NM Private Facility A	\$1.10	3,000
NM Private Facility B	\$0.94	3,200
NM Private Facility C	\$1.05	UNK

Source :NMCD and facilities

Lack of consistent food count policies and ineffective monitoring tools may result in overpayments. A small sample from two facilities revealed possible overpayment of almost \$4,000 for a one month period. A critical factor in determining the cost of the department's food service contract is the number of meals the contractor serves. The department and its facilities lack a documented meal count procedure. A precise meal count system is essential for the department to ensure accurate invoices from the contractor. Without an accurate meal counts there is significant potential for inaccurate billing by the food service contractor.

Some facilities do not routinely compare facility maintained meal count numbers with amount of billed meals by the contractor leading to possible overpayments. An examination of a sample of the public facilities' invoices indicated discrepancies in facility maintained meal counts and the amount of meals billed by the contractor. For example, based on one month at one unit at one facility we found a possible overpayment of \$3,048.

Inaccuracies exist in the training academy (TA) food service invoices as well. Summit provides food service to the TA. Based on this sample, it appears that the TA business office staff is not verifying signatures with the number of meals for which Summit invoices that could lead to significant overpayment over a longer period of time.

The table below provides a summary of meal-count differences from the samples examined at PNM and the department's TA.

Table 11. Contractor and Facility Meal Count Comparison

Facility	Sample Dates	Contractor Meal Count	Facility Meal Count	Difference	Cost of Difference
PNM	June 5-June28, 2006	12,459	10,395	2,064	\$3,048
Training Academy	July 1-31, 2005	1,453	1,283	170	\$964

Source: Facility maintained meal count numbers and contractor invoices

Facility and Contractor Document Maintenance Is Lacking. The contract requires Aramark to generate, maintain, and have readily available several documents critical to the food service preparation, operations and cost. Review team site visits indicated that facility and contractor document maintenance was deficient.

For example, kitchen inspection records were not consistently kept; food substitution logs were not routinely present; food quality surveys were frequently not done or present for inspection; and employee and inmate food service training certifications were either not done or maintained. Additionally, contractor generated monthly and quarterly reports were not completed. Without these reports much of the necessary documentation for assessing contractor performance is lacking as well as the status reports that document ongoing successes and problems. During interviews with contractor and facility staff, it was apparent that both sides were not adequately familiar with the terms of the contract. The facilities also did not emphasize contract oversight based on the contracts terms therefore allowing the contractor to become negligent in the completion of some duties.

The department does not regularly monitor or evaluate Aramark contract performance or enforce sanctions. Department management does not use compliance information generated by each facility regarding food service for decision making. For example, management does not use quality assurance reports generated by each facility to monitor Aramark's performance. Additionally, the quality assurance audit tool does not review items specific to the particular contract. The only items that are reviewed in contracts are duplicative with ACA standards.

In 2004, the Aramark contract evaluation and monitoring was decentralized. Instead of one central office staff member monitoring Aramark's performance through the contract provisions, the wardens assigned a staff member at each facility to monitor Aramark's performance, typically the facility's quality assurance manager.

The department does not monitor all the performance measures in the Aramark contract. Contract performance measures provide objective tools to assess contractor performance and ensure accountability. When performance problems are identified they are not disseminated to the appropriate levels of management. Compliance with contractual performance measures is not assessed; hence penalties associated with the sub-par performance are not enforced.

Recommendations. Establish a department-wide meal count procedure for each facility to follow and review the procedure with both facility staff and the contractor.

Compare facility-maintained meal counts with contractor billings and reconcile the differences before payment is made.

Review the contract with facility staff and contractor to ensure all the terms are met and the required documentation is generated and maintained.

Reassess the reporting requirements of the contract to ensure all reported items are useful to NMCD management and facility staff. Determine the useful information needed, the reporting frequency, the reporting format and track contractor's compliance submitting required reports.

Use contractor reports to gauge performance, identify issues, and track food service delivery trends.

Compare the Training Academy self-collected numbers (source data) with contractor generated numbers to ensure accurate bi-weekly billing.

Redevelop the department audit tool to better capture both ACA standards and key contract provisions and performance standards. If necessary this audit tool can provide adequate evidence and documentation to make a decision on a contractor sanction based on performance.

Assign one central office staff to coordinate food service compliance and contract monitoring activities. This staff person should consolidate the information generated and reported at the facility level into an aggregate report that provides management with a high level summary of facility collected information and contractor performance.

Develop an internal procedure to disseminate the information collected at the facility level to management to assist in making management decisions and engaging contractors.

Assertions and Formulas Used in Report

Assertions:

Fixed debt service per diem is calculated on \$50 million dollars for LCCF and \$27 million dollars for GCCF plus five percent return on investment over twenty years. In 1998, treasury bonds were selling at five percent interest rate; therefore, five percent return on investment was added in actual construction cost for GCCF and LCCF.

According to the contracts of LCCF and GCCF, the department agreed to pay at least 90% of the facilities rated capacity for LCCF and GCCF. Therefore, we made an assertion that contractor for both facilities covered fixed debt service cost in first 1080 inmates at LCCF and 540 inmates at GCCF, 90 percent of the 1200 capacity for LCCF and 600 capacity for GCCF.

Formulas:

- Historical debt service per diem
 - Actual construction cost/life of the asset (20 yrs)/90% of the facilities rated capacity
- Current debt service per diem:
 - Cumulative CPI times historical debt service per diem
- Savings from not applying CPI to debt service up to FY06
 - Historical debt service minus current debt service times 90% of the facilities rated capacity
- Savings from not applying CPI to debt service over ten years
 - Savings from restructuring in FY06 from LCCF and GCCF times 10 plus Additional savings from not applying CPI for 10 years

Other State Comparisons

After various interviews with corrections departments' staff and review of private facilities' contracts, the facilities with the following characteristics were selected for comparison:

- Constructed after 1996
- Operated by GEO or CCA
- House medium security male inmates
- Provide similar services to inmates as shown in the table below

Services and Programs Provided to Inmates at Private Facilities

	LCCF	Idaho	Oklahoma	Texas	GCCF	Colorado	Montana
Food Service ¹	✓	✓	✓	✓	✓	✓	✓
Health Care Services ²	³	✓	✓	⁴	³	✓	✓
Academic, Vocational Services	✓	✓	✓	✓	✓	✓	✓
Recreation and Hobby	✓	✓	✓	✓	✓	na	✓
Religious Activities	✓	✓	✓	na	✓	na	✓
Inmate Work and Pay	✓	✓	✓	✓	✓	✓	✓
Inmate Commissary/Canteen	✓	✓	✓	✓	✓	✓	✓

Source : NMCD and other states' corrections departments

na = Not addressed in the contract.

¹ = The contractor is required to provide three meals per day. Three meals must provide 2900-3000 calories for each inmate per day.

² = Health care services include all medical, mental health and dental services.

³ = New Mexico sub-contracted health care services.

⁴ = Texas corrections department contracts with the Correctional Health Care Committee to provide complete health care services

HEALTH CARE
IN
NEW MEXICO CORRECTIONS DEPARTMENT FACILITIES

A Report to the Legislative Finance Committee

By

Steven S. Spencer, MD, FACP and B. Jaye Anno, PhD, CCHP-A

April 2007

Health Care in New Mexico Corrections Department Facilities

Steven S. Spencer, MD and B. Jaye Anno, PhD

Report to the Legislative Finance Committee

Table of Contents

Executive Summary	i
Introduction	1
NMCD Central Office	1
Lea County Correctional Facility – Dr. Anno’s Report	4
Lea County Correctional Facility – Dr. Spencer’s Report	9
Central New Mexico Correctional Facility, Dr. Anno’s Report	14
Central New Mexico Correctional Facility, Dr. Spencer’s Report	18
Penitentiary of New Mexico, Dr. Spencer’s Report	24
New Mexico Women’s Correctional Facility, Dr. Spencer’s Report	28
Western New Mexico Correctional Facility, Dr. Spencer’s Report	33
Final Conclusions and Recommendations	36

Executive Summary

In compliance with our contract with the Legislative Finance Committee we have evaluated the health care provided by Wexford Health Sources, assessed the monitoring and oversight function of the NMCD, and made recommendations for improvement. Our sources of information included many relevant documents and reports, at the NMCD Central Office and at individual prison facilities. Site visits were made to Lea County Correctional Facility (LCCF) and Central New Mexico Correctional Facility (CNMCF) by Drs Spencer and Anno, and to the Penitentiary of New Mexico (PNM), New Mexico Women's Correctional Facility (NMWCF), and Western New Mexico Correctional Facility (WNMCF) by Dr. Spencer. We had excellent cooperation from all Wexford and NMCD staff, and we encountered some exceptionally capable Wexford employees who should be retained.

In regard to the contractor's performance, the major deficiencies include staffing vacancies for which no financial penalty has been assessed; failed recruitment and retention programs; an inadequate Continuous Quality Improvement program; inadequate record and reporting systems; a chronic illness care program that fails to meet national standards, due partly to the NMCD requirement to use forms that lack adequate reminders; and an inadequate detoxification protocol. There is a need for logs and spread sheets that document the timeliness and completeness of important aspects of care; Nursing Treatment Protocols that do not require physical assessment skills that are inappropriate for an LPN; arrangements with consultants who are closer to Hobbs than Albuquerque; a system-wide Hepatitis C tracking system modeled after the one at WNMCF; a grievance process that records the informal as well as the formal grievances; and better coordination between psychiatry and mental health staff.

In regard to the NMCD role, authorized staffing is inadequate, needing more physician, dentist, optometrist, clerical and nursing positions. Physical therapy should be universally available. Dietitian counseling services and appropriate special diets should be available. The vacant NMCD Medical Director position is a serious deficiency, greatly compromising the oversight responsibility of the Department. A full time contract monitor is also recommended. The dismal geriatric housing at CNMCF is counter-therapeutic. Other space needs include more clinic space at the level II facility at PNM, and more examining rooms at NMWCF. Equipment needs include more computer terminals, and expansion of the Pyxis pharmacy system. There is a need for an in depth review of the Hepatitis C policy concerning access to treatment. NMCD should be represented at Hepatitis C Treatment Review Committee meetings and should have access to the collegial review meetings or their immediate transcripts. Intake procedures should include MMR vaccine for eligible women.

Issues pertaining to both Wexford and NMCD concern the need for improved communication through a computerized information system accessible at all facilities, with standardized reporting of important aspects of care.

Introduction

On January 30, 2007 a contract was signed by David Abbey, Director of the Legislative Finance Committee of the State of New Mexico and Steven S. Spencer, MD and B.Jaye Anno, PhD, Contractors. This specified that the Contractors “shall provide professional assistance to the Legislative Finance Committee (LFC) as outlined below:

- A. Evaluate quality of health care provided by Wexford Health Sources in New Mexico Corrections Department (NMCD) facilities.
- B. Assess monitoring and oversight function of the NMCD.
- C. Recommend improvements to health care operations.”

This report is offered in response to that stated scope of work. Site visits commenced on February 2, 2007, with a visit to the NMCD central office, interviewing Dr. [REDACTED], Acting Health Services Bureau Chief. Dr. [REDACTED] was very helpful in providing information including many documents and reports. He continued to be helpful in the ensuing weeks, responding to requests for additional information and reports.

Drs. Spencer and Anno then made site visits to Lea County Correctional Facility (LCCF) on February 5 and 6, and to Central New Mexico Correctional Facility (CNMCF) on March 1 and 2. Subsequently Dr. Spencer made site visits to the Penitentiary of New Mexico (PNM) on March 14, to the New Mexico Women’s Correctional Facility (NMWCF) on March 20, and to the Western New Mexico Correctional Facility (WNMCF) on March 21, 2007.

While Dr. Spencer and Dr. Anno wrote independent sections of this report, they consulted with each other regarding the final conclusions and recommendations.

The report is organized by facility, but its conclusions and recommendations are system-wide, since the LFC scope of work asks for this approach.

We must acknowledge the assistance and cooperation we received from all staff, Wexford and NMCD, at each facility we visited. There was never an effort to conceal or obfuscate, and we felt that in each case we were treated with honesty, sincerity and helpfulness. For that we are indeed grateful, as it not only facilitated our work, but made it pleasurable.

NMCD Central Office

Dr. Anno and Dr. Spencer met with Dr. [REDACTED] at the NMCD Central Office. Dr. [REDACTED] previous position has been Quality Assurance Manager, but he is now acting Health Services Bureau Chief. Dr. [REDACTED] has not been fully involved in the Medical Director job since February last year, having taken a great deal of sick leave and then finally retiring on October 1 of 2006.

The ADP (average daily population) of the NMCD is now approximately 6800.

There is an open position for clinical physician, what used to be called Department Medical Director. The organizational chart would show the Health Services Bureau Chief reporting to the

Deputy Secretary (Erma Sedillo), who reports to the Secretary of the New Mexico Corrections Department. Positions reporting to the Bureau Chief are: the Administrative Assistant (Janelle Chavez), the Medical Records Manager who is based at Los Lunas (Sandy LeChalk), Yolanda Herrera RN, who is the Director of Nurses for the Department, based in Albuquerque, the Mental Health Director [REDACTED], PhD (director of mental health for the state facilities and indirectly for the contract ones), and the Clinical Psychiatrist, [REDACTED] MD who is .75 FTE. Dr. [REDACTED] has contracted with [REDACTED], MD at .5 FTE to assist in the position of Medical Director through June 30 of this year.

Dr. [REDACTED] provided us with a number of documents for our review.

Nursing Treatment Protocols.

These state that nursing staff may not elect to give medication without a physician's signature or verbal order. The individual protocols for each condition are faithful to this direction. They include points at which referral to a licensed provider is indicated. Most of the protocols are quite reasonable. However, since most of the nurses carrying these protocols out are LPNs, the physical examination expertise required by some of the protocols is inappropriate. For example, the "Chest pain-cardiac origin" protocol requires listening to the lungs and obtaining an EKG. The ability of an LPN to make the distinction of chest pain of cardiac origin is questionable, and if it is suspected, the licensed provider should be notified prior to spending time obtaining an EKG. In addition, the "Vaginal yeast infection" protocol allows the nurse to dispense Miconazole nitrate vaginal cream after making her own diagnosis, which is probably not justified. The protocol does not even include any description of the typical vaginal discharge. This is another instance in which a licensed provider should be involved in the care the patient.

The chronic care tracking system for Hepatitis C consists of many pages of inmate names and numbers, but the other columns are not completed, such as the date last seen, next appointment, etc. There is a packet for each facility. In other words, this chronic care tracking system as presented to the Central Office is not a tracking system at all and consists merely of a list of those infected with Hepatitis C.

The weekly Hepatitis C TRC (Treatment and Review Committee) patient lists are more informative. There is a report titled "Inmates Completed Hepatitis C Medication Treatment", one titled "Inmates on Hepatitis C Medication Treatment", one titled "Inmates Stopped Hepatitis C Medication Treatment", and another titled "Active Hepatitis C List". It is not clear how frequently these lists are updated, and there may be a need for more integrated statewide reporting system. The ECHO program gave NMCD a grant for Hepatitis C care. This funds one nurse. Dr. [REDACTED] at the University of New Mexico is the Hepatitis C authority to whom the TRC presents candidates for treatment. This committee is to include members from the NMCD and Wexford. The Department buys Hepatitis C and HIV medications from the state Department of Health. Care of HIV patients is overseen by Dr. [REDACTED] of UNM. New arrivals are screened for Hepatitis C at intake according to risk factors or at their own request. HIV testing is also offered, but requires a written consent, and Dr. [REDACTED] says about 98% request this.

New arrivals are also supposed to receive Hepatitis B vaccine, DT vaccine and maybe rubella vaccine, although Dr. [REDACTED] is uncertain about this and refers us to the yellow form in the medical record.

The Wexford collegial review process occurs weekly and results in a printed report regarding decisions on off-site referrals. If approved, the on-site physician orders the appointment to be made within the designated time frame.

The audit tools used by NMCD twice a year are also supposed to be used by Wexford on site on a more frequent basis. They were used by Dr. [REDACTED] as well. The problem with the tools for auditing chronic illnesses is that they do not have specific clinical criteria, only calling for adequate or inadequate.

Tele-psychiatry is being used at WNMCF, LCC F, NMWCF and GCCF (Santa Rosa). This is done with out-of-state psychiatrists, two of them, who are supposed to come on site every six months. The other facilities use direct psychiatric services on site. The new RFP will require in-state tele-psychiatrists.

There is a lack of consistency regarding the reporting of MRSA. Some facilities reported monthly and some provide a cumulative report for the whole year. Some of the reports do not even contain the name of the reporting facility. It would be more appropriate for the central office to track and trend MRSA cases on a monthly basis, with reports covering all facilities.

A review of the health services monthly reports is of interest. However, one must question the accuracy when Roswell Correctional Center reports 1163 nursing encounters, a disproportionate number for the facility population. The definition of nursing encounter needs clarification.

Contract Review

The following points are worthy of note on review of the NMCD — Wexford contract:

P. 4 — The arrangement for NMCD filling vacancies is cumbersome.

P. 7 — Physicians must be ACLS certified. Physician peer review is to occur quarterly. The contract allows five working days for corporate response to off-site requests. The collegial review meetings occur weekly.

P. 8 — Are there any minutes of the Wexford/NMCD meetings? These are supposed to occur 10 times a year.

P. 8 & 9 — Intake procedures are outlined here. They include an EKG, if over 50 years of age. Current CDC recommendations regarding immunizations advise MMR vaccine for women of child-bearing age.

P. 10 — Sick call may be done by RN or mid-level, LPN not mentioned.

P. 16 — HIV and HCV lab and meds not paid by Wexford.

P. 17 — Monthly on-site pharmacist review and quarterly Pharmacy and Therapeutics Committee meeting.

P. 23 — Requires EMR (electronic medical record). Also requires a designated infection control nurse.

P. 25 — Addresses chronic care clinics.

P. 34 --- Penalties for vacancies

P. 75 — Mental health staff are state employees, except for the psychiatrist.

P. 87 — HIV exclusions and Department of Health arrangements.

Lea County Correctional Facility – Dr. Anno’s Report

Health services at the Lea County Correctional Facility (LCCF) in Hobbs, New Mexico were audited on February 5th and 6th by B. Jaye Anno, PhD, CCHP-A and Steven S. Spencer, MD, CCHP-A. Dr. Anno reviewed the health care staffing and their credentials; meeting minutes, statistics, and policies and procedures; the continuous quality improvement program, timeliness of sick call, off-site referrals for both medical and psychiatric consults, health care grievances, and the adequacy of New Mexico Corrections Department’s (NMCD) monitoring of its contract with Wexford. In doing so, she reviewed a number of documents and interviewed staff.

Introduction

The Lea County Correctional Facility is owned by The GEO Group, Inc. GEO has a contract with the NMCD to provide housing and other correctional services to approximately 1200 male inmates. GEO employees also provide mental health services. There is a mental health director, a clinical supervisor, and six counselors. Medical and dental services, however, are provided through a separate contract that NMCD has with Wexford. Psychiatric care is also provided by Wexford via telemedicine.

Staffing and Credentials

Wexford has 19.2 medical and dental positions at LCCF. At the time of our audit, 17.2 positions were filled. The facility’s medical director position has been vacant for at least two months. Dr Velasquez from Roswell comes in on week-ends to help out. Dr. Anno was told that a physician has been hired to fill the slot, but he cannot work until he receives his New Mexico license. LCCF also has a vacant night RN position. Coverage for this position is provided by a PRN (“as needed”) LPN or other nursing staff working overtime.

All qualified health professionals had proof of licensure on file at the facility. The dentist and the physician’s assistant (PA) also had current DEA licenses. All professional staff were current in CPR certification except the part-time dentist and one LPN.

While the number of positions Wexford has is consistent with the 19 positions suggested by NMCD in Appendix D of their contract, we question whether this staffing is sufficient to accomplish the scope of work in the body of the contract. For instance, in Section II.J.3., the contract states that the oral health program “shall provide for the basic oral health needs of the inmate population ...to maintain optimal (emphasis added) oral health and to restore adequate function and mastication,” yet the suggested minimal staffing for dental services is only a 0.4

dentist, a 0.6 dental assistant, and no hygienist, which is what Wexford has. Historically, inmates have extensive dental needs, and a 0.4 dentist would barely have time to address urgent conditions for 1200 inmates let alone provide “optimal” care. The wait time for routine dental care now is about two months. Also, there is only one clerical position and nursing time needs to be increased.

Meeting Minutes, Statistical Reports, and Policies and Procedures

Dr. Anno reviewed the meeting minutes and statistical reports for 2006. Meetings with the warden, mental health staff, and relevant health services staff (“MAC” meetings) were held monthly. Wexford staff meetings were also held monthly. Health services statistical reports were compiled monthly. LCCF does have a site-specific policy and procedure manual.

Continuous Quality Improvement (CQI) Program

Wexford refers to its internal CQI efforts as “Quality Management.” There is a Quality Management Program manual for 2006 developed by corporate office. On page 5, it lists 23 items to be reviewed annually at each site. Audit tools are included. The items to be reviewed are consistent with the requirements of the National Commission on Correctional Health Care’s guidelines on CQI. Wexford’s manual also requires quarterly audits of chronic care clinics and a reporting calendar. At the front of this manual, LCCF staff signed that they had reviewed it.

From the list of the required 23 items to be audited, the LCCF health services administrator developed a schedule of which audits were to be done each month. Dr. Anno reviewed these audits and found them to be consistent with corporate requirements. There were also two year-long studies to be conducted: a process study on sick call and an outcome study on diabetes. However, in the material Dr. Anno was given to review, data collection did not occur quarterly. Data were gathered for the process study in August and October, and for the outcome study in June, August, and October. It was not possible to determine how well LCCF staff were doing in either of these areas, because the summaries have not yet been completed in either study.

While for the most part, Wexford staff at LCCF are following corporate requirements for conducting CQI studies, a question remains as to the effectiveness of this approach. To be useful for the staff at a specific site, CQI studies should be problem solving, not paper pushing. In other words, staff at a given site should review aspects of care that are not operating as efficiently or effectively as they would like at their particular facility. Simply completing the studies designed by corporate office is not going to solve problems at the local level.

Sick Call

Wexford uses a written sick call request system for routine care. Inmates obtain the slips from correctional officers in their housing units. They fill them out and put them in a medical box. Nursing staff collect the slips Sunday through Thursday. Nurse sick call is held Monday through Friday. If inmates put their slips in by noon, they are seen the next day (except on the weekend).

Nurse sick call is held in the exam rooms in the housing units. If the inmate’s complaint can be handled with over-the-counter medication pursuant to nursing protocols, that is accomplished. If

something more is required, the inmate is put on the list to see a provider, which can take up to two weeks after the referral.

Dr. Anno requested ten charts from the sick call list of 12/29/06: five from segregation and five from housing units 2 and 3. Two individuals had left the facility, so she reviewed eight charts as noted below. Personal information of inmates and Wexford staff has been removed from Appendix B.

ID#	Housing Unit	Date of Request	Date Rcvd	Date seen by nursing	Date seen by provider	Complaint
	Seg	12/25	12/28	12/29	1/8	blood in stool
	Seg	12/27	12/28	12/29	1/3	pain
	Seg	12/27	12/28	12/29	NA	cough
	H 2 &3	12/27	12/28	12/29	2/14 sched.	Pain
	H 2 &3	12/12	12/28	12/29	NA	paper signed
	H 2 &3	12/27	12/28	12/29	1/3	back pain
	H 2 &3	12/26	12/28	12/29	1/5	ear flush
	H 2 &3	12/22	12/28	12/29	1/3	collarbone

There are a few problems with the current sick call system. First, NCCHC standards as well as Wexford’s contract with NMCD (Section II.F.2.a.) require nursing staff to pick up sick call requests and review them seven days per week, not five. Second, Dr. Anno was told that inmates who do not show for sick call for any reason (including lockdowns) must submit a new sick call request. This is inappropriate. Any individual not seen for any reason other than a refusal of care should be scheduled automatically for the next sick call. Finally, two weeks is too long of a delay to see a provider.

More puzzling is the requirement (II.F.2.a.) in NMCD’s contract with Wexford stating that triage and screening “...shall take place through direct contact with the inmate by a registered nurse (RN) or mid-level provider (NP or PA).” NMCD’s suggested minimum staffing for LCCF in Appendix D of the contract calls for 8.4 LPNs and only two RNs, one of which is not currently filled. With this staffing pattern, it should not be surprising that LPNs do the triage and screening for sick call.

Off-site Specialty Referrals—Medical

When a provider at LCCF makes a referral for off-site specialty care for a medical condition, the referral goes to the administrative assistant. She faxes the referrals to Wexford’s corporate office, and each Wednesday, a conference call is held with Wexford’s regional physician and the LCCF provider to discuss the case. The regional physician decides whether to approve the referral or to defer a decision pending alternative treatment or gathering additional information. This process is referred to as “collegial review.” Under the terms of its contract with NMCD (Section II.D.2.), Wexford has five working days to respond to non-urgent consultation requests, which they are meeting.

The contract also specifies the time frames for completing the appointment to a specialist by discipline (Section II.G.3.). For example, a routine referral for urology must be completed within 60 days whereas one for oncology must be completed within 30 days. Approved specialty

referrals are sent to NMCD's Bureau of Health Services. Staff there track the timeliness of outside specialty referrals.

One problem identified is that the administrative assistant at LCCF only tracks the referrals that are approved. It does not appear that anyone at NMCD's Bureau of Health Services reviews the cases that are deferred to determine whether the deferral was medically appropriate. This is an important oversight function and should be a part of the next vendor's contract.

Dr. Anno tried to determine the number of referrals that had been deferred by comparing the list of names presented by the LCCF provider with the list of approved referrals from corporate office. She asked for copies of both lists for December 2006 and January 2007. Unfortunately, the administrative assistant only had copies of both lists for four weeks as noted below.

Date of Collegial Review	# of Referrals by LCCF	# Approved by Wexford
11/30/06	8	1
12/21/06	6	2
1/18/07	15	8
1/25/07	11	4

Of the 40 cases presented those four weeks, only 15 (37%) were approved by Wexford. However, without an NMCD physician reviewing the cases that were deferred, it is impossible for NMCD to know whether those decisions were medically appropriate.

Dr. Anno looked at the charts of the inmates who were deferred on 1/25/07. Inmate # [REDACTED] was referred for an MRI of his knee and Wexford's regional physician wanted more information. Inmate # [REDACTED] was referred for an optical evaluation and Wexford's physician wanted him reevaluated by the optometrist. Inmate # [REDACTED] was referred for an ophthalmology consult, and Wexford's physician wanted him to be seen by the optometrist first. In the remaining four cases (# [REDACTED] and [REDACTED]), paper work in their charts indicated that their referrals had been approved, but for some reason, they were not on the corporate approval list. At a minimum, the LCCF administrative assistant needs to check her list against the corporate list to ensure that all of the inmates who are approved for outside consults get scheduled.

Finally, Wexford's contract with NMCD (Section II.G.1.) states that the "CONTRACTOR shall endeavor to consolidate the scheduling of appointments and services for inmates with community physicians, hospitals and other providers and services to minimize the impact upon security staff, and available vehicles." However, Wexford uses a provider in Albuquerque for its off-site consultations, which is about a six-hour drive from Hobbs. This not only places a burden on security staff and vehicles, but it serves as a disincentive for inmates to complete their appointments, because they have to go to Albuquerque and back the same day.

Psychiatric Consultations

Wexford is also responsible for psychiatric consultations. GEO mental health staff make the referrals and give them to Wexford's clinic coordinator. She, in turn, sets up the appointments with one of two psychiatrists who see patients via telemedicine. Unfortunately, Dr. Anno was told that the equipment does not always work and that the audio is choppy. In fact, both the Monday and Tuesday psychiatric clinics were cancelled when we were on-site. The GEO mental

health director has only recently begun to track the frequency of cancellations of the psychiatric clinics. This should be tracked regularly so the problem can be addressed by Wexford.

Dr. Anno also reviewed the log that GEO staff keep of their mental health caseload. She identified eight individuals who were not followed up appropriately as follows:

Inmate # [REDACTED]: He should have been scheduled to return to the psychiatric clinic on 9/13/06. He had not been scheduled yet.

Inmate # [REDACTED]: He was scheduled to return to clinic on 12/6/06. He has not been seen, but was rescheduled for 2/13/07.

Inmate # [REDACTED]: He was supposed to be seen on 12/14/06. He was not and has not been rescheduled.

Inmate # [REDACTED]: He was scheduled to be seen on 12/12/05. He was not and was never rescheduled.

Inmate # [REDACTED]: He was scheduled to be seen on 1/10/06. He was not and has not been rescheduled.

Inmate # [REDACTED]: He was scheduled to be seen on 11/13/06. He was not and has not been rescheduled.

Inmate # [REDACTED]: He was scheduled to be seen on 12/15/06. He was not and he has not been rescheduled.

Inmate # [REDACTED]: He was scheduled to be seen on 9/01/06. He was seen on that day and scheduled to return to clinic on 10/3/06. He was not seen on 10/03 and has not been rescheduled.

Obviously, a better system needs to be put in place to ensure that psychiatric patients are followed on a timely basis.

Grievances

Dr. Anno reviewed all of the health care grievances for 2006. Surprisingly, there were only 148 health care grievances for the entire year. This is an average of only 12 per month, which represents only one percent of the population. We recommend that NMCD health staff interview a sample of inmates to determine whether the present grievance system is effective.

Contract Monitoring

LCCF has a full-time contract monitor. However, he is only responsible for monitoring NMCD's contract with The GEO Group. NMCD's Bureau of Health Services is responsible for monitoring the Wexford contract, but there is no designated contract monitor position. The position of Bureau Chief was held by a physician until a year ago when he went on extended medical leave. Currently, there is an acting Bureau Chief, a vacant quality management position, a 30 hour per week clinical psychiatrist, a state-wide director of nursing, a state medical records

manager, and an administrative assistant. The acting Bureau Chief held the quality management position until recently. He indicated that NMCD plans to hire a clinical physician sometime soon.

Bureau of Health Services staff do audit the Wexford facilities at least annually. However, their auditing tools are designed more to determine the extent of the facilities' compliance with national standards rather than compliance with specific terms of Wexford's contract. The current contract provides for numerous financial penalties to be assessed if Wexford violates specific terms (see Sections IX.2.1-21 and IX.3). However, these areas are not all regularly monitored by the Bureau of Health Services. The only financial penalty ever assessed against Wexford was in 2002 for \$35,000 owing to insufficient psychiatric coverage. On the medical side, Wexford has refused to provide staffing vacancies until recently, according to the acting Bureau Chief. The last two quarters, Wexford has reported aggregate staffing levels, but not site-specific information. This should be a requirement of the new contract.

We recommend that a health care contract monitoring position be approved by the legislature in time for the contract with the new vendor. The almost \$34 million spent on this contract annually as well as the potential liability to the state if adequate care is not provided justify adding this position. This individual should be a state employee and should NOT be paid by the vendor as provided for in Wexford's contract (Section IX.1.4). The position may well pay for itself if the financial penalties for staffing vacancies and other areas of non-compliance are actually tracked and assessed.

Lea County Correctional Facility – Dr. Spencer's Report

Plant and equipment:

My inspection of the facility showed the place to be spacious and clean. The following deficiencies were noted, however:

There were no paper towels in the inmate bathroom.

There was no peak flow meter in the Cabinet, where it was supposed be located. The PA said that he left it at home in the pocket of another jacket.

The radiation certificates posted in the x-ray rooms were out of date. The last one from the state radiation control Bureau was dated January 25, 2005. The certification of registration to operate in New Mexico had expired on September 30, 2006. However the "Intellamed" inspection stickers on the equipment itself were current.

Programs and Staffing

An x-ray tech comes in for one day every other week, to take plain films. These are developed on site and taken back to Lubbock, Texas. Urgent cases go to Lea Regional Medical Center (LRMC).

All laboratory specimens are sent to SED Labs. Dipstick urinalyses are done in the exam rooms. Accucheck blood sugars are done in the clinic. A courier comes in the early afternoon daily

from SED Labs, Monday through Friday.

The pharmacy has ample space and stock medications. A standard k.o.p (keep on person) policy excludes psychotropic medications. There is a Medline at the clinic for all inmates except those in unit one, which is a P.C. (protective custody) unit. The Medline is held b.i.d. (twice a day) at 7 a.m. and 7 p.m. A medication cart is taken to unit one, and a separate Medline is held there. All psych meds are crushed or floated. A consulting pharmacist makes an inspection monthly, and I reviewed the last report, of January 9, 2007.

Optometry services are provided by a father and two sons, who come in on Saturdays. The optometry equipment appears to be first-rate.

The dental assistant has been in her job since August of 2006. She was very frank and helpful about the problems with dental services. The dentist, Dr. [REDACTED], was supposed to be on site every Friday and Saturday. However he is now going to school for further training. So was on site only twice in January and 1 1/2 days in February. He sees 15 to 16 patients per day. There is a wait time of about two months for non-emergency cases. The dental assistant says that she was caught up last fall, but fell behind when Dr. [REDACTED] started school, even though another dentist came in to help out in September and October, Dr. [REDACTED]. Dental sick call requests are triaged by a nurse who actually sees the patient and then refers to the dental assistant for scheduling.

Health maintenance and periodic health assessment are done in accordance with a birthday list. Inmates are given annual PPD test and a DT vaccine if needed, as well as a physical exam yearly, if over 50, otherwise biennially. I reviewed the PPD testing logs and find that the results of the tests are not recorded on the logs, though there is a column to do this. The number of positive tests, however is reported on the monthly HSR report. There are currently three inmates receiving INH.

[According to Wexford staff] there was an increased prevalence of MRSA infection in housing unit one last summer. A thorough inspection was therefore carried out, all skin lesions were cultured and treated, the unit was cleaned thoroughly, tattoo guns were confiscated, and the number of cases has decreased since. I reviewed the infection control manual and find no problems with it. There is no designated infection control nurse.

I also reviewed the Wexford, Policies and Procedures Manual. In my judgment the one on detoxification, intoxication and withdrawal is inadequate. It mentions a few symptoms that indicate progression of the condition and says that these inmates should be kept under constant observation by qualified healthcare staff, or sent to CNMCF-LTCU or to the nearest hospital if severe. However, there is no scoring system, no guidelines for monitoring severity. I strongly recommend that the CIWA (Clinical Institute Withdrawal Assessment) protocol and scoring system be adopted. It is readily available on line.

There is no physical therapy service available here, and there has been none for the last four years, according to [Wexford staff].

A treatment review committee meeting is held every Monday, but no Hepatitis C patients are on treatment here due to the absence of a Medical Director. All such patients are sent to CNMCF.

There are currently six HIV patients on treatment, and Dr. [REDACTED] comes on site to see them approximately once a month. His last visit was in December.

Peer review reportedly is done by the regional medical director.

“Staffcare” is a temp agency, which is providing the PA. The PA has been here over a year, but prefers not to work for Wexford.

Sick call is done by LPN and RNs, rotating this responsibility. A physician or the PA signs off on their work.

There are no electronic medical records as required by contract.

There are no pharmacy and therapeutics committee meetings, only monthly staff meetings. Infection control meetings are also held as a part of the regular staff meetings. I did not review the minutes of these meetings.

Telemedicine is used only for psychiatry, three times a week. Dr. [REDACTED] and Dr. [REDACTED] each have their own caseload. They came on site once last year, not twice as required by contract.

[Some Wexford staff are] very unhappy with the Wexford operation citing a number of cases that “fell down a crack,” the collegial review process and cited for example, a patient with a colostomy that should be re-anastomosed, but was denied. [Staff] cited another case of a cataract that should be operated but was denied; another one who was denied referral to an allergist, and cases of chronic illness that had gone months without their being seen. One such was a diabetic who went from February 2006 to January 2007, without being seen by a provider although he continued to receive his daily insulin. [Staff] said that diabetic diets are not correct, that they have no calorie restriction and pointed out that since Dr. [REDACTED] left the job year ago there has been no NMCD participant in the collegial review meetings.

Dr. [REDACTED] has been working for Wexford only since last October. He has been regularly providing services at RCC two days a week for four hours each. He also covers some of the juvenile facilities. He does not attend collegial review meetings. He has no complaints about Wexford. He has been coming to this facility since December, mostly on weekends, but did provide two whole weeks of coverage, this being the second of those weeks. The first was January 15-21, and also one weekend in December.

The nurses on duty asked if they could meet with me collectively, and this was done. They were all unhappy, and attributed the problems to insufficient numbers of nursing staff, and also to the administrative style of the HSA, who they said was unreasonable in her demands and interferes with their ability to do their job, and that she requires them to continue medications beyond the expiration date of the order. The new Director of Nursing has been in place only for 2 1/2 months and is already interviewing for another job. [Some] of the LPNs have been here [for a long time], but the others a much shorter time. They also feel that having only one nurse on duty at night is not safe, nor is it adequate for patient needs.

Physician and Dentist Staffing

A review of the physician staffing for the past five months shows that a physician was on site 21

days in September, 22 days in October, and 20 days in November, all of these being Dr. [REDACTED]. He then left, and December shows 16 days of on-site physician and January only seven days.

A dentist was on site 5 days in September, 9 in October, 6 in November, 8 in December, and only 3 in January.

Chronic Illness Care

I made an effort to select charts to review from the Chronic Care Tracking System. However, this log is very far out of date and incomplete. When I inquired about this I was told that it was because the nurses had failed to make an appropriate date entry in the log after a patient was seen. However, the problem seems to be greater than that. There are erroneous diagnoses, notably the eight cases of diabetes insipidus. On further investigation, I found that there are no cases of diabetes insipidus, and that these are all diabetes mellitus. There are also many cases listed with no diagnosis, and some with other erroneous diagnoses. In other words, the log is inaccurate and not very useful, and my attempt to make a random selection of charts became a hit or miss exercise.

I was told that all the clinical forms used by Wexford are actually NMCD forms. In the case of the chronic care forms, this is unfortunate, because the Wexford forms are preferable. Wexford's chronic care guidelines are reasonable and comply with national guidelines. They refer to their appended chronic illness clinic form, which is one form to be used for all clinics, and they refer to their disease specific flow sheets. These flow sheets include brief reminders of the parameters to be followed. Regrettably, this is not the system followed by Wexford, under direction from the NMCD. The NMCD chronic care clinic form is a hybrid of encounter form and flow sheet, not specific to any individual condition and not useful as a flow sheet. As an expected result, my review of the medical records showed a number of instances of failure to comply with standard chronic care guidelines.

Records of two patients with HIV infection were selected for review. Their care seemed appropriate. Dr. [REDACTED] had seen them both on December 13, 2006.

The records of five patients with diabetes were selected for review. Only one of these patients had documentation of a careful foot examination on his last visit. This is required by the guidelines, but there is no reminder on the encounter form. Blood sugar control was poor in three of these five patients, one of whom had not been followed closely enough, having gone six months between visits. Of the three patients receiving insulin, only one was reliably getting twice daily glucometer tests. Of the five patients, only one had the desired blood pressure of less than 130/80. All five had had the required annual blood chemistry and lipid profile. However, only two had received an annual electrocardiogram. Only three had annual microalbuminuria tests. Four of the five had had annual urinalysis and fundoscopic examination. Four of the five were appropriately receiving an ACE inhibitor and four were receiving aspirin. Only three of the five had received Pneumovax and annual influenza vaccination. There was no evidence of diet counseling in any of these patients.

The medical records of five patients listed as having asthma were selected for review. However, one of them did not have any evidence of asthma at all and one had asthma so mild that I excluded him from review. Of the remaining three, a peak expiratory flow rate was tested on

each visit only in two of the three, a baseline chest x-ray had been done in only two, and none of the three had received Pneumovax or annual influenza vaccine. It is of interest that the Wexford chronic care guidelines do not require either of these vaccinations for patients with chronic respiratory conditions, although they should.

The records of four patients with epilepsy were chosen for review. All four of these patients received appropriate laboratory tests every six months including drug levels. Drug side effects were addressed at each visit in only one of these patients. (The chronic clinic form does not include a reminder for this.) Only two of these patients had not had a seizure since the previous visit, but the other two patients' lack of satisfactory control was being appropriately addressed. All four had been restricted to lower bunks.

The medical records of three patients with hypertension were selected for review. None of these had adequate control of their blood pressure.

In summary, the chronic care program at LFCC is far from satisfactory.

Conclusion

The health care program at LCCF suffers from the following problems or deficiencies:

- The x-ray equipment inspection and certification is in need of updating.
- Staffing is inadequate, especially nurse staffing, and the turnover rate is unacceptably high.
- Physician staffing has been irregular and insufficient for the past two months.
- Dentist staffing has also been insufficient for the past two months.
- Record-keeping and tracking has been inadequate.
- The detoxification protocol is inadequate, and I recommend adopting the CIWA one.
- There is no physical therapy service available as required by contract.
- There has been no NMCD participation in the off-site collegial review meetings.
- There have been no pharmacy and therapeutics committee meetings.
- There are no electronic medical records as required by contract.
- The chronic illness clinic program is unsatisfactory. The logs are grossly inaccurate and incomplete. There are many examples of failure to follow guidelines. The forms that are in use should be replaced using Wexford's or ones similar to those. One staff person should be assigned the responsibility for the organization and tracking of chronic illness clinic patients. The CQI program should monitor the chronic illness program using tools that reflect compliance with specific guidelines.

- Last but far from least, there is a dysfunctional working relationship between management and staff. This is probably responsible for the difficulties in recruitment and retention.

Central New Mexico Correctional Facility – Dr. Anno’s Report

Health services at the Central New Mexico Correctional Facility (CNMCF) in Las Lunas, New Mexico were audited on March 1st and 2nd by B. Jaye Anno, PhD, CCHP-A and Steve Spencer, MD, CCHP-A. Dr. Anno reviewed the health care staffing and their credentials; meeting minutes, statistics, and policies and procedures; the continuous quality improvement program, timeliness of sick call, off-site referrals for both medical and psychiatric consults, health care grievances, and the adequacy of New Mexico Corrections Department’s (NMCD) monitoring of its contract with Wexford. In doing so, she reviewed a number of documents and interviewed the following people on-site.

Introduction

The Central New Mexico Correctional Facility houses approximately 1400 male inmates. There are 330 Level I beds, 330 Level II beds, and 720 general population beds (including 300 in the Reception and Diagnostic Center [RDC]). There is also a 35 bed long-term care unit (LTCU) and a 104 bed mental health treatment center (MHTC) that includes 20 acute care beds. Medical and dental services are provided through a separate contract that NMCD has with Wexford. Psychiatric care is also provided by Wexford via telemedicine. Mental health services are provided by NMCD employees.

Staffing and Credentials

Wexford has 80.325 medical and dental positions at CNMCF. At the time of our audit, there were two RN vacancies, a PA Vacancy, and one MD vacancy. The latter two positions were expected to be filled on March 5th. Coverage for the vacant nursing positions is provided by agency nurses or other nursing staff working overtime.

All but four qualified health professionals had proof of current licensure on file at the facility, and these had just expired the previous day. The administrative assistant was working to get them updated. All but three providers had proof of current licensure and DEA registration on file. Again, for these three, they had just expired and the administrative assistant was following up. Five of the 14 providers were not current in CPR certification.

Meeting Minutes, Statistical Reports, and Policies and Procedures

Dr. Anno reviewed the meeting minutes and statistical reports for 2006. Meetings with the warden, mental health staff, and relevant health services staff (“MAC” meetings) were held only three times during 2006 and not at all during the first two months of 2007. The health services administrator (HSA) stated he had only been there a few months and was still learning his job. There was no evidence that Wexford staff met monthly. According to the HSA, they just started tracking attendance and developing minutes in January of this year. Health services statistical reports were compiled monthly. CNMCF does have a site-specific policy and procedure manual.

Continuous Quality Improvement (CQI) Program

Wexford refers to its internal CQI efforts as “Quality Management.” There is a Quality Management Program manual for 2006 developed by corporate office. On page 5, it lists 23 items to be reviewed annually at each site. Audit tools are included. The items to be reviewed are consistent with the requirements of the National Commission on Correctional Health Care’s guidelines on CQI. Wexford’s manual also requires quarterly audits of chronic care clinics and a reporting calendar

From the list of the required 23 items to be audited, the CNMCF health services administrator developed a schedule of which audits were to be done each month. Dr. Anno reviewed these audits and found them to be consistent with corporate requirements. There were also two year-long studies to be conducted: a process study and an outcome study. However, these studies have not been started.

While for the most part, Wexford staff at CNMCF are following corporate requirements for conducting CQI studies, a question remains as to the effectiveness of this approach. To be useful for the staff at a specific site, CQI studies should be problem solving, not paper pushing. In other words, staff at a given site should review aspects of care that are not operating as efficiently or effectively as they would like at their particular facility. Simply completing the studies designed by corporate office is not going to solve problems at the local level.

Intake Process

CNMCF serves as the reception center for male inmates for the state. New admissions are screened by nurses the day they arrive. A physical exam is provided within 7 days. Inmates also receive a mental health evaluation and a dental examination.

Dr. Anno requested 12 charts from the new admissions list to determine the timeliness of CNMCF’s intake process. One individual had transferred out and one chart could not be located. Of the 10 charts reviewed, the results were as follows:

Inmate#	Date of RS	Date of PE	Date of MHE	Date of Dental Exam
65	6/7/06	6/20/06	6/7/06	6/19/06
64	11/3/06	11/29/06	11/9/06	5/24/06?
66	1/10/07	1/15/07	1/10/07	1/31/07
65	2/7/07	2/16/07	2/7/07	2/26/07
66	2/8/07	2/16/07	2/8/07	2/22/07
66	2/13/07	2/19/07	2/13/07	None
62	2/15/07	2/20/07	2/15/07	2/20/07
66	2/16/07	2/20/07	2/22/07	None
66	2/21/07	2/26/07	2/26/07	None
66	2/22/07	3/1/07	2/22/07	None
63	2/21/07	2/27/07	2/22/07	None

Key: RS=receiving screening, PE=physical exam, MHE=mental health evaluation

From the chart reviews listed above, physical exams are not always completed within 7 days as required by NMCD policy and the standards of the National Commission on Correctional Health Care (NCCHC). Initial mental health evaluations appear to be completed on the day of arrival, which is excellent. According to NCCHC standards, dental exams should be completed within 30 days of an inmate’s arrival. In five instances, the 30 days had not lapsed. In the other five cases, dental exams were completed within 30 days.

Sick Call

Wexford uses a written sick call request system for routine care. Inmates obtain the slips from correctional officers in their housing units. General population inmates fill them out and put them in a medical box located at the dining hall. Nursing staff collect the slips for segregated inmates during med pass. Nurse sick call is held Monday through Friday. If inmates put their slips in by noon, they are seen the next day (except on the week-end).

Nurse sick call is held in the clinic or in an exam room in the segregated housing units. If the inmate’s complaint can be handled with over-the-counter medication pursuant to nursing protocols, that is accomplished. If something more is required, the inmate is put on the list to see a provider.

Dr. Anno requested ten charts from the sick call lists of 2/19/07 and 2/21/07: three RDC, three from segregation, and four from general population. Two individuals had left the facility, so she reviewed eight charts as noted below.

<u>ID#</u>	<u>Housing Unit</u>	<u>Date of Request</u>	<u>Date Rcvd</u>	<u>Date seen by nursing</u>	<u>Date seen by provider</u>
46	RDC	2/19/07	2/20/07	NA	2/21/07
66	RDC	Health service request not in chart			
65	Seg	Health service request not in chart			
63	Seg	2/18/07			2/21/07
55	Seg	2/18/07	2/18/07	2/19/07	2/22/07
64	GP	2/18/07			2/19/07
46	GP	Health service request not in chart			
33	GP	2/17/07		2/19/07	2/21/07

While sick call does appear to be provided on a timely basis, there were some problems with recordkeeping.

Off-site Specialty Referrals—Medical

When a provider at CNMCF makes a referral for off-site specialty care for a medical condition, the referral goes to the off-site specialty coordinator. She faxes the referrals to Wexford’s corporate office, and each Thursday, a conference call is held with Wexford’s regional physician and the CNMCF provider to discuss the case. The regional physician decides whether to approve the referral or to defer a decision pending alternative treatment or gathering additional information. This process is referred to as “collegial review.” Under the terms of its contract with NMCD (Section II.D.2.), Wexford has five working days to respond to non-urgent consultation requests, which they are meeting.

The contract also specifies the time frames for completing the appointment to a specialist by discipline (Section II.G.3.). For example, a routine referral for urology must be completed within 60 days whereas one for oncology must be completed within 30 days. Approved specialty referrals are sent to NMCD's Bureau of Health Services. Staff there track the timeliness of outside specialty referrals.

One problem identified is that the off-site coordinator at CNMCF only tracks the referrals that are approved. It does not appear that anyone at NMCD's Bureau of Health Services reviews the cases that are deferred to determine whether the deferral was medically appropriate. This is an important oversight function and should be a part of the next vendor's contract.

Also, the off-site coordinator does not track the timeliness of the outside specialty referrals. There is no way to tell when or whether an appointment has occurred except to pull each individual's chart. "Date of appointment" and "Date seen" should be added to the Collegial Review Log. Finally, appointment cancellations owing to lack of transportation are not currently tracked. This is important to monitor regularly.

Psychiatric Consultations

Wexford is also responsible for psychiatric consultations. Mental health staff make the referrals and give them to Wexford's psychiatric staff. According to the mental health staff Dr. Anno spoke with, inmates are usually seen the next session after the referral.

Grievances

Dr. Anno reviewed all of the health care grievances for 2006. Surprisingly, there were only 50 informal and 21 formal health care grievances for the entire year. This is an average of only 4 per month, which represents significantly less than one percent of the population. We recommend that NMCD health staff interview a sample of inmates to determine whether the present grievance system is effective.

Other Issues

There is a small geriatric population at CNMCF. The conditions under which they live are disgraceful. They are housed in three dilapidated trailers. The quarters are cramped and there is barely enough room for wheelchairs to pass down the aisle. The floors are rotting and some of the plumbing does not work. This situation needs to be remedied as soon as possible.

Contract Monitoring

NMCD's Bureau of Health Services is responsible for monitoring the Wexford contract, but there is no designated contract monitor position. The position of Bureau Chief was held by a physician until a year ago when he went on extended medical leave. Currently, there is an acting Bureau Chief, a vacant quality management position, a 30 hour per week clinical psychiatrist, a state-wide director of nursing, a state medical records manager, and an administrative assistant. The acting Bureau Chief held the quality management position until recently. He indicated that NMCD plans to hire a clinical physician sometime soon.

Bureau of Health Services staff do audit the Wexford facilities at least annually. However, their auditing tools are designed more to determine the extent of the facilities' compliance with national standards rather than compliance with specific terms of Wexford's contract. The current contract provides for numerous financial penalties to be assessed if Wexford violates specific terms (see Sections IX.2.1-21 and IX.3). However, these areas are not all regularly monitored by the Bureau of Health Services. The only financial penalty ever assessed against Wexford was in 2002 for \$35,000 owing to insufficient psychiatric coverage. On the medical side, Wexford has refused to provide staffing vacancies until recently, according to the acting Bureau Chief. The last two quarters, Wexford has reported aggregate staffing levels, but not site-specific information. This should be a requirement of the new contract.

We recommend that a health care contract monitoring position be approved by the legislature in time for the contract with the new vendor. The almost \$34 million spent on this contract annually as well as the potential liability to the state if adequate care is not provided justify adding this position. This individual should be a state employee and should NOT be paid by the vendor as provided for in Wexford's contract (Section IX.1.4). The position may well pay for itself if the financial penalties for staffing vacancies and other areas of non-compliance are actually tracked and assessed.

Central New Mexico Correctional Facility – Dr. Spencer's Report

Plant and Equipment:

We inspected the health care units in the Main facility and in the LTCU-MHTC facility (Long Term Care Unit – Mental Health Treatment Center). They were clean and well-equipped, with adequate examining and treatment space. There is an excellent physical therapy unit, a 4 chair dialysis unit, two radiology units, and three negative pressure rooms. There are currently six patients receiving dialysis. The drug room in the LTCU has a state-of-the-art Pyxis program, a computerized medication stock monitoring system. This is not yet available in the Main facility, but it would be desirable to have it there, too. I was told that there is also a need for more computers, vital sign monitors, and IV pumps.

There are two telemedicine rooms. One is in the MHTC and is used for psychiatry consultations with Dr. [REDACTED] from other sites in the state. The other telemedicine room is used for the Hepatitis C weekly presentations, involving Dr. [REDACTED], Professor of Gastroenterology at UNM.

The health-care unit at the Main facility has 4 examining rooms plus an emergency room. There are also several adjacent observation cells, none of which were occupied at the time of my visit. These may be used by custody or medical, but only for very brief periods of observation, and not for suicide watch or critically ill patients.

There are three trailers, for geriatric housing, with a total of 42 beds. We visited one of these and found it to be a far less than satisfactory housing arrangement for anyone, particularly elderly man. It was dark and gloomy, crowded and in need of repair. The floor was especially in poor condition.

Staffing:

An atmosphere of mutual regard and friendliness is apparent in the health care staff at CNMCF and I had the pleasure of being assisted by some very capable staff. Particularly helpful was the Director of Nursing who clearly is highly competent in her leadership role, and has the respect of her team members. She has been working at CNMCF for five years, and as DON for the past 10 months.

Some of the provider staff (physicians, dentists and physician assistants) have also been at CNMCF for a considerable period of time: Dr. [REDACTED] from 2002-03 and again since November 2005 at 0.6 FTE; Dr. [REDACTED] (psychiatrist) since January 2003 at 0.25 FTE; and Dr. [REDACTED] (dentist) since September 2001 at 0.2 FTE. The other eight providers, on the other hand, have been here less than 18 months. This suggests a problem with retention of provider staff.

There is only one clerical position for all the health care units. This is clearly inadequate. Apparently the number of RN positions was significantly reduced with the Wexford contract, and this should be re-evaluated.

Reportedly staffing was extremely low last summer. Therefore Wexford hired a recruiter to remain here in New Mexico and that person was successful in filling many vacancies. That recruiter however left New Mexico in September, and recruiting is again being done from the Pittsburgh home office.

Intake Procedures:

A PPD skin test is done on the arrival date and blood is drawn for a CBC, CMP, RPR, and Hepatitis B antibody, also HIV and Hepatitis C tests if agreed to by the inmate. Two-stage PPD testing is done, the second test taking place about two weeks later. Laboratory services are provided by SED Labs in Albuquerque, a courier picking up specimens on a daily basis. Dipstick urinalysis, stool for occult blood, and glucometer testing are the only laboratory procedures done on site. X-rays are developed on site, looked at by the providers, and then shipped to a radiology group in Texas for a definitive reading.

Dental Care:

The dental operatory is spacious and tidy, has 3 chairs, a laboratory and an office. Monday, Wednesday and Thursdays are reserved for RDC inmates, initial examinations in those mornings and return visits for treatment in the afternoons. Dental sick call is conducted on Tuesdays and averages 15 to 20 patients. A review of the appointment book with Dr. [REDACTED] showed the average wait time for non-urgent sick call is no more than one week, with follow-up visits about 2 weeks later. Fridays are reserved for patients in segregation units.

Sick Call:

Sick call is held five days a week, twice a day at the Main facility and once a day at the other areas. Sick call request boxes are emptied each night at midnight, and those patients are seen the following morning. They are not called out from their housing units, but simply show up and are seen.

Pharmacy and Medication Distribution

Medication distribution is via the pill call window at the Main facility and an effort is made to prescribe on a b.i.d. basis. There is a k.o.p. (keep on person) policy except for the MHTC and for controlled or psychotropic medication. Medications are supplied by a remote pharmacy in Boswell, Pennsylvania. Stock medications are apparently adequate for starter purposes, until the blister packs arrive from Boswell. A contract pharmacist comes in monthly to do audits and drug room inspections. Pharmacy and therapeutics committee meetings are held quarterly.

Chronic Illness Care

Oversight of chronic care scheduling at the Main facility is the responsibility of one LPN and this is commendable. However he does not have consistent access to the computer, so does most of the scheduling manually. Every week or two he and the charge nurse update the tracking system spreadsheet on the computer. (In contrast, at the Level 2 facility and the MHTC health care staff have daily access to the computer spread sheet and enter information daily.) Each day that a chronic illness patient is seen, the LPN books him for the next appointment. Reportedly the intent was to have the chronic care registry accessible throughout the state, but this is not yet happened. The main use of the tracking system spreadsheet is to discover appointments that have been missed and reschedule them. A copy of the updated tracking system list is also used by the NMCD Medical Records Manager, who assembles such lists from all facilities monthly and forwards them electronically to the central office in Santa Fe. It is not clear that these lists of names with their diagnoses are put to any use at the central office. However, the total numbers seen at the various clinics are tabulated and reported on the monthly statistical report sent from each facility to the central office.

Chronic illness patients are seen all days of the week, except for HCV (Hepatitis C virus) patients on treatment, who are seen by one designated PA monthly. He is also the one who presents HCV patients (at the Main) to the weekly TRC (Treatment and Review Committee) meetings. There is one designated nurse, who sees the HCV patients weekly to give them their injections. The NMCD medical records manager maintains the HCV data base. She compiles this from all sites and sources, even from SED lab.

I selected records at the Main from the chronic care tracking system list for my review. This list seemed to be reasonably up-to-date, in light of the above comment about the periodic entries from manual records. However many of the entries did not have specific diagnoses, and as noted at LCCF, the diagnosis of diabetes insipidus was entered instead of diabetes mellitus. This error should be easily correctable.

The records of six patients with diabetes were reviewed. A careful examination of the feet was documented on the CCC (Chronic Care Clinic) visits for only one of these patients. Although this is a standard requirement, the encounter form used does not specify this. An annual test for microalbuminuria had been done on four of these patients. Five patients were appropriately receiving an ACE inhibitor, but only one was receiving daily aspirin. Annual urinalysis and annual fundoscopic examination were not done on three patients. In two patients, no electrocardiogram could be found. These patients were on oral hypoglycemic agents and their blood sugar control was good. Of the four patients receiving insulin, control was satisfactory in three only. Blood pressure was at the desired level of less than 130/80 in three of the six patients. There was no evidence that any of these patients had received diet counseling, and my inquiries

led me to believe that dietitian services at CNMCF do not include patient counseling. Only one of these six patients has received Pneumovax (pneumonia vaccine). Although this is a standard recommendation at the national level, it is not included in Wexford's chronic care guidelines.

The records of seven patients with hypertension were reviewed. Four of these had not received a baseline chest x-ray. No electrocardiogram had been done on two of the patients. An annual urinalysis was lacking in three patients. Blood pressure was controlled at the desired level of less than 140/90 in only four of the seven patients. There was documentation of patient education in only one of these patients.

The records of two patients with epilepsy were reviewed. Seizures were controlled in both cases. One of them had not been restricted to a lower bunk. Drug levels had appropriately been tested in both cases. One record did not have the diagnosis on the problem list.

Records of three patients with asthma were requested for review. One of these was at another facility and one of them did not have asthma, so only one was actually reviewed. He lacked a baseline chest x-ray, and peak expiratory flow rate was not repeated at each chronic care visit. He had not received Pneumovax, although this is standard recommendation for such cases.

Records of two patients with Hepatitis C infection were reviewed. One of them was receiving treatment and the other not. Care was appropriate in both cases.

There are only eight HIV infected patients in the entire CNMCF facility, and all are on treatment. I did not review their records. Dr. [REDACTED] comes to the facility as needed and manages their care.

Infirmery Care

I spent some time in the LTCU interviewing Dr. [REDACTED] and reviewing some records with [Wexford staff]. Dr. [REDACTED] is a board-certified internist and attends here at the LTCU Wednesday Thursday and Friday of each week. There has been some recent turnover and changes in physician staffing here, resulting in a considerable variation in the coverage of the first two days of the week. However, beginning next week Dr. [REDACTED] and Dr. [REDACTED] will be alternating five-day week coverage. Dr. [REDACTED] said there has been a marked improvement in the past eight or nine months regarding off-formulary drug prescription. He also was pleased with improvements in the collegial review process, saying it is now rare to have any denials.

Although there is no methadone maintenance program in the NMCD, methadone can be given here at the LTCU for pain.

The LTCU has 35 beds, can house women as well as men. Patients are categorized as acute, regular housing, and permanent housing. Physician requirements are for daily rounds on the acute patients, weekly on the regular housing and monthly on the permanent housing patients. Admission history and physical examination are to be done within 24 hours or the next working day. Nursing requirements are for nursing notes every shift, including vital signs, on the acute patients, twice a week on regular housing and permanent housing patients. The charge nurse recently resigned, and there were two agency nurses covering the unit. The nurses work 12 hour shifts.

There were six acute level patients at the time of my visit. These included a woman with carcinoma of the esophagus receiving chemotherapy, a man who just received a total hip replacement, a man recovering from self-inflicted injuries, a man who was post-op laparoscopic cholecystectomy, a man who recently was discharged from the hospital following myocardial infarction and stent placement, and another man with an abscess on his arm. I reviewed these records and found care to be appropriate in each case.

Death Reviews

Mortality reports, autopsy reports and medical records of 13 deaths that occurred within the past 18 months were reviewed. I was pleased to read the honesty of the report and recommendations for improvement, regarding a death that occurred during the Thanksgiving weekend of last year. The report was done by the CNMCF Medical Director. This death apparently was a wake-up call regarding weekend coverage of patients discharged from the hospital.

Hepatitis C virus screening and treatment:

The NMCD Hepatitis C program policy and procedure, # H-01 states that as many as 35 to 40% of the prison population in United States are infected with HCV. This is lower than the 40 to 60% nationwide prevalence usually stated. A review of the available data regarding HCV screening, prevalence, and treatment shows that of the average daily population of the NMCD of 6800, only 1589, or 23%, are HCV infected. Of those identified as HCV positive, only 24, or 1.5% are receiving treatment. These figures seem low in comparison with national data.

CDC recommendations are that all inmates should be questioned regarding risk factors for HCV infection during entry medical examinations, and those with risk factors should be tested for HCV. However, the NMCD policy states that “All inmates who request HCV screening will have an ALT (a liver function test) drawn, if not already done. (It is not clear whether this policy is followed, or whether an HCV test is done at intake on inmate request.) If the ALT is elevated it will be redrawn in two months, and if it is again elevated, an HCV test (ELISA) will be drawn.”

This is the beginning of an extensive and complicated series of tests and barriers presented to the inmates before they can be considered for treatment. Those who finally make it through the complex screening procedure (1.5% of those infected) are presented to the TRC (Treatment Review Committee) weekly conferences, chaired by a recognized HCV Authority at UNM.

The ECHO program is a federally funded statewide HCV screening and treatment program, and includes qualified medical expert participation. However, the screening procedure is very extensive and time consuming, and the eligibility criteria for treatment are quite strict. As a result, very few of those infected are receiving treatment. Since there seems to be a significant discrepancy between the New Mexico and the national data, I recommend that the HCV policy be reviewed and revised, if necessary, and finally endorsed and signed off by the UNM authority, to make sure that quality of care, rather than cost considerations, are driving the selection decisions.

Conclusion:

The following matters are deserving of attention at CNMCF:

- The geriatric housing trailers are a counter-therapeutic environment, and should be replaced.
- There is only one clerical staff position authorized. This is grossly inadequate, and results in nursing staff having to perform clerical duties, when their time should be more appropriately used. Several additional clerical positions are needed.
- Additional computer posts are needed.
- The excellent Pyxis medication program and equipment should be available throughout the health care system.
- There may be other equipment needs, and the nursing and provider staff should be surveyed regarding this matter.
- The Chronic Care Tracking System has limited practical value. Its usefulness could be improved with better computer access for the staff responsible for scheduling appointments. In addition, many of the patient entries are lacking a diagnosis, and the diagnosis of diabetes mellitus is erroneously entered as diabetes insipidus.
- Patients with diabetes need improvement in their care and in their standard of care. They should receive Pneumovax (pneumonia vaccine); their blood pressures are not well controlled; they should receive prophylactic aspirin; they should routinely have a careful examination of their feet; they should have an annual eye examination; they should receive a diabetic diet, and dietary counseling should be provided.
- Patients with hypertension should have a baseline chest x-ray and electrocardiogram, and an annual urinalysis. There should be documentation of patient education for these and all chronic illness patients, but this is lacking.
- Patients with asthma should receive Pneumovax, and should have peak expiratory flow measured at each of their quarterly visits.
- These many deficiencies in the care of chronically ill patients are probably due largely to insufficient reminders on the forms that are in use. Wexford's Chronic Care Guidelines are satisfactory, except for the absence of Pneumovax. Their disease-specific flow sheets serve as useful reminders to the provider for what needs to be done. However, the Wexford flow sheets are not being used. Instead, a generic NMCD chronic care encounter form is used. This form has only a very few disease-specific reminders listed on a side bar, and no flow sheets are used.

The care of chronically ill patients would be greatly improved if adequate encounter forms and flow sheets were to take priority over printing and paper costs.

- The complicated screening and selection process for eligibility for treatment of Hepatitis C needs to be reviewed. An infection prevalence of only 23% may not compare convincingly with national data.

Penitentiary of New Mexico – Dr. Spencer’s Report

Plant and Equipment

The Penitentiary of New Mexico is a complex of three prison facilities with a total average daily population of approximately 900. The level II facility has a population of 320, and levels V and VI have 288 each. The level II facility is a minimum restrict unit, and its clinic space is far too small and crowded. Levels V and VI are maximum-security units, and their clinic space is adequate. The level VI facility occupants are generally long-term, whereas level V has frequent turnover. At level II all patients are seen in the clinic, for nurse or provider sick call. In levels five and six nurse sick call is conducted in small examining rooms in the housing units. I visited once such room and found it entirely adequate.

There is an automated external defibrillator (AED) in each housing unit in levels V and VI and in the medical units of all three facilities. There is one radiology unit for all three facilities, located in the level VI facility. There is also one optometry unit for all three, located in the level V facility. In the level VI facility there is also a telemedicine unit, which is used for the statewide TRC (Hepatitis C) weekly conferences, presided over by Dr. [REDACTED]. There are glucometers and peak flow meters at each facility clinic. The medical unit in level VI also has a “crisis room” used for suicide watch.

There is a need for more computer terminals and access to a centralized medical information system; the need for such a network is obvious.

Staffing:

Staffing is marginally adequate at best. There is a need for more dentist time, optometrist time, another clerical position, and more LPN’s.

There are some staff vacancies such as the medical records position and the charge nurse position at the level II facility.

Sick Call

In the level II facility, the inmates place their sick call requests in locked boxes in the hall. The nurse picks these up every evening Monday through Friday. (There is no medical staffing here on weekends.) Sick call is held in the medical unit in level II. In the level V and VI units sick call requests are handed to the nurse at the time of medication distribution. The requests are triaged and booked for either the next nurse sick call or the next provider sick call (mid-level or physician). No log is kept to reflect timeliness of sick call response, but I was assured that all inmates are seen at the next sick call, that no backlog occurs.

Pharmacy and Medication Distribution:

At the level II facility the inmates come to the pill window to receive their medications. No patients here are on narcotics and there are no diabetics who receive insulin at this facility, either. There is a keep-on-person policy except for psychotropic medications.

In the level V and level VI facility, the nurses take medication carts to the housing units. It is during these medication rounds that they may be given sick call requests directly from the inmates, and as noted above, conduct sick call in special examining rooms at each housing unit.

Chronic Illness Care:

There is a commendable effort at PNM to make full use of the chronic care tracking sheets. Associated chronic disease diagnoses are entered, along with date last seen, date of next appointment and actual date seen. Dr. [REDACTED] has a special interest in Hepatitis C, and it is significant that of the 24 patients in the entire state system that are under treatment for Hepatitis C, 10 are located at PNM. This may be pure chance, or it may reflect a more conscientious effort to move these patients into the treatment protocol.

I selected records from the chronic care tracking list at level V and level VI. These included four patients with diabetes. On only one of these patients was a careful foot examination done at each visit. An annual electrocardiogram was done on only one patient. An annual urinalysis was done on only two of the four. An annual funduscopic examination was lacking in three of the four. Blood sugar control is fair to good in two of the four. Blood pressure was at the desirable level in only two of the four. One patient with microalbuminuria was not receiving an ACE inhibitor as he should have been. Only one of the four patients was receiving prophylactic aspirin. One of these patients, who transferred from SNMCF in January had received Pneumovax while there. I was told that Pneumovax is not given at PNM. I was also told that there is no dietary counseling from a dietitian at PNM. These are clear deficiencies in care. The diabetic diet has also been inadequate. I reviewed the diet list provided by the Aramark food service contractor. The usual diet for diabetics has been, "No Concentrated Sugars." Only very recently has an effort been started to prescribe an ADA diet of specified caloric value.

Records of six patients with hypertension were reviewed. An annual urinalysis was lacking in four of them. In only one of them was the blood pressure controlled at the desired level of 140/90 or less. Documentation of patient education was lacking in two of these patients.

The records of three patients with epilepsy were reviewed. No significant deficiencies were found in the care of these patients. The diagnosis was not mentioned on the problem list in one of them, and presence or absence of signs or symptoms of drug toxicity was not documented in two of them.

The records of six patients with asthma were reviewed. One of these patients did not have peak expiratory flow rate measured at each visit. Two of the group had not had a chest x-ray. Although Pneumovax is a standard recommendation for patients with asthma, only two of this group had received it, and one of them was a recent transfer from SNMCF. Annual influenza vaccine was also lacking in three of these patients.

The records of two patients with Hepatitis C infection were reviewed, and their care was appropriate.

Dental Care

As noted above, the dentist hours are inadequate. There is a dentist, 20 hours a week for all of PNM. He comes in Monday and Saturday for 10 hours each day. At the present he has no

assistant. There is a dental operatory at level V and another level VI. The dental records at level VI show that he sees 10 to 12 patients each day that he is here, and there are 53 on the waiting list. That waiting list may be unreliable however. The HSA reviewed and counted the number of dental sick call requests at both level V and level VI. At level V there was 1 from December, 1 from January, 9 from February and 6 from March. These were sick call requests from inmates that had not yet been seen by the dentist. At level VI there were 3 from November, 9 from December, 15 from January, and the ones submitted since then could not be located. It is clear that not only is there insufficient dental time on-site, but also that the record keeping regarding the waiting list is unreliable. I was told that the inmates no longer submit any sick call requests for dental care unless they have a very serious problem or a toothache, since they know that the chances are they will not be seen for many months.

Optometry Services.

The situation for optometry is even worse than that for dental care. Unfortunately, no spreadsheets or logs are maintained for dental or optometry services that would show the date of request and the date seen. Likewise, the waiting list information is equally unreliable for optometry as for dental care. The optometrist provides 16 hours of service per month for the entire PNM complex. He does this by coming in every other Tuesday, rotating among the patient group at level II, V, VI, and the Santa Fe County Jail. As a result, he is able to see about 10 patients at any one facility every two months. All patients are seen at the optometry unit in level V. There are currently 71 patients on the optometry waiting list for level V and level VI. I was informed that the inmates are being told that there is about a one year wait to be seen by the optometrist. I was also told the Dr. [REDACTED] intends to send diabetics off-site for their annual fundoscopic examinations, since these are not been done in the required timely fashion.

There is clearly a need for much more optometry time.

Off-site Care:

As previously mentioned, “collegial review” phone conferences are held twice a week. Dr. [REDACTED] attends and referees these, along with the corporate quality assurance medical director. I reviewed the PNM medical transport calendars for January, February and March of this year. They show 8 transports for off-site specialty care for January, 9 for February and 13 scheduled for March. I have no way of judging appropriate timeliness of these off-site services from the information I have reviewed.

Grievances:

I was provided with the health-care grievances for January, February and March of this year. The grievance log records the date of grievance and date of response, the nature of the grievance and nature of the response, and the category of the grievance. To my great surprise, there was only one grievance in January, three in February and one so far in March. Only one of these grievances concerned dental care, and the response included the statement that there is a backlog of 89 inmates waiting for dental service.

Conclusion:

The following matters are deserving of attention at PNM:

- Clinic space at level 2 is far too small and crowded.
- There is a need for more computer terminals and access to a centralized medical information network for the entire prison system.
- Staffing is marginally adequate at best, with a need for more LPN's, another clerical position, and a serious need for more dentist time and optometrist time.
- There are currently some vacancies in important positions.
- There is a need for reliable logs to be kept for recording the timeliness of responses to sick call requests, off-site consultation requests, dental and optometry requests. The current record-keeping for these is clearly inadequate and unreliable.
- The care of diabetic patients does not meet national standards. As mentioned previously, the Wexford chronic care guidelines and flow sheets would be an improvement over the forms put in place by NMCD. The current one-size-fits-all encounter forms lack important reminders, and as a result, many deficiencies in care are occurring. These include a failure to give ACE inhibitors when indicated, a failure to provide prophylactic aspirin, a failure to give Pneumovax, a failure to perform a careful foot examination on each visit, and a failure to have an annual funduscopy examination performed by an eye specialist. Blood pressure is not controlled to the desirable level, nor is blood sugar adequately controlled.
- Pneumovax (pneumonia vaccine) should be provided to diabetics and to those with chronic respiratory problems such as asthma.
- Dietitian counseling should be available to patients for whom it is indicated, including diabetics.
- Appropriate ADA diets for diabetic patients should be ordered and available.
- Patient education should be done and documented on chronic illness visits.
- Patients taking antiepileptic drugs should be examined for presence of signs or symptoms of drug toxicity.
- Annual influenza vaccine should be given to all patients with chronic respiratory problems.
- Dental services are grossly insufficient.
- Optometry services are grossly insufficient.

- Pending adequate on-site services, diabetic patients should be sent off-site to ophthalmologists for their annual dilated funduscopy examinations.

New Mexico Women's Correctional Facility – Dr. Spencer's Report

The population of this facility on this date is 584. This consists of the following units: Unit A, (RDC) 78 inmates; Unit B, (TCU) 80 inmates; Unit G, approximately 286; Unit F-1 special needs inmates approximately 10, faith-based inmates approximately 10; Unit, F-2 about 20 beds (minimal custody); SHU (segregation), about 14; Diagnostic unit, five cells adjacent to the mental health unit.

Plant and Equipment:

Space is barely adequate, with one "emergency room" that is used for sick call encounters, the physician's office and PA's office, each of which is also an examining room. There is also some new telemedicine equipment, which is used for psychiatry encounters twice a week. Dr. [REDACTED] and Dr. [REDACTED] each has his own caseload, and they interview their patients without any other staff present. The plan is to use telemedicine also for the TRC conferences.

There is no infirmary here; patients needing that level of care are sent to CNMCF. High-risk patients are housed in the cells adjacent to the mental health unit. There are five such cells with open visibility. At the time of my visit, one was occupied, with one officer conducting constant suicide watch.

There is no x-ray equipment on site. A portable x-ray is brought in as needed.

Staffing:

The Health Services Administrator, is deserving of recognition for the excellent job she is doing, as well as for the help she provided to me. The physician, Dr. [REDACTED], and the PA are also to be commended for their clinical skills, as reflected in the medical records I reviewed.

Authorized staffing positions are not adequate. There is a need for more nursing and clerical positions. It is clear is that nurses are spending time performing clerical functions that should be fulfilled by clerks. Further complicating the situation are several vacancies. For example, the dental hygienist position has been vacant for several months.

There is one full-time physician, and one full-time physician's assistant. There is no consulting dietitian to advise patients. There is no physical therapist. Optometry and ophthalmology services are off-site. Pregnant patients are seen by a local family practitioner. While there are two family practitioners in Grants that deliver patients, one of them refuses to see inmates. There is no board-certified obstetrician available in Grants.

A review of the monthly health services report shows that there is no differentiation between patients seen by the physician, the physician's assistant, or the nurse. It is suggested that the category of provider be specified in these statistical reports.

Intake Screening:

There are 30 to 40 intakes per month. Two-stage PPD testing is appropriately done here. The practice is to read the first stage PPD at 72 hours, return the patient 14 to 30 days later and plant the second stage, reading that at 72 hours later. This is certainly acceptable, but involves one more nursing encounter than is necessary. A significant reaction to the first stage will almost always still be apparent at one week, so the first stage can be read at that time and the second stage planted at the same visit.

Routine laboratory tests done at intake consist of a CBC, comprehensive metabolic panel (CMP), lipids, RPR, Hepatitis B core antibody, HIV test if consented to, urinalysis and HCG. Routine immunizations consist of Hepatitis B vaccine, if indicated by the antibody tests, and tetanus-diphtheria vaccine if indicated. MMR vaccine (Measles, Mumps, Rubella) is not offered. According to the CDC adult vaccine recommendations, MMR should be given to all women of childbearing age who are not currently pregnant, unless they have evidence of Rubella immunity.

The initial health assessment is reportedly done within seven days, as policy dictates. The forms and the chart reviews indicate that this is a good comprehensive history and physical examination. These are done by the Physician Assistant.

The only computerized spreadsheet that records intake information is a complex one, updated at the time of physical examination, but including annual physical examination dates, with columns for incarceration date, physical examination, Pap smear, PPD, Hepatitis B status, and mammogram. There is a need for a spreadsheet that reflects only the timeliness of intake procedures. This would be useful for CQI review purposes.

Emergency and Hospital Care:

The Mount Taylor ambulance service is promptly available. Patients are taken to Cibola General hospital for emergency and primary care admissions. More complex cases are referred to Lovelace Hospital in Albuquerque.

Sick Call:

Sick call is conducted five days a week. For the RDC and segregation inmates, sick call requests are picked up by the nurses at the time of medication distribution. For general population inmates, they can slip their sick call requests into a pharmacy window at any time, or just come to the clinic and sign up and wait to be seen. There is also an opportunity every day during the lunch hour for inmates to sign up for sick call, as a desk in the dining hall is staffed by health services for one hour each day. A registered nurse triages all requests, and reportedly all those who need an encounter with health care staff are seen the same day. There is no log that reflects timeliness of sick call requests and encounters, but it seems clear that access to care is appropriate. However, for purposes of CQI review it would be desirable if a log were kept reflecting the times of receipt of sick call requests, and the times these were fulfilled by patient encounters.

Specialty Care:

Diabetic eye examinations are referred to an ophthalmologist in Albuquerque, following approval by the collegial review committee. There has been no problem in getting these done. There is an optometrist in Grants, who sees patients for refraction and prescription for glasses. Six patients are sent to him at a time, at least twice a month. I reviewed the off-site schedule and collegial review presentation records, but was not able to make any judgments regarding timeliness of this process, since there is no coordinated or combined spreadsheet covering this activity. The medical director feels that there is no difficulty with the collegial review process, that she gets approval for the off-site services that she requests.

Dental Care:

The dental operatory has two chairs. There is a dental assistant at only 0.5 FTE. There are two dentists, each coming one day a week. One comes on Wednesday for 10 hours and sees only the RDC inmates, performing a charted dental examination, a Panorex film, and bite-wing x-rays as indicated. The other dentist comes for 12 hours on Fridays and sees those who need care. It is clear that more dental service is needed. Currently the backlog for dental care is approximately 130 patients. It was over 200 last September, but since then a second dentist has been coming on site and the backlog has been reduced to 130.

Mental Health Care:

Dr. [REDACTED] is the regional director of psychiatry, and comes on site twice a month to see high-risk patients. There are two other psychiatrists at remote locations in Illinois and Massachusetts. They see each of their patients by telemedicine, every one to three months. They also come on site twice a year. The telemedicine encounters are with only the patients, without accompaniment by mental-health caseworkers.

Non-psychiatric mental health care is provided not by Wexford, but by Forensic Health Services (FHS). I spoke with the Mental Health Director. He has a staff of 10 clinicians plus administrative staff and one test proctor. These clinicians do the 60 day diagnostic and evaluations (D&Es) for the women intakes, as well as their mental health caseload. The MH Director makes every effort to insure that those clinicians who have done a D&E are not subsequently providing mental health services to those same inmates.

There is a multidisciplinary team (MDT) which meets weekly to discuss medical, mental health, or security issues. This team includes custody representatives, but the custody staff members are ones with senior experience. There is no mental-health housing unit at this facility.

Pharmacy and Medication Distribution:

There are three medication passes per day at the pharmacy pill window. There is a keep on person policy for general population. This is a standard k.o.p. policy that excludes psychotropic medications, which are all crushed and administered at the pharmacy window. Patients in RDC and segregation have their medications delivered to them three times a day, by medication cart. Medications are in standard blister packs. There are stock medications in the pharmacy. A consulting pharmacist inspects the unit monthly, and I viewed his reports.

Infectious Disease Surveillance:

There are currently five patients on prophylactic INH for TB infection. There is only one case of HIV on treatment. There are three cases of Hepatitis C virus under treatment. Cases of MRSA have been carefully tracked, and currently there are none under treatment.

There is no designated Hepatitis C coordinator, so that task of tracking and scheduling is carried out by the Medical Director, who is also the one who presents the cases at the TRC teleconferences.

Chronic Illness Care:

Chronic Illness patients are mostly seen by Dr. [REDACTED]. Cases were selected from the Chronic Care Tracking System, which was last updated two weeks earlier. The records of 7 patients with diabetes were reviewed. Careful examination of the feet for circulation, sensation and infection is a standard of care, and was documented in 5 of the cases. A baseline and annual electrocardiogram was lacking in 4 patients. Only 2 of the group had annual urinalyses and tests for microalbuminuria. Five of the 7 had received an annual fundoscopic examination by a specialist. Blood sugar was satisfactorily controlled in all but one. Blood pressure was at or below the desired level of 130/80 in all but one patient. An ACE inhibitor was prescribed where indicated in all but one patient, but recommended aspirin was not given to 5 of the group. Pneumovax had been given to only one of the 7 diabetics, and annual influenza vaccine was documented in only one. However, Dr. [REDACTED] is analyzing the reports on last season's influenza vaccine administration, and that data has not yet been entered into the medical charts, so presumably it was given to more than one of this group of 7 diabetics.

Records of seven patients with hypertension were reviewed. A chest x-ray was lacking in all but one. Baseline and annual EKG were done in only two of the cases. An annual urinalysis was lacking in four cases. The blood pressure was satisfactorily controlled in all but one case, and that was a patient with diabetes.

The records of 8 patients with asthma were reviewed. Peak expiratory flow rate was faithfully tested at each visit in all of these patients. A chest x-ray had been done on only one of the group. None of the eight had received Pneumovax. Documentation of annual influenza vaccine was missing in all of the group, but that may be due to the factor cited above with the diabetics.

The records of three patients with seizure disorder were reviewed. Blood counts and drug levels had been ordered appropriately in all three. Seizures were controlled in all three, and they had all been restricted to a lower bunk.

The records of the three pregnant patients were reviewed, and their care has been appropriate.

Continuous Quality Improvement (CQI) Program:

Minutes of the monthly staff meetings were reviewed, and these include CQI reports. Sample auditing tools were also reviewed. Staff does the auditing, some aspects of care on a monthly basis, others quarterly.

Grievances:

Last October, a unit management system was put in place by CCA. There are two unit managers with about 300 inmates each, and the team for each manager consists of counselors, case managers and caseworkers. The counselors are correctional officers. Informal complaints are presented in writing and are sent to the appropriate staff member, the HSA if it is a medical grievance. A response in writing is returned to the unit management team, and if the matter is not thereby resolved, the inmate files a formal grievance. Records are kept only of the formal grievances. I reviewed the monthly reports of these. There were only nine in September, none in October, one in November, none in December, and only one in January.

Conclusion:

The following matters are deserving of attention at NMWCF:

- Space is barely adequate, with the doctor's and PA's offices having to double as examining rooms. A couple of dedicated examining rooms would be desirable.
- Authorized staffing positions are not sufficient. There is a need for more nursing positions. The situation is further complicated by the existence of several vacancies. The physician should not have to be the one serving as Hepatitis C coordinator. This responsibility should be assigned to a nurse.
- Physical therapy services should be provided on-site.
- It is recommended that the monthly health services reports reflect the number of patients seen by the physician and the number seen by the physician's assistant, rather than lumping them together in one total figure.
- It is suggested that the reading of the first stage PPD and the planting of the second stage be done at the same visit, one week after planting the first stage. This would eliminate one nursing encounter.
- It is recommended that one nurse be assigned responsibility of Hepatitis C coordinator.
- It is recommended that MMR vaccine be offered to all women of childbearing age who are not pregnant and who do not have proof of immunity to rubella.
- There should be a spreadsheet that records the timeliness of the intake procedures, and does not combine this with the information regarding the annual physical examinations.
- There should also be a spreadsheet or log for sick call, reflecting the date of receipt of sick call requests, the date seen, by whom seen, and the disposition of the case.
- As recommended at other facilities, it would be highly desirable if there were a spreadsheet or log maintained regarding the off-site referral process, reflecting the date of request, the decision of the collegial review presentation, the date an appointment was

made and the date the patient was actually seen. Without this, a significant CQI review cannot be conducted.

- There is clearly a need for more hours of dental service. The current backlog of 130 patients waiting to be seen is unacceptable.
- The care of chronically ill patients, while timely and conscientious, fails to comply with nationally accepted clinical guidelines. These guidelines are reproduced in the Wexford chronic care guidelines, except that Wexford failed to include Pneumovax for diabetes patients. Review of the medical records of a sample of chronically ill patients shows that Pneumovax has not been given to any of the patients with diabetes or asthma. Electrocardiograms, chest x-rays, urinalyses, tests for microalbuminuria, prophylactic aspirin, and careful examination of the feet were all frequently lacking when indicated. As mentioned earlier, these deficiencies would not be likely to occur, if flow sheets and forms with guideline reminders on them were utilized in place of the ones currently in use.
- Dietitian counseling services should be available to patients when needed.

Western New Mexico Correctional Facility – Dr. Spencer’s Report

The average daily population of this facility is approximately 400, housing classification levels 2, 3, and 4. Monthly statistical health services reports were reviewed. They are completed faithfully by the Administrative Assistant. In recent months, a weekly statistical report has also been prepared.

Plant and Equipment

This is an excellent clinic facility with plenty of space, a large emergency room and two examining rooms. There are four isolation rooms for suicide watch or short-term observation, and an additional room with a restraint bed. None of these were occupied at the time of my visit. The ER contains an electrocardiogram and a crash cart with monitor/defibrillator. AEDs have been purchased for the facility, but the training has not been done yet.

There is a dedicated telemedicine room used for psychiatry and the TRC meetings. The telemedicine equipment was provided by the ECHO program. There is a small laboratory room for performing dipstick urinalyses and centrifuging blood. Blood specimens are sent to SED Labs. Glucometer testing is done at the pharmacy pill window.

There is an x-ray room. A technician comes in once a week, and the films are shipped to a radiology group in Texas. Radiology safety inspection certificate is current.

There is an optometry room, and the optometrist who comes in does the diabetic eye exams.

The dental clinic is a two chair operator. There is a separate Panorex room.

Staffing:

The physician, Donald Horney M.D., attends here Monday and Thursday for 10 hours each, coming from Gallup, New Mexico. This is not sufficient physician time, since he has to spend a significant amount of each of those days preparing for the TRC conference or the collegial review conference. Additional physician time is recommended, so that he can see chronic care patients as well.

The pharmacy is staffed 24 hours seven days a week, by pharmacy techs, who work 12 hours shifts, 7 a.m. to 7 p.m. The rest of the health care staff works five days a week, 8:00 to 4:30.

Emergency and Hospital Care:

Patients are taken to Cibola General Hospital for emergency and primary care. More complex cases are then flown to the Lovelace Hospital in Albuquerque, after stabilization.

Sick Call:

There is a drop box for sick call requests in the clinic, accessible for the inmates on the minimum-security side of the facility. For those in the segregation and lockdown units, the sick call requests are given to the nurse at the time of medication distribution. Sick call requests are triaged by the clinic coordinator, who then prepares the call out list of those to be seen, and the nature of the request.

Dental Care

The dentist comes in one day a week. There is no longer a dental hygienist here. The dentist sees about 14 patients a day including the annual examinations. There is no serious backlog of patients waiting, with 42 on the wait list, 26 of whom are for cleaning (prophylaxis).

Chronic Illness Care:

The Hepatitis C files and data are very well-organized, the best I have seen in the state.

Chronic illness patients are seen by the PA, occasionally by the physician. Due to the lack of familiarity with the Wexford chronic illness guidelines, and the inadequacy of the forms used for this operation, care of these patients was found to be less than entirely satisfactory. Charts were selected for review from the chronic care monitoring system, which is updated at each patient encounter.

The medical records of six patients with diabetes were reviewed. There was a failure to perform a careful examination of the feet for circulation, sensation and infection at each chronic care visit in 5 of these patients. An annual electrocardiogram was done in only 3 of these patients. Five of them had been appropriately tested for microalbuminuria, but only 2 had an annual urinalysis done. They had all received their annual funduscopic examination. In 4 of the 6 the blood sugar was not well controlled. The blood pressure was well controlled at or below the recommended level of 130/80 in four of the six. An ACE inhibitor was being given to those for whom it was indicated. Aspirin was appropriately given to all but one. Dietitian counseling is not available at

this facility. Two of these patients had received Pneumovax, but none of the group had received their last annual influenza vaccine.

The medical records of 3 patients with hypertension were reviewed. A baseline chest x-ray had not been done in 2 of the 3, nor had a baseline EKG been done. An annual urinalysis was lacking in 2 of the 3. Blood pressure was not well controlled in one of them. In one case, the last chronic care visit was over 4 months previously, whereas these are supposed to occur quarterly. Documentation of patient education was insufficient.

The medical records of 5 patients with asthma were reviewed. The peak expiratory flow rate had been measured at each chronic care visit in all but one of these cases. A baseline chest x-ray had been taken in only one of the five. None of the group had received Pneumovax or the last annual influenza vaccine.

The medical records of 3 patients with seizure disorder were reviewed. Seizures were well controlled in all 3, but in one case the patient was not being seen every three months. Drug levels were not appropriately tested in one case. The presence or absence of signs or symptoms of drug toxicity was not documented in 2 of the 3.

Pharmacy and Medication Distribution:

Patients come to the pharmacy pill window three times a day, except for the segregation and lockdown units, where the nurse delivers medication to them. Glucometer testing is done at the pill distribution point, and insulin is administered by the patients themselves under supervision.

Infection Control:

Reportedly, there were only six cases MRSA in the past year, and none currently. There are no cases of Hepatitis C on treatment at this facility, since they are sent to CNMCF. Dr. [REDACTED] comes in quarterly to see the HIV patients, of which there are three on treatment at the present. There have been no cases of active tuberculosis in recent months, and there is no negative pressure room in this facility. There are currently 14 patients taking prophylactic INH.

Continuous Quality Improvement Program:

I reviewed the quality management program minutes of the past few months, but there is apparently very little CQI activity taking place. I was told that the Director of Nursing audits the psychiatry and chronic care charts quarterly, but those studies were not available at this time.

Conclusion:

Although health-care operation that WNMCF is very efficiently run, the following matters deserve attention:

- There is a definite need for more physician hours, for seeing patients and for providing clinical leadership in the chronic care program.

- There is a need for a dental hygienist. It would be more efficient and less expensive if a hygienist were there to do the cleaning (prophylaxis), while the dentist does examinations and treatments.
- The care of chronic illness patients, fails to comply with national standards and Wexford guidelines. As mentioned earlier, this problem would be largely corrected with the use of more appropriate forms that include guideline reminders. The deficiencies are particularly striking in the case of diabetics,
- Pneumovax should be available, and provided to those chronic illness patients for whom it is indicated.
- Influenza vaccine should also be available for annual provision to those patients for whom it is indicated.
- Dietitian counseling should be available to patients for whom it is indicated, including diabetics.
- There is a need for much more significant CQI activity, with more frequent monitoring, reporting, and remedial action.

Final Conclusions and Recommendations

The New Mexico Corrections Department and Wexford Health Services each have some highly capable, conscientious and dedicated employees. A few of these whom we met are cited in our report, but there are undoubtedly additional ones who deserve commendation. We want again to express our gratitude to those who were so helpful to us and enabled us to do our work efficiently and with pleasure. Our role, however, is not to identify individual employees for praise or criticism, but to identify systemic problems and to make suggestions for corrective action. We therefore offer the following comments, which are not presented in any order of priority:

1. There is an urgent need to fill the NMCD Medical Director position. This person's responsibilities should include providing clinical oversight of the contractor's performance, and attending the off-site referral ("collegial review") meetings and the Hepatitis C Treatment Review Committee (TRC) meetings.
2. The NMCD-Wexford contract has some requirements that are not all being fulfilled at all facilities. These include Wexford/NMCD meetings 10 times a year, quarterly Pharmacy and Therapeutics Committee meetings, electronic medical records, and penalties for staffing vacancies.
3. The present contract does not provide adequate authorized staffing positions. There is insufficient physician staffing at LCCF and WNMCF, insufficient dental staffing at LCCF, PNM, NMWCF and CNMCF, insufficient optometry staffing at CNMCF and PNM, insufficient clerical staffing at all facilities, and insufficient nursing (particularly RN) at all facilities.

4. Compounding the inadequacy of authorized positions is the vacancy rate. Wexford has had difficulty with recruitment and retention, and reportedly the penalties for vacancies have not been enforced.
5. It is clear that there is a need for better systems for communication between NMCD and Wexford, and for closer monitoring. We recommend that a health care monitoring position be added to the NMCD Central Office staff. Additionally, there is a need for a computerized medical information system, accessible at all facilities by NMCD and the contractor. This would enable a much needed consistency in reporting, and would also provide system-wide access to information regarding tracking of chronically ill patients, progress of the Hepatitis C treatment screening procedure, timeliness of the off-site referral process, among other things.
6. The Continuous Quality Improvement (CQI) program needs improvement in design and implementation. It should clearly be a multidisciplinary effort and involve NMCD staff, including the Warden or his representative, as well as the contractor's health care staff. In addition to carrying out the monitoring assignments of the corporate office, it should also identify suspected site-specific problems, study and monitor them, implement corrective measures, and evaluate subsequent outcome.
7. There should be a standardized log or computer spread sheet for documenting the components of the intake process, at RDC and NMWCF. This would make it easily possible to monitor the timeliness of the various procedures. Our review of samples of charts at RDC revealed that there are some failures to meet required time frames. Sampling charts is a very cumbersome way to determine compliance. This information should be readily available for routine CQI studies, from an activity log.
8. Likewise, there should be a standardized log for documenting timeliness of the sick call activity. There is a lack of consistency among the facilities in recording sick call requests for time received, time of encounter, and disposition of case, i.e. whether referred to practitioner, etc. This information also should be readily for routine CQI studies.
9. The contract calls for sick call triage and screening encounter to be done by a RN or mid-level provider (PA or NP). In actuality these activities are being done mainly by LPNs. Several of the Wexford Nursing Treatment Protocols are not appropriate for implementation by LPNs, and it is essential that staffing provides that a RN (or a midlevel provider) is always on site when sick call is being conducted, to be called upon for serious medical problems that exceed the capability of the LPN.
10. Although nurse sick call is held five days a week, inmates must have the opportunity *daily* to request health care. (National Commission on Correctional Health Care standard.) A nurse should collect and triage sick call requests daily, and this is not being done at LCCF.
11. Sick call "no shows" should be re-scheduled, not dropped from the list. A "no show" may be due to a variety of causes, some serious, and deserves follow-up.
12. The chronic illness clinic program is unsatisfactory system-wide. The logs, or "Tracking System" are inaccurate and incomplete. There are innumerable examples of failure to follow nationally accepted guidelines, most of which are stated in the Wexford chronic care guidelines. However, the forms that are in use are NMCD forms, and they are less than satisfactory.

Wexford's forms are better, and include disease-specific flow sheets that have brief reminders of the parameters to be followed. Such guideline reminders are essential in prison health care. The system now in place does not allow for a significant CQI monitoring of chronic illness care, because it lacks disease-specific criteria. This important aspect of care is not meeting quality standards.

13. Related to the chronic illness program is the fact that Pneumovax (pneumonia vaccine) is not available to patients with diabetes or chronic respiratory conditions, and it should be available.

14. MMR (measles, mumps, rubella) vaccine should be offered to all women of child-bearing age who are not pregnant and do not have proof of immunity to rubella. This is a CDC recommendation that is not being followed.

15. The off-site referral process needs better documentation. All components of this activity should be recorded on the same spread sheet, not on separate sheets of paper, and should include the denials, and the date of each step in the process. Although reportedly the "collegial review" process is now more responsive to the attending physicians' requests, there are still a significant number of denials, and insufficient means of tracking and evaluating these denials. The NMCD Medical Director should be able to attend the collegial review meetings, and at least should be notified of the denials, so that he can investigate them as part of his oversight responsibility.

16. Hobbs is a long distance from Albuquerque, where Wexford has identified its consultants. This constitutes a disincentive for patients and staff when consultations are recommended. Although Las Cruces is also distant, it is closer to Hobbs than Albuquerque, and it is suggested that the contractor identify appropriate consultants there.

17. The HIV screening and treatment program is operating very satisfactorily at the patient care level, with an agreement between the NMCD and the New Mexico Department of Health. However, the agreement requires the DOH to provide quarterly reports and an annual summary. Our efforts to obtain these were not successful, so we wonder whether they in fact are being provided.

18. The Hepatitis C virus (HCV) program, on the other hand, raises some questions. The UNM gastroenterologist who makes the clinical treatment recommendations is a nationally recognized authority on HCV. However, the procedure for determining eligibility for treatment is very cumbersome and lengthy, raising the question of whether he is being presented with all the cases deserving of treatment. Enthusiasm for such treatment seems to vary among clinicians at the several NMCD sites. Record keeping also varies, and the Clinic Nurse/HCV Coordinator at WNMCF has a model system for tracking these patients.

There is a need for clarity regarding testing for HCV. Policy requires laboratory evidence of impaired liver function on two occasions, two months apart before HCV testing can be done. However, our information is that clinicians often order an HCV test on inmate request, without waiting for repeat liver function tests. CDC recommendations are that all inmates should be questioned regarding risk factors for HCV infection at the time of entry medical examinations, and those with risk factors should be tested. Only 23% of the approximately 6800 NMCD inmates have been identified as HCV infected, a figure considerably lower than prevalence

figures generally cited for prisons. Of those 23%, or 1589 inmates, only 24 (1.5%) are receiving treatment.

For these reasons there is a need to be certain that quality of care, rather than cost considerations, are driving the selection process. The UNM consultant, Dr. [REDACTED], should be asked to review the policy again to make sure that all eligible candidates will be presented to him in a timely fashion. He should also be asked to review the data, which should be collected in the fashion modeled at WNMCF.

19. Wexford's detoxification protocol is inadequate. Although detoxification is more frequently required in jails than prisons, the need does occasionally arise in prisons, and it can be a life or death matter. The contractor should adopt the CIWA protocol (Clinical Institute Withdrawal Assessment), which is readily available on line.

20. There are some space and equipment needs that should be addressed. These include the counter-therapeutic housing for elderly men at CNMCF, inadequate clinic space at the level II facility of PNM, additional computer stations at all clinics, extending the Pyxis medication program and equipment to all facilities, and the need for examining rooms at NMWCF that do not have to double as offices.

21. The grievance process should record and track the informal grievances as well as the formal ones.

22. Dietitian counseling should be available to all chronically ill patients who require a special diet. This should be a component of patient education, an area that is neglected in the care of the chronically ill.

23. Appropriate ADA diets for diabetic patients should be ordered and available.

24. Where adequate on-site services are not available, diabetic patients should be sent off-site to ophthalmologists for their annual retinal examinations.

25. At LCCF there is a need for better coordination between the institutional mental health staff (GEO) and the contract psychiatrists, regarding scheduling, tracking and follow-up. This may be something deserving of attention at the other facilities as well. Consideration should also be given to routinely having the appropriate mental health staff attend the telemedicine psychiatry encounters. Since the patient is being cared for by mental health staff as well as by the psychiatrist, it would seem helpful to the communication process if both were present at these telemedicine visits.

26. Physical therapy should be available to inmates who need it at all facilities, not just CNMCF.

27. Monthly health services reports at NMWCF should reflect the number of patients seen by the physician and the number seen by the physician's assistant, rather than lumping them together in one total figure.

28. It is recommended that at each facility the responsibility of HCV Coordinator be assigned to one nurse. Likewise, it is recommended that at each facility the responsibility of chronic illness coordinator be assigned to one nurse. It is clear that spreading these responsibilities among several people does not result in as reliable a program.

B. Jaye Anno, PhD, CCHP-A

Steven S. Spencer, MD, FACP

Date

Date

DEPARTMENT RESPONSES

STATE OF NEW MEXICO
CORRECTIONS DEPARTMENT

REC'D MAY 22 2007

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May 22, 2007

Mr. David Abbey, Director
Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, New Mexico 87501

Dear Mr. Abbey:

On behalf of the New Mexico Corrections Department (Department), I would like to thank you for the opportunity to comment on the LFC Report on the review of the Department. This letter will serve to provide the comments of key positions of the Department regarding the findings and recommendations found in the report.

The report begins by recalling what happened in New Mexico's prison system in 1980 as a result of crowded and inhumane conditions of confinement and quality of life for both inmates and staff.

Since that time, the Department has made great progress in improving its conditions of confinement. The Department, in fact, has recently commissioned a book entitled, [From the Ashes: 27 years of Progress in New Mexico Corrections](#) which documents the history of the Department. Developing a secure, rehabilitative prison environment took years of hard work and dedication to address one of the main problems that led to the 1980 riot—prison overcrowding. The state spent millions in taxpayer dollars building new prisons and complying with a federal court mandate that dictated how to run our prisons.

Specifically, regarding the LFC review, the Department will meet with the private prison operators to discuss and attempt to resolve, to the extent possible, concerns raised in this audit report.

The Department acknowledges there has been a disjointed approach to prison planning and commits to commissioning a study for this purpose.

David Abbey, LFC Director
Corrections Department Response to LFC Audit
May 22, 2007
Page 2

In regards to medical costs and adequate medical care for inmates, the Department acknowledges that there are system-wide problems with healthcare delivery. The Department also acknowledges that the key areas of staffing vacancies, and departmental monitoring require a new approach, including new contract requirements, internal resource allocation and legislative funding. Departmental reorganization, the medical RFP and subsequent contract, coupled with the tasks completed and scheduled will serve to address and satisfactorily resolve these issues.

The Department has also made successful efforts in monitoring the Wexford medical contract and has recovered money from them for staffing shortages and improper billings totaling \$159,517. Also, the Department just received Wexford's quarterly report for January, February and March 2007, and will analyze their billings for staffing shortages.

The Department is confident in our ability to manage our prisoners and probationers and parolees, and is very proud of the many accomplishments during this administration.

The following are a few highlights of this administration's accomplishments:

- Required all prisons to be smoke-free without any legislative mandates
- Received accreditation by the American Correctional Association for all divisions and prisons
- Began emergency preparedness training for all staff
- Began use of force training for all correctional offices
- Reduced prison violence resulting in safer prisons
- Advocated and received 20-year retirement for correctional officers
- Developed a population control committee
- Created a victim services coordinator
- Created a family services/constituent services coordinator
- Utilize over 1,000 volunteers to assist in different programs
- Created a probation and parole security threat intelligence unit to apprehend violent fugitives
- Increased number of probation/parole officers
- Implemented 24-hour call center to monitor sex offenders on community supervision
- Initiated criminal background checks on all probationers and parolees

We appreciate the opportunity to testify before the committee on our responses to the audit to explain any discrepancies in the report and to clarify the Department's position on various issues.

As the Secretary of the Corrections Department, I take full responsibility for issues raised in this report. As a Department, we are already discussing, addressing and implementing changes.

Sincerely,



Joe R. Williams
Secretary of Corrections

Attachments

TABLE OF CONTENTS

NEW MEXICO CORRECTIONS DEPARTMENT (NMCD) RESPONSE TO THE LFC's FINDINGS AND RECOMMENDATIONS

PRIVATE AND PUBLIC PRISONS

Privatization of Prisons: County Jail Legislation	Pages 1 & 2
Public Prisons	Pages 2 & 3
Comparison New Mexico Prisons To Other States	Page 3
CPI/Per Diem/Lease Purchase	Pages 3 - 5

INMATE POPULATION GROWTH AND LONG-TERM PLANNING

Population Projections	Page 6
Long-term Planning for Bed Space	Pages 6 & 7

FOOD SERVICE

Pages 8 & 9

QUALITY ASSURANCE

Pages 10 & 11

MEDICAL

Pages 12 - 15

ADDICTIONS

Pages 16 - 21

MENTAL HEALTH

Pages 22 - 24

Response to Dr. Spenser-Anno Report by John Robertson, M.D.

APPENDIX 1

Response to Dr. Spenser-Anno Report by Dan Collins, Ph.D.

APPENDIX 2

NEW MEXICO CORRECTIONS DEPARTMENT (NMCD) RESPONSE TO THE LFC's FINDINGS AND RECOMMENDATIONS

NOTE: DUE TO THE SIMILAR NATURE AND REDUNDANCY OF THE FINDINGS AND RECOMMENDATIONS IN THE LFC AUDIT REGARDING THE PRIVATIZATION OF PRISONS, THE DEPARTMENT WILL ADDRESS THOSE ISSUES IN AGGREGATE INSTEAD OF INDIVIDUALLY.

PRIVATE AND PUBLIC PRISONS

Privatization of Prisons: County Jail Legislation

New Mexico does have the highest rate of private prison use in the nation because of the legislature's involvement in the decision regarding the location of correctional facilities and housing of inmates in Cibola County, Torrance County Santa Fe County, Lea County, Guadalupe County and Clayton.

In regards to the statement in the LFC audit: "an inefficient design make New Mexico's public prison facilities increasingly expensive to operate," the report does not mention the legislature's "politicized process" of the issue regarding the location of prisons. This includes the decision after the riot to build small prisons in rural areas all around the state that do not lend themselves to economies of scale.

The report makes no mention of the legislature's 14-year delay in addressing the lease-purchase problem created by the 1989 Montano decision and makes no mention of legislative involvement with entities involved in financing the Lea County and Guadalupe County that put an end to the project contemplated by the competitive RFP process that preceded the "county jail" solutions. The fact is that the current operator of the prisons in Santa Rosa and Hobbs, The GEO Group, Inc. (formerly Wackenhut), along with several other vendors submitted competitive bids for the Guadalupe and Lea county facilities pursuant to a competitive procurement issued by the state in 1996. The current operator won the competition to design, build and operate the two prisons for the state with the projects to be financed through the issuance of revenue bonds that would be repaid by the state (with the state owning the facilities at the end of the bond repayment terms). The financing was effectively blocked by members of the state legislature and the operator was forced to proceed under the cited county jail legislation using its own funds to pay for the construction of both facilities.

The state's election to use another's capital for the construction costs of detention space frees up capital that the state may prefer to use for other infrastructure needs.

The Department was facing serious overcrowding during Governor Johnson's administration and was even housing inmates out-of-state in Arizona and Texas. The reason that the Department had to use the "county jail" solution was because of the Montano decision. Rather than commending the Department for the creative use of existing law to solve the Montano problem and the lack of capital funds available at the time, the report characterizes the Department's efforts finding a "legal loophole". This was not a "legal loophole"; it was the law.

With regard to the Lea County and Guadalupe County correctional facilities, the report suggests over and over that the state was somehow competitively disadvantaged as a result of the contracts being negotiated through the cited county jail legislation rather than through competitive bidding; this is absolutely incorrect.

Although this administration inherited this reliance upon privatization in the prison system, we feel it has evolved into a good mix for the state. Personnel from both the public and private facilities learn from each other and compete to implement best practices for the New Mexico prison system. The department recognizes that there are different cultures in public facilities versus private facilities and although they may be somewhat similar, they are united but unique. Instead of looking at the use of privatization in such a negative manner, New Mexico should be proud that we are leading the nation and that it is working so well. This administration believes there is enough of an advantage to continue leasing beds from private prisons in the state, particularly due to the high cost of maintaining existing public prisons.

The State in fact pays for hundreds of buildings, not just prisons, across the state that it will never own. In light of the fact the state is struggling to deal with old, outdated facilities that it currently owns, in regards to private prisons, the state is not facing such a dilemma with respect to the facilities it pays to use on a “pay-as-you-go” basis.

Public Prisons

The designs implemented over 20 years ago for the Corrections Department were considered to be “state of the art” design for correctional facilities. It is true that the majority of the prison buildings located statewide are in dire need of maintenance as stated in the report. However, the state always has difficult choices to make when appropriating the limited amount of funds to all capital outlay needs throughout the state.

It is true that the majority of the prison buildings located statewide are in dire need of maintenance as stated in the report; it is also true that the funding received by the Department is allocated to repairing physical plant problems as they are prioritized. Considerable monies have been allocated over the past three years to repair problems in the physical plant conditions at the facilities statewide.

The funding received by the Department for maintenance and repairs is allocated to repairing physical plant problems as they are prioritized. Considerable monies have been allocated over the past three years to repair problems in the physical plant conditions at the facilities statewide.

Capital appropriations directed to Corrections for repair and maintenance have always been quickly allocated by priority to help “band-aid” the problems by which facilities are challenged. It is the Department’s intent to allocate wisely and to provide as much remedial work as possible with the monies allocated.

Recent building construction efforts have utilized best practice building practices in the newly opened Mental Health Treatment Center located in Los Lunas. This facility has given the department the capabilities of providing mental health care to inmates that would be otherwise housed in prisons that were not set up for this specialized type of inmate. The

design actually allowed for less correctional officers on staff due to the direct visibility at master control.

Public institutions are designed to house all levels of inmates. For optimum security and control, one officer is assigned to the housing control center and one or two correctional officers are assigned to the housing unit floor depending on the shift assigned. In contrast, privately run institutions are designed to house Level III inmates, which are double celled, and require less supervision.

Comparison New Mexico Prisons To Other States

The attempt to compare the cost of operations between one jurisdiction and another is misleading. The private prison contracts in New Mexico require the operators of these facilities to provide substantially more space and programs to inmates than is required in the comparison states cited in the reports. There is no similar type of facility to compare with other states due to different missions, programs, quality of life, classification, etc. The largest component of a facility's costs are 1) its capital costs; 2) its labor costs; 3) the level of required inmate programs; and 4) culture and gang activity. Construction costs are higher in New Mexico than in the comparison states (none of the comparison states require cells as large as those required to be built in New Mexico). Labor costs are also significantly higher in New Mexico than in Oklahoma or Texas, two comparison states used by the LFC audit. The other jurisdictions do not require the owner/operator to pay an eight percent gross receipts tax on every dollar of revenue received by the owner/operator.

CPI/Per Diem/Lease Purchase

The report completely ignores the fact that all pricing assumptions for private prison contracts were carefully reviewed and considered by the Attorney General's Office, the General Services Department and the Department of Finance and Administration when the contracts were initially negotiated. Very capable individuals in these state agencies spent a great deal of time and effort going through every provision of these contracts, and in particular, those sections dealing with compensation.

The report fails to mention that the general restriction on the annual increase in the Lea County and Guadalupe County agreements to 80 percent of the CPI rather than 100 percent of the CPI was the Department's method of not paying an inflationary increase on construction costs. (Approximately twenty percent of the per diem was for construction costs.) The operator and the state agreed to this provision when the original contracts were negotiated. This twenty percent provision still remains in those contracts and should offset the report's cost assessment to a great extent. The 20 percent of the original negotiated per diem rate that was agreed to represent the owner's return on invested capital (fixed construction costs) has never been adjusted by an annual CPI. The LFC report indicates the department could not provide supporting documentation for this claim. However, rarely is there documentation of negotiations. The supporting documentation is found in the final contract, which states that the increase is limited to 80 percent of the CPI.

Most of the difference in the cost of housing prisoners from FY01 through FY06 is simply a matter of reasonable annual pricing adjustments consistent with the CPI and increased operator obligations such as security upgrades and programming. State spending on private prisons has also increased substantially due to an increase of inmate population, which has grown 21 percent from FY01 to FY06. Costs over time are also affected by increases in wages and the cost of necessary goods and services. The department believes

that the mixed use of public and private prisons in the state is working well but recognizes that there is a savings by leasing beds.

The Department eliminated the second tier (lower) per diem rate at Lea County Correctional Facility and Guadalupe County Correctional Facility in 2001 to pay for the security and other upgrades required as a result of the riots/disturbances at those facilities and recommendations from the Independent Board of Inquiry (IBI) Report.

The Legislative Finance Committee staff does not favor CPI increases, although the report seems to suggest that for the medical contract, the inflationary increase should be limited to the CPI, but not 2 percent in excess of CPI.

If we don't use CPI increases, it is difficult to get a long-term contract at the Department's discretion. In other words, we would have to allow the contractor to terminate without cause with perhaps 180 days written notice.

It is virtually impossible to expand Camino Nuevo Correctional Center because of its small site. This facility will never achieve an economy of scale. The Department will not be able to negotiate an equal per diem rate/tier, or perhaps even a lesser per diem rate/tier at CNCC as compared to NMWCF. The Department was forced to use this facility because of overcrowding at the NMWCF. There was also the ACLU lawsuit and the New Mexico Population Control Commission to deal with. It will be impossible to get 10 to 50 inmates housed at no additional cost as suggested by the LFC.

The Department has amended the NMWCF contract to temporarily (May and June, 2007) reduce the minimum guarantee from 580 to 530. This will result in cost savings by not requiring the Department to pay for beds it is not using. The Department is in the process of negotiating what will happen beginning July 1, 2007.

The per diem at Clayton is higher due largely, if not entirely, to higher construction costs. If the Department had waited to sign the Clayton agreement until the Montano decision/Constitutional amendment issue was finalized (voted on by the voters), the costs would now be even higher. Because of this uncertainty, DFA wanted the Department to stay away from any express lease-purchase language. Again, fortunately, the agreement expressly provides that the Department/state may purchase the facility and does not prevent an amendment adding a lease-purchase arrangement. The Department may pursue this option.

The Clayton agreement does not prohibit the Department from amending the contract to provide for a lease-purchase agreement. In fact, the agreement expressly allows for the Department to purchase the facility.

The Department will consider lease-purchase agreements for Clayton, as well as future facilities, although perhaps not those located on sites currently owned by private entities (i.e., LCCF and GCCF).

Department Action Items

The Department will meet with the private prison operators to discuss and attempt to resolve, to the extent possible, concerns raised in this audit report.

NMCD will attempt to renegotiate the private prison contracts to ensure staffing levels are maintained at a reasonable level including some mandatory posts. In addition, the department will monitor vacancy rates at private prisons on a more regular basis and will track, monitor and enforce the number of programs canceled and identify the reason for any cancellations.

The Department will also require contractors to submit monthly reports indicating coverage for the mandatory positions and we will monitor and enforce them accordingly.

INMATE POPULATION GROWTH AND LONG-TERM PLANNING

LFC Finding: Executive policy combined with the department's lack of active long-term planning to accommodate inmate growth had led to a disjointed and costly approach to acquire needed bed space.

NMCD Response:

Population Projections

With regard to the LFC's finding indicating the Department will require additional bed space by 2009, based upon internal (compiled by the department) inmate population projections, the department projects it may require additional bed space in FY2011, not as soon as FY2009, as indicated in the LFC finding. The department disagrees with the figures provided in this finding because the numbers were based upon projections compiled by the department's consultant on inmate population projections, JFA Associates LLC., which have been unpredictably overstated this fiscal year. Historically, the department's population projections from JFA have been generally accurate, within 2 percent of the actual inmate population over a 12-month period. However, recent JFA's projections are 8 percent higher than the actual population. Therefore, the department is not completely relying on JFA's projections to provide accurate information other than their rate of growth from where the department is now.

The department has internally revised the inmate population projections by applying the same or a similar rate of growth to the projections based on where the department is now. As a result, reaching capacity is predicted to happen in FY2011. The major reason for the change is that the department has actually seen a decline in population rather than an increase so that where the population projections start is even lower than the starting place was at the beginning of FY2007. The department will be receiving updated population projections from JFA by June 30, 2007.

Long-term Planning for Bed Space

The legislature's "politicized process" of the issue regarding the location of prisons includes the decision after the riot to build small prisons in rural areas all around the state that do not lend themselves to economies of scale. In the past, the legislature's involvement played a significant role in the decision regarding the location and housing of inmates in Cibola County, Torrance County Santa Fe County, Lea County, Guadalupe County and Clayton. Currently, the legislature's involvement is playing a significant role in the decision regarding the location of any expansion to the prison system. The report's recommendations regarding statutory changes do not fully address this issue.

The Department acknowledges there has been a disjointed approach to prison planning and commits to commissioning a study for this purpose. In the interim, the department plans to continue to populate the Camino Nuevo Correctional Center for female offenders and for male offenders, continue to populate Springer and Clayton. And, when the time is appropriate and in order to achieve better economies of scale, the Department expects to lease additional bed space at existing facilities (e.g. Guadalupe County Correctional Facility, Lea County Correctional Facility) for male offenders.

Unless and until the Springer Correctional Center is expanded, it will never lend itself to an economy of scale. However, part of the Legislature's concern once the Department

obtained the facility was to ensure that every existing employee received a Department or other state job. Again, at the time, it only makes sense for the Department to utilize the facility in order to reduce overcrowding and reduce the possibility of litigation by inmates, such as re-activating the Duran consent decree (as to the surviving provisions that address overcrowding) and potential ACLU litigation.

The Department agrees with removing restrictions on prison locations set out in statute. Although the Department has no strong objections, there appears to be no need to repeal the statutory authority that allows the Department to use special funds (i.e., permanent fund land income) to acquire prisons.

FOOD SERVICE

LFC FINDING: IMPROVED MONITORING OF FOOD SERVICE CONTRACTS COULD REDUCE COSTS AND INCREASE DEMONSTRATED QUALITY.

LFC Finding: The Aramark contract provisions are generally structured in the best interest of the department.

NMCD Response:

The Safety Programs Manager will be the custodian of the monthly food service inspections and will meet monthly with each of the private food providers to discuss issues and initiate corrective action for ongoing or common facility issues. Information from these meetings will then be distributed to all inspectors. (Via e-mail)

LFC Finding: The department meals call for 3,400 calories per day for an inmate, which is more than comparable entities and makes meals more expensive.

NMCD Response:

Food is also very important to the security and safety of a prison. The calorie count of 3,400 calories per day required by the Department is a contributing factor in the cost of meals. This calorie count is necessary to serve a southwest style meal which is nutritionally adequate and transportable.

There are three major reasons for the difference of the cost of meals versus other entities: 1) this was the lowest price offered in a competitive bid process; 2) meal costs are part of the per diem of private prisons; and 3) the delivery system is not as complex in a private facility versus a public facility. Private facilities were designed differently so that there is no additional cost for delivery of meals considering meals are prepared on-site. However, for public facilities, the food vendor prepares food in a central kitchen and delivers to correctional units. Employees who enter high security prisons are more costly than average food service workers and must stand by until the meal is consumed. (labor cost)

To address economies of scale, the contract was set up so that the vendor could absorb the cost/loss at small facilities and remote locations where not enough meals are served to pay for the operation. (e.g. Roswell Correctional Center)

The private prison food cost on the report does not take into account the coordinating management, and the dietician that are required for a statewide food service operation that serves approximately 10,000 meals a day.

LFC Finding: Lack of consistent food count policies and ineffective monitoring tools may result in overpayments.

NMCD Response:

Facility meal billings need to be looked at a little closer. The details of how the billings are established are important. For example if a sack lunch is made and charged and the facility uses population count for billing, it could result in a “double billing” when only one meal is consumed. Special diets, officer meals, medical snacks, special details, and transports, could also account for some of what appears to be excessive charges.

In order to keep better track of these details, Adult Prisons and the Training Academy are in the process of developing and implementing a standard counting system and form for meals served that can be easily audited and/or reconciled.

LFC Finding: The department does not regularly monitor or evaluate Aramark contract performance or enforce sanctions.

NMCD Response:

Facility personnel will conduct monthly inspections and the Safety Programs Administrator will perform an annual inspection for both public institution and the training academy food service facilities/vendors. The inspection form will be re-developed and broken into three parts.

- 1. Food safety/security**
- 2. American Correctional Association standards**
- 3. Contract compliance**

Training of all staff assigned to the inspection team will be conducted on an annual basis or as necessary for new inspectors. The safety programs manager will be the custodian of the monthly food service inspections and will meet monthly with each of the private food providers to discuss issues and initiate corrective action for ongoing or common facility issues. Information from these meetings will then be distributed to all inspectors.

QUALITY ASSURANCE

LFC FINDING: THE DEPARTMENT ENSURES BASIC COMPLIANCE WITH POLICIES BUT COULD IMPROVE PRISON OPERATIONS FURTHER BY INCREASING ITS FOCUS ON PERFORMANCE.

LFC Finding: The department ensures basic compliance with policies but could improve prison operations further by increasing its focus on performance.

NMCD Response: Due to the complexity of the prison operations, the Department will move toward performance standards in conjunction with and as the American Correctional Association moves in the direction of compliance standards. The Department will also look to enhance our performance-based measures and sanctions for lack of performance.

- **LFC Finding:** *The department does not measure or monitor performance in key aspects of prison operations such as its inmate classification system.*

NMCD Response:

The NMCD acknowledges the lack of performance-based measures in the key aspects of the operations of our prisons. The Department is currently in the process of restructuring a Deputy Director position that will be responsible for compliance and monitoring at both private and public facilities. This position will coordinate with other staff (Classification Bureau) in order to ensure compliance and improve performance measures. We will provide monitoring and training to staff in order to accomplish this.

The Department is currently in contract negotiations with a new medical vendor with whom we are holding accountable for maintaining low vacancy rates. The Department agrees that there should be an automatic deduction penalty for unfilled mandatory positions.

LFC Finding: The department has implemented an extensive quality assurance (QA) process to ensure basic compliance with policy and the American Correctional Association (ACA) accrediting standards.

NMCD Response: The Department is in the process of restructuring our quality assurance office by designating a deputy director who will be in charge of compliance and monitoring at both private and public facilities. This position will coordinate with other department and private facility staff in order to ensure and enforce compliance, and improve performance measures to include a focus on staffing levels at private facilities. The oversight process will include recommended sanctions for not meeting certain requirements in the contracts. We will, as a Department, provide monitoring and training in order to implement these improvements.

LFC Findings: Central office does not always use QA information to improve compliance or monitor performance of public and private prisons. The department could increase efficiencies by integrating contract monitoring criteria with key compliance audits of private prisons.

NMCD Response:

The Department recognizes the need for better lines of communication in regards to our contract monitoring and compliance audits. We will review and update the measures along with the restructuring process. We believe our staff has taken appropriate measures by having key central office staff continually visit and monitor our facilities to evaluate quality of life and conditions of confinement by having quarterly warden's meetings, weekly phone calls, frequent visits and peer interaction. We disagree that we do not utilize data obtained to ensure corrective action and to validate information provided. The Department will work in concert with the ACA standards to enhance our performance-based measures.

MEDICAL

LFC FINDING: THE DEPARTMENT NEEDS BETTER OVERSIGHT TO CONTAIN MEDICAL COSTS AND ENSURE THE PROVISION OF ADEQUATE CARE.

In regards to medical costs and adequate medical care for inmates, the Department acknowledges that there are system-wide problems with healthcare delivery. The Department also acknowledges that the key areas of staffing vacancies, and departmental monitoring require a new approach, including new contract requirements, internal resource allocation and legislative funding. Departmental reorganization, the medical RFP and subsequent contract, coupled with the tasks completed and scheduled will serve to address and satisfactorily resolve these issues.

The Department has also made successful efforts in monitoring the Wexford medical contract and has recovered money from them for staffing shortages and improper billings totaling \$159,517. Also, the Department just received Wexford's quarterly report for January, February and March 2007, and will analyze their billings for staffing shortages.

LFC Finding: The quality of inmate medical care varies by facility, however the department has failed to systematically ensure Wexford delivers adequate medical services.

NMCD Response:

NMCD acknowledges that there are system wide problems with health care delivery. The Department also acknowledges that the key areas of staffing vacancies, and departmental monitoring require a new approach, including new contract requirements, internal resource allocation and legislative funding. Departmental reorganization, the medical RFP and subsequent contract, coupled with the tasks completed and scheduled will serve to address and satisfactorily resolve these issues.

- **LFC Finding:** *Wexford's insufficient record keeping, the lack of meaningful and consistent reports and poor communication between Wexford and the Department has limited oversight of access to care, particularly for off-site specialty care.*

NMCD Response:

NMCD acknowledges that the record keeping has been inadequate and requires compliance with national and community standards. This will be overseen by CQI studies coupled with increased departmental oversight. The new contract will stipulate timely reports and impose penalties for non-compliance.

- **LFC Finding:** *The Department's lack of a medical director during part of 2006 greatly compromised its oversight responsibility for quality of care.*

NMCD Response:

Effective May 2007, the NMCD has hired Stephen Vaughn, M.D. as its medical director. He is in transition and will assume full-time duties effective June 14, 2007.

- **LFC Finding:** *Improved monitoring of inmate's access to care and addressing complaints is needed.*

NMCD Response:

The new medical director's responsibilities will include providing clinical oversight of the contractor's performance and attending the off-site referral ("collegial review") meetings and the Hepatitis C Treatment Review Committee (TRC) meetings. He will also be responsible for conducting regular provider meetings, Pharmacy and Therapeutics Committee meetings between NMCD Health Services Bureau and the medical contract vendor. Concerning electronic medical records (EMR), the NMCD is exploring linking with existing EMR's in other state entities, specifically UNM (Power-chart) and/or pending EMR chosen by the Department of Health. These explorations are preliminary in nature, but will take a "strategic view" of the best long-term interests of the state.

- **LFC Finding:** *Corrections Department oversight and the quality improvement program have failed to identify problems in a timely fashion.*

NMCD Response:

The Department has proposed reorganization administratively (both for Health Services and other contract monitoring) specifically addresses this concern. New positions and reassigned duties, with a combined focus on problem recognition and solutions, will be an integral part of departmental oversight. NMCD Health Services Bureau will be updating the current auditing tools and will conduct regular site audits on delivery of health care.

- **LFC Finding:** *Wexford's chronic illness program fails to meet national standards, resulting in poor medical outcomes for inmates.*

NMCD Response:

NMCD acknowledges that the Chronic Disease Management program has been inadequate and has so informed the new medical contractor. The expectation is that this shall substantially improve as this is the "hub" of any well-functioning medical care delivery system.

LFC Finding: The department has not effectively monitored the cost of medical services or enforced key contract provisions such as staffing requirements.

NMCD Response:

The Department has made successful efforts in monitoring the Wexford contract recovering money from Wexford for staffing shortages and improper billings. The Department has recovered \$35,000 in staffing shortages for psychiatrists and \$53,517 in staffing shortages for other positions from June 2005 through December 2006. The Department also recovered approximately \$71,000 from Wexford for improper billings (double billing) on Camino Nuevo Correctional Center inmates. Also, the Department just received Wexford's quarterly report for January, February and March 2007, and will analyze the bill for staffing shortages.

- **LFC Finding:** *The contract with Wexford provides for an automatic price increase, regardless of performance or justification for increased medical costs.*

NMCD Response:

The Legislative Finance Committee does not like CPI increases, although the report seems to suggest that for the medical contract, the inflationary increase should be limited to the

CPI, but not 2 percent in excess of CPI. If we don't use it, it is difficult to get a long-term contract at the Department's discretion. In other words, we would have to allow the contractor to terminate without cause with perhaps 180 days written notice.

Clarifying the definition of and procedure for collecting “paybacks” for failure to meet staffing levels will address vacancies in the medical contract. The Department will enforce contract provisions for collecting "paybacks" by utilizing a Deputy Director made responsible for specifically monitoring contract compliance. Also, the Department will require Contractors to submit monthly staffing reports.

- **LFC Finding:** *The department does not regularly obtain information about Wexford medical spending to ensure the adequacy of the contract amount and prevent inappropriate cost containment that could impact inmate care.*

NMCD Response:

The Department is currently negotiating a new contract (with a new vendor) that will eliminate vacancy savings, and spells out clear penalties and shall be enforced. Final staffing pattern is under negotiation but will increase by at least 15%.

Because of penalty clauses, the new medical contractor will have a substantial vested interest in compliance with negotiated staffing patterns.

NMCD and new medical contractor will jointly address and assure that this is improved with a focus on “medical outcomes.” NMCD will mandate and assure that this is up to date and reports are rendered in a timely manner and lead to appropriately focused Corrective Action Plans.

- **LFC Finding:** *The department has allowed Wexford to by-pass using local medical providers in some areas, such as Hobbs, which results in increased security and transportation costs for off-site care.*

NMCD Response:

New Mexico has a shortage of consultants throughout the state, particularly in more remote areas. While NMCD acknowledges that contracting with local consultants and decreasing transports is optimal, other options are being explored, namely:

- Increased use of telemedicine for consultant services
- On-site clinics using UNM/community physicians on-site
- Reduction of level of services for certain medically complex patients at remote sites by movement into the Albuquerque area so as to increase access and reduce transport distances.

- **LFC Finding:** *The department lacks adequate staff to oversee a complex and expensive medical system that serves over 6,500 inmates across ten facilities.*

NMCD Response:

NMCD acknowledges with the increasing numbers, medical complexity, and aging of the prison population, coupled with overall greater disease burden, that reorganization and assignment of health services monitoring as an important priority mandates immediate

attention. The NMCD is in the process of reorganization including reporting lines, position reclassifications, and position creation to provide the necessary support.

ADDICTIONS

LFC FINDING: MORE INFORMATION IS NEEDED TO DETERMINE BOTH THE QUALITY AND EFFECTIVENESS OF THE DEPARTMENT'S INPATIENT ADDICTIONS SERVICES.

LFC Finding: The department allocates about 700 beds to therapeutic communities (TC) which serve as residential substance abuse rehabilitation programs.

NMCD Response:

We disagree with the finding that we do not have sufficient dedicated housing units. All New Mexico Therapeutic Communities (TC) do operate in dedicated housing units. Some of these units, due to staffing and treatment space constraints include a "contracted bed population". Contracted beds (originally called "Drug-Free") were part of the Duran Substance Abuse expert's recommendations to continue TC graduates, and individuals waiting for treatment, in positive living environments with some continuity of care programming. TC inmates, in our system, do interact with the general population inmates for many activities including education, food services, recreation etc.

LFC Finding: National evaluations demonstrate that in-prison therapeutic communities can significantly reduce recidivism based on meeting certain program standards.

NMCD Response:

We agree that in-prison Therapeutic Communities can significantly reduce recidivism based on certain program standards.

NMCD Addictions Services does work towards the model and requirements for impacting recidivism with Therapeutic Community programs. Our policy seeks to attract and impact offenders within two years of release, create generally separate units within general populations, utilize standardized program components throughout our TC system, and make recommendations for specific targeted aftercare. We utilize assessments, interviews, and records reviews to screen inappropriate placements and attempt to prioritize the placement of offenders. We also utilize a plethora of approaches within the TC programs to raise inmate's engagement in treatment.

Our efforts are impacted by the following challenges within our overall correctional system:

- 1) Lack of resources at the Reception and Diagnostic Center to conduct extensive addictions assessment and referral to specific addictions programming.
- 2) Housing units and prisons, which by their design and security parameters, do not allow true full separation of Therapeutic Community inmates and programming from general population.
- 3) Population pressures which result in significant transfers of inmates prior to their program completion. This does not allow them to leave from a TC program directly to community aftercare.
- 4) Many TC residents are initially exposed to TC programming, especially many more violent offenders at Level III prisons, and have longer time to release. This again limits those directly transitioning to the community.

5) Limited community and corrections resources to provide intensive TC focused aftercare.

LFC Finding: The department’s TC program meets many, but not all, national standards but the lack of coordinated aftercare programs and other deficiencies may severely limit its overall effectiveness.

NMCD Response:

We disagree with the recommendation of having a formal plan. We have a plan in place to include aftercare programming.

All paroled inmates with substance abuse difficulties are mandated into services. Improving the quality and tracking of these services for TC inmates is important and requires efforts by all the groups mentioned. We have long supported dedicated aftercare services. Besides the Ft. Stanton and Women’s Recovery Academy we also worked with a program for women TC graduates, through Center on Alcoholism, Substance Abuse and Addictions (CASAA) a few years back (it ended with the loss of federal funding).

- **LFC Finding:** *Lack of totally separate housing unit.*

NMCD Response:

We disagree with the finding that we do not have sufficient dedicated housing units. All New Mexico Therapeutic Communities (TC) do operate in dedicated housing units. Some of these units, due to staffing and treatment space constraints include a “contracted bed population”. Contracted beds (originally called drug-free beds) were part of the Duran Consent Decree’s substance abuse expert’s recommendations to continue TC graduates, and individuals waiting for treatment in positive living environments with some continuity of care programming. TC inmates, in our system, do interact with general population inmates for many activities including education, food services, recreation etc.

- **LFC Finding:** *Mixing treatment methodology.*

NMCD Response:

We disagree with the finding that mixed modalities are not effective. Adding critical information, such as infectious disease prevention, and supportive treatment elements (AA/NA, Cognitive Behavioral), to TC programs are part of efforts to improve program effectiveness and are supported by much of the current approaches and research efforts nationally. (DeLeon, 2000) Inclusion of AA/NA, or other 12-step programming, is conducted in all TC programs nationally (in prison and in communities) and most residential treatment in the community. It adapts well to the TC model, and is essential to the ability to provide community continuity of care, especially in a rural state like ours.

Cognitive behavioral approaches are among the best-researched and efficacious modalities for dealing with offenders, criminal thinking, and potential impact on recidivism. These approaches are widely used in TC programs; prison based Moral Reconciliation Therapy (MRT) programs and federal substance abuse treatment programs.

We are currently working with Texas Christian University on integrating and researching “Targeted Interventions for Corrections’ in some of our treatment programs. This is an

attempt to evaluate and utilize state-of-the-art approaches to specific treatment difficulties offenders' face.

- **LFC Finding:** *Lack of routinely paroling/discharging inmates near or at TC graduation.*

NMCD Response:

We disagree with the finding that we do not routinely parole or discharge inmates near or at therapeutic community (TC) graduation.

Department policy prioritizes inmates for TC inclusion with two years or less to release. Classification transfers (mostly related to population control issues) and large TC programs at Level III are the major challenges to releasing inmates closer to TC completion.

TC programming has been demonstrated to have many institutional benefits. Studies report it assists institutional adjustment, reduces violence, reduces disciplinary reports, reduces assaults and improves attendance for correctional staff. Based on the research literature, impacts on recidivism are primarily a function of quality and availability of aftercare. Transfer information is available but due to lack of integration of systems is time consuming and difficult to report. It has not been systematically evaluated.

Department efforts to reduce some of the impact of transfers include CQI efforts to improve programs and their consistency, standardized curriculum guidelines, and availability of TC programming at all Level II facilities and nearly all prison complexes.

- **LFC Finding:** *Transfers among facilities impacts inmates' therapeutic progress and may reduce the TC program's overall effectiveness.*

NMCD Response:

We disagree with the finding that inmate transfers between facilities reduce the overall effectiveness of the TC program.

TC transitional aftercare programs are available at both Ft. Stanton (men) and the Women's Recovery Academy. Department efforts at increasing continuity of care include: Re-entry committees and coordinators at all facilities, community transition coordinators and transitional reporting centers. Addiction Services participates in the Governors Substance Abuse Committee, DWI Leadership Council and Value Options meetings to improve community aftercares services and identify needs

We are developing a pilot project for aftercare of co-occurring inmates in our TC programs with the Behavioral Health Co-occurring State Incentive Grant (COSIG) staff. Close efforts to utilize the AA/NA aftercare networks and faith-based mentoring through the Santa Fe Archdiocese are in place. Lack of community resources in New Mexico is a major factor.

- *LFC Finding: Lack of formal aftercare services.*

NMCD Response:

We disagree with the recommendation of having a formal plan because we already have a plan in place to include aftercare programming.

All paroled inmates with substance abuse difficulties are mandated into services. Improving the quality and tracking of these services for TC inmates is important and requires efforts by all the groups mentioned. We have long supported dedicated aftercare services. Besides the Ft. Stanton and Women's Recovery Academy we also worked with a program for women TC graduates, through Center on Alcoholism, substance abuse and Addictions (CASAA) a few years back (it ended with loss of federal funding).

LFC Finding: The department has not regularly evaluated the quality of services delivered and its recent attempt at quality assurance needs improvements to make reports more useful.

NMCD Response:

We do agree with the finding that our Continuous Quality Improvement (CQI) needs improving along with evaluating the quality of services rendered.

Department focus has been on program expansion to serve greatly expanding substance abuse offender population. Quality evaluation has been a recent effort due to staffing limitations. CQI currently focuses on assuring continuity of treatment, standardization of treatment approaches, technical assistance to new programs and compliance with existing policies. CQI can, as stated in the recommendations, expand and improve. The current process involves direct observation and review of files and treatment processes, as well as interviews with staff and clients. It is not based simply on data reported by program administrators.

CQI narrative reports are a summary. Underlying data is available and may be shared with program management, and departmental evaluators. Follow-up 30 day reports are also planned for response to corrective actions.

Many aspects of the current CQI process was based on observation and participation in the State of California Pacific Southwest Addiction Technology Transfer Centers approach to "Best Practice CQI" conducted within their extensive prison TC system. It also utilizes a standardized approach to the core elements of Therapeutic Communities based on TC expert practice.

Lack of computerized, integrated data collection is a major obstacle to program evaluation and quality improvement information. We will discuss this at length with our IT division.

- *LFC Finding: More information is needed to determine both the quality and effectiveness of the department's inpatient addictions services.*

NMCD Response:

NMCD acknowledges the current lack of quality performance measures for the Department's inpatient addiction services and we agree that the CQI process can be improved through data efficacy review and data reporting which would be a reasonable enhancement to the process. The TC program performance information is available and can be reported through improved data collection, computerization and integration of existing systems. The effectiveness of the Department's inpatient addictions services remain intact due to studies that report it assists in institutional adjustment, reduces

violence, reduces disciplinary reports, reduces assaults and improves attendance for correctional staff.

LFC Finding: Addictions services does not track the most basic information needed to assess program effectiveness, such as the percentage of inmates completing the inpatient program.

NMCD Response:

We do agree with the finding that we do not track the effectiveness of the program; however our program termination is effective.

Drug Use: Information regarding urinalysis testing is kept in program areas. It has also been a part of the CQI process. It is not currently reported by the Addictions Bureau as overall data, but can be easily tracked and provided. It is also reported yearly for graduates of Residential Substance Abuse Treatment (RSAT) programs.

Program Termination: The global database, which is highly time consuming and not integrated with other computerized systems, does have information for all program terminations, graduates, transfers, and drug of choice. Reasons for termination are generally violations of major program rules, significantly poor treatment progress or security violations. More extensive breakdowns can be developed, though a reasonable percentage of terminations are certainly expected in any treatment or correctional setting.

Percentage of TC participants completing within 12 month: This information can be available through a time-consuming analysis of the global reports. Due to transfers, we are aware of low percentage graduates within 12 months, especially those entering the Level III Lea County Correctional Facility program. Better systems need to be developed to track this type of data. We will communicate our needs with the Department's IT division.

Average cost per TC participants: We have developed estimates for RSAT program participants based on treatment funding vs. days of treatment provided. Overall statistics would need to be developed with many costs variables established. Cost for treatment is very low compared to community residential when housing/security costs are removed. The Department will look into generating a cost benefit analysis.

Recidivism Rates for TC participants and graduates: We support these efforts to examine "graduates" vs. "participants" especially those completing programming close to release. Alignment with departmental systems and databases as well as integrating data is critical. National experts tie recidivism to continuous time in treatment, release to the community closely following program completion and especially quality aftercare. The Department is planning to implement an offender program module to better track inmate program participation, success and failures.

NMCD Response to LFC Recommendations Regarding Addiction Services:

Recommendation One: We agree with the recommendation of collecting and reporting TC program performance and also tracking the inmate transfers.

Our limited data reviews indicate significant transfer and subsequent TC drop out rates. The CQI process can be improved and data efficacy review and data reporting would be a reasonable enhancement to the process. TC program performance information is available

and can be reported through improved data collection, computerization and integration of existing systems. The Department will discuss an approach to better collection of data.

Recommendation Two: We disagree with the recommendation of freezing department funding.

Any disruption in funding would likely result in an extensive period of time to rebuild workforce and implement programs. New Mexico faces major substance abuse workforce issues and trained staff to work in prisons are quite difficult to find.

MENTAL HEALTH

LFC FINDING: THE DEPARTMENT DOES NOT REGULARLY ASSESS THE IMPACT OF MENTAL HEALTH SERVICES ON INMATES' ABILITY TO FUNCTION IN A PRISON ENVIRONMENT OR SOCIETY UPON RELEASE.

LFC Finding: The department's extensive mental health quality assurance activities focus on compliance with policies and are not used by management to monitor performance.

NMCD Response:

We agree that the QA audit tool needs modification and reduction. The QA audit tool was designed and implemented during the years that NMCD was under Duran Consent Decree reporting requirements. At the present time, the facility managers audit 96 areas in 30 patient charts. This process takes 8 to 10 hours per month. Since many of these items are routinely at 100% compliance, this time investment is excessive, and the content areas of the areas queried needs overhaul. The number of items in the QA audit tool will be reduced, while simultaneously refining the quality and relevance of the content areas audited. Content areas of the new audit tool will focus on timely access to mental health care as well as needed assessment of the clinical effectiveness of care in improving inmate/patient functioning. It is anticipated that the new audit tool will yield information that is more clinically relevant to monitoring the outcome of treatment, quality of services provided by mental health staff, and needs for improvement in service delivery. Information derived from the new audit tool will be made accessible to wardens and other Central Office management staff at quarterly performance meetings. The newly designed QA audit tool should be completed no later than October 1, 2007.

LFC Finding: The department lacks meaningful performance and outcome data to ensure mental health services.

NMCD Response:

The Mental Health Services Bureau needs to begin collecting and reporting data on four key statistical areas relating to suicidality, crisis intervention, and return to MHTC. We agree with this finding, but need to point out that 3 of the 4 measures are reported monthly, and we have been doing so for many years in the Mental Health Monthly Statistical Reports.

The LFC audit report refers frequently to the Mental Health Services Bureau Quarterly Quality Assurance Report, but there is no mention of the Monthly Mental Health Services Bureau Statistical Report. This monthly document provides approximately 50 to 80 pages of monthly statistical data. It includes data from each facility on three of the four measures recommended. The three data points reported monthly are the suicide rate; rate of suicide attempts resulting in injuries; and the percent of inmates discharged from the Mental Health Treatment Center (MHTC) who return within 6 months. We are not currently reporting the fourth data point, which is the percent of inmates discharged from MHTC who do not require crisis intervention services within 6 months. We agree that this is valuable information to collect and analyze. We will add that reporting measure no later than July 1, 2007.

The NMCD Mental Health Services Bureau should begin work with the Behavioral Health Collaborative and national experts with the goal of developing a methodology for

demonstrating whether inmates receiving mental health services show improved functioning in a prison environment. Seek outside training to assist the Mental Health Services Bureau to develop continuous quality improvement (CQI) strategies and QA best practices. We agree to conduct a study of this observation.

For a 20-year period, the Mental Health Services Bureau was accustomed to collecting and analyzing data in compliance with the dictates of the Duran Consent Decree. In that period, there has been considerable change in the way in which behavioral health care data is collected and utilized by managed care organizations, and other third-party payers of such services, including state and federal government. The MHS Bureau will immediately begin to seek information regarding state-of-the-art methodology related to the collection and analysis of behavioral health data. The goal of the planned modification in data collection will be to find key measures that reliably convey the effectiveness of the services provided. Such information will enable the Mental Health Services Bureau to determine efficacy of treatment, and to modify practice and service delivery to improve patient outcomes. We will begin to seek trainers to come on site to help us to develop in these areas, and/or will attend national conferences that include needed educational trainings in these areas.

LFC Finding: Inmates generally have sufficient access to behavioral health services, but better monitoring is needed to ensure the effectiveness of services.

NMCD Response:

NMCD acknowledges that the Department's Mental Health Bureau should begin to work with the Behavioral Health Collaborative and national experts with the goal of developing methodology for demonstrating whether inmates receiving mental health (MH) services demonstrate improved functioning in a prison environment. The Department's Addictions Services also acknowledges that quality evaluation has been a recent effort due to staffing limitations, but agrees that, as in the recommendations, can be expanded and improved.

- *LFC Finding: The department does not regularly assess the impact of mental health services on inmates' ability to function in a prison environment or society upon release.*

NMCD Response:

NMCD acknowledges that the Department's Mental Health Bureau should begin to work with the Behavioral Health Collaborative and national experts with the goal of developing methodology for demonstrating whether inmates receiving MH services demonstrate improved functioning in a prison environment. We will initiate this collaborative process and will seek trainers and/or national conferences to attend to meet this need.

LFC Finding: The department lacks needed bed space for acute mental health care for female inmates.

NMCD Response:

The Department disagrees with this finding to utilize Camino Nuevo as a mental health unit for women. The Camino facility is a Level I and II low custody facility. Interfacing it with women who have serious mental health needs would compromise the security of the facility. The Department would have to install security fences and lighting and have CCA

hire more staff to manage that particular unit. The Department agrees to look at creating a mental health unit to accommodate more women at the New Mexico Women's Facility in Grants. Currently that facility has retrofitted five cells to handle the mentally ill inmates.

LFC Finding: State law requires the department to perform diagnostic evaluations of county jail inmates, taking up valuable bed space for unknown results.

NMCD Response:

The Department agrees with this recommendation but we also understand that it is not realistic. It would require a statutory change. In the meantime, county jails and judges would most likely not want to keep these inmates in their jails any longer than necessary due to the cost. It could also be difficult for some counties to find licensed professionals to conduct these diagnostic evaluations.

NMCD Responses – Solutions
To Critical Findings of the LFC Audit– From the Text of Spencer-Anno Report
By John Robertson, M.D.
Cited problem is “underlined”
NMCD response follows in text that is “*Italic-Bold*”.

Inadequate oversight and staffing for contract compliance
Central Office (*page 2 Spencer-Anno report*)

NMCD acknowledges with the increasing numbers, medical complexity and aging of the prison population, coupled with overall greater disease burden that reorganization and assignment of health services monitoring as an important priority mandates immediate attention. The NMCD is in the process of reorganization including reporting lines, position reclassifications and position creation to provide the necessary support to assure that

Nursing treatment protocols

Will review and develop as appropriate with the new medical contractor.

Chronic Care Tracking System-Hepatitis C

Re-evaluation of system needs, and meetings set up with Dr. Arora and UNM faculty to properly coordinate care to this population of inmates.

Intake Vaccinations at CNMCF (Reception and Diagnostic Center)

Will address in the new contract.

Audit tools

Will develop at central office level and utilize existing models as appropriate.

Tele-psychiatry

Refer to Dr. Collins Response (Appendix 2)

MRSA reporting consistency

Will rely on DOH for direction and development of a consistent tracking and reporting protocol

Health Services – Monthly Reports

Addressed in RFP and new medical contract

Contract review

Vacancy filling & Penalties

Physician-ACLS qualifications

Meetings & Minutes

Sick Call

HIV & HCV labs

PT & T Committee

EMR

HIV and the DOH

The above will all become part of contract monitoring and compliance assessment.

Off-site Specialty Consults

NMCD acknowledges the importance of off-site services and the need for more rigorous oversight. This will be part of the monitoring duties of the reorganized health services.

Psychiatric Consultations

Refer to Dr. Collins response (Appendix 2)

Contract Monitoring

See prior information on Health Services reorganization and new contract requirements.

Equipment

NMCD acknowledges the need to assure appropriate supplies and equipment. NMCD will assure that all equipment is certified as required.

Programs & Staffing

Refer to new staffing pattern.. Re: Physical therapist may be restricted to fewer sites and care of inmates with these requirements in Santa Fe, CNMCF or Las Cruces.

NMCD agrees to review and update the detoxification policy and bring it up to date.

HCV program is being reorganized and the sites where treatment will be delivered will be restricted.

Re: Psychiatry, see new requirements per RFP

Chronic care log...NMCD acknowledges that these are out of date and lacking in accuracy. This will be a high priority for the new medical contractor and the NMCD will audit to assure compliance with this important management tool.

Summary of points in the Spencer-Anno Report (Cite pages 44 – 48, Points 1-28)

“Final Conclusions and Recommendations”

1. NMCD Medical Director
 - *Effective July, 2007 Stephen Vaughn, Ph.D., M.D. will assume full-time duties in this position providing Health Services the necessary leadership. (Attach updated CV for LFC review)*
2. NMCD-Wexford Contract shortfalls concerning:
 - Meetings including statewide with NMCD & site and regional staff, Pharmacy and Therapeutics Committee
 - Electronic Medical record (EMR)
 - Penalties for staffing vacancies
 - *These issues (excepting the EMR) are all addressed in the RFP and will be specifically spelled out in the new medical contract, effective July 1, 2007.*
 - *Concerning EMR, the NMCD is exploring linking with existing EMRs in other state entities, specifically UNM (Powerchart) and/or the pending EMR chosen by the Department of Health. These explorations are preliminary in nature, but will take a “strategic view” of the best long-term interests of the state.*
3. Staffing Issues in current contract
 - *NMCD acknowledges that the existing contract staffing levels are not adequate for present Departmental needs. This is addressed in the new RFP and is currently in negotiation. (Attach here Staffing matrix proposal)*
4. Vacancy rate- retention issues and penalty enforcement
 - *See answer above, this is addressed in the RFP.*
5. Communication issues and monitoring

Options for EMR as well as improved computer support and electronic information exchange is currently being addressed in contract negotiations

- *This is under review and will be an on-going project and focus for the first year of the contract*
6. Continuous Quality Improvement (CQI)
- *The NMCD's proposed reorganization administratively (both for Health Services and other contract monitoring) specifically addresses this concern. New positions and reassigned duties with a combined focus on problem recognition and solutions will be an integral part of departmental oversight.*
- (Insert here – Reorg information plan and information)*
7. Documentation and the Intake Process
- *The NMCD acknowledges that the RDC process is critical to successful delivery of health services. Under the director of its new Medical director, Dr. Vaughn, with assistance from Dr. Devendra Singh (who set up the highly effective and efficient RDC process at WNMCF in the 1980's) the department will coordinate with its new medical vendor to improve and address the process as an early priority.*
8. Sick call tracking & documentation
- *The NMCD agrees that this requires system-wide standardization and will mandate this as a necessary CQI activity by the medical contractor. The format will be subject to departmental approval and will be monitored for accuracy of reports and subsequent improvements made based upon the data.*
9. Sick call triage (Provider levels)
- *The department concurs that RN and mid-levels are the appropriate health care staff to conduct sick call and triage patients. This is to be negotiated in the new contract and will be monitored by the NMCD to assure compliance.*
10. Sick call schedule-Frequency
- *NMCD acknowledges the NCCHC requirements that sick call be available 7 days/week and will include in monitoring parameters timeliness of access to a higher level provider for inmates whose complaints can no be simply addressed by nursing protocols.*
 - *Concerning expertise level for conducting sick call the NMCD agrees that a RN should conduct these and will negotiate this into the new contract. The new staffing level will cover this requirement.*

11. Sick call “No-shows”
 - *The department concurs that no-shows should be followed up and will work to assure that this is the standard operating procedure under the new contract.*

12. Chronic disease management-CQI and Oversight
 - *NMCD will make this a primary focus of overall system oversight and management. This will evolve with the new contract requirements, coupled with the reorganization of departmental oversight.*

- 13 & 14. Pneumococcal pneumonia (“Pneumovax”) vaccination
Measles, Mumps and Rubella (MMR) vaccine
 - *The NMCD will commit to these as standard operations include this in the new contract and track compliance (rate of vaccination offering and delivery) as an “outcome measure”.*

15. & 16. Off-site referral process
Consultants, access and remote sites
 - *Various options will be discussed with the medical contractor, other state entities (UNM) and local physician groups to best structure a system to provide access in the most efficient and effective manner. Telemedicine (multiple subspecialties) is being explored as an option as are on-site specialty clinics.*

17. HIV screening & Management – Joint Powers Agreement with the DOH
 - *Will rely on DOH for direction and maintenance of this important joint health care mission. NMCD commits to audit outcomes (clinical parameters) as part of its CQI and to seek continued funding from the legislature as needed to serve this sub-population of inmates.*

18. Hepatitis C Infection – Screening, treatment and management
 - *With the new medical contract, effective July, 2007 the department will enter into direct discussions with the UNM – ECHO program to assure a more effective collaboration. It is anticipated that this may require changes in operating procedures of the programs, new staffing assignments and changes in policy. The department is confident that this can be satisfactorily restructured and increase access and completed treatment. Once established, this will be a focus for CQI and internal monitoring.*

19. Detoxification Protocol
- *The NMCD will commit to review and revise this protocol to assure compliance with national and community standards as appropriate for prisons.*
20. Geriatric Housing Unit CNMCF – Space and equipment needs system wide
- *The NMCD agrees to address this in the new contract as well as with state entities and the legislature so as to best provide care to this growing sub-population of the NMCD.*
 - *During the contract negotiations and the first months of the contract the department will perform an equipment inventory and develop a plan for maintenance and upgrades as required by clinical need.*
21. Grievance process
- *The NMCD will commit to review, revise and audit as appropriate the medical grievance process. The department will work with the medical contractor and draw on best practices for tracking and assuring that the grievance process is responsive and creditable*
22. & 23. Dietitian counseling/patient education
ADA diets for diabetic patients
- *This issue will be jointly addressed with the new medical contractor as well as the departmental food services contractor.*
24. Annual exams (Dilated funduscopy examination) for diabetic retinopathy
- *The department concurs that annual DFE is the community standard of care for diabetics and will incorporate this standard into policy as well as an “outcome” measure in monitoring for contract compliance.*
25. Coordination at LCCF between mental health and Psychiatry
- *Refer to Dr. Collins response (Appendix 2)*
26. Physical Therapy availability and access
- *The department concurs that physical therapy access and availability is an important aspect of health care. Because of the statewide shortage of qualified therapists, the department will undertake to study with the new contractor a systems approach to assure that all medical necessary physical therapy is available to inmates who require this care. Options include consolidation of inmates with special needs, local contracts and a traveling physical therapist.*

27. NMWCF – Monthly reports

- *The department concurs that under the current contract reports have been inadequate in both frequency and content. This will be addressed in the new contract and appropriately enforced.*

28. Site nursing assignments for specialty services, i.e. HCV, Chronic care

The department concurs that continuity and efficiency are best achieved by specific assignments of responsibility. As noted in our response to item # 18, HCV is being specifically reevaluated. Based on final determination of site missions, staffing and system needs,, the NMCD will develop and institute the necessary changes to assure programmatic success.

NMCD Responses to Dr. Anno-Spencer's Findings

By Dan Collins, Ph.D.

NMCD Psychiatry Services response to LFC audit report

Finding- Technical problems with telemedicine equipment at LCCF. **We agree there have been technical problems in the past.**

Recommendation- We feel most of these technical problems have been fixed. LCCF and most other telepsychiatry facilities received major equipment upgrades recently including new polcom units and 42-inch monitors. There have been occasional technical problems periodically with telepsychiatry, which is a new treatment modality that relies heavily on technology such as the polycom unit, the monitor and the telecommunication lines all working well. All technical problems are reported to the Department's Health Service Bureau Clinical Director of Psychiatry using the NMCD telepsychiatry reporting form. If a telepsychiatry clinic does not occur due to technical problems, a lockdown of the facility or any other reasons the telepsychiatry clinic is rescheduled for a later date, usually the next week or sooner.

NMCD has a telepsychiatry monitoring process in place. All NMCD documents regarding the telepsychiatry clinic monitoring process are kept at the Central Office Health Services Bureau with the NMCD Clinical Director of Psychiatry. It is unclear if the LFC medical auditors knew about this telepsychiatry clinic monitoring process since the documents are kept by NMCD in a binder at Central Office, not at each facility.

Finding- At LCCF, the "Geo Mental Health Director has only recently begun to track the frequency of cancellations of the psychiatric clinics. This should be tracked regularly so the problem can be addressed by Wexford." "Obviously, a better system needs to be in place to ensure that psychiatric patients are followed on a timely basis." **We disagree that this is the process for scheduling and monitoring Psychiatry Chronic Care Clinics at LCCF.**

Recommendation-There is a system in place at LCCF that was not mentioned in the LFC auditors report. Psychiatry Chronic Care Clinic scheduling is not the responsibility of the Geo Mental Health Manager. The Geo staff does not make the actual psychiatry appointments. The GEO mental health log referred to in the LFC audit report is used for mental health caseloads, not scheduling psychiatry chronic clinic appointments.

Wexford is responsible for all Psychiatry Chronic Care Clinic scheduling and coordination of the on-site psychiatry chronic care clinics and telepsychiatry clinics. It is unclear if the LFC medical auditors actually reviewed the Wexford Psychiatry Chronic Care Clinic scheduling logs and the Wexford Psychiatry Chronic Clinic Master Log. Reviewing the Geo Mental Health records or logs will not provide up to date information whether the inmates were re-scheduled or not in the psychiatry chronic care clinic.

Wexford medical staff, not Geo Mental Health staff, fills out the cancellation data. The frequency of cancellations is tracked using the Tele-Psychiatry Consultation reporting form

which includes data on number of patients refusing appointments, any no shows for appointments and rescheduled patients due to any cause.

Finding- At LCCF, telepsychiatrists “came on site once last year, not twice as required by contract.” **We agree there have been telepsychiatrist facility visit problems in the past.**

Recommendation-Wexford agreed verbally to have the telepsychiatrists do site visits at each facility they cover every six months and hold onsite psychiatry clinics. This has been a compliance issue with Wexford. The times when this occurred the Department had to repeatedly request Wexford to have the telepsychiatrists come to New Mexico to make facility site visits and hold on-site psychiatry clinics. The new RFP and contract requires all in-state telepsychiatrists and every three-month on-site psychiatry clinic visits.

Finding- At CNMCF, “psychiatric care is provided by Wexford via telemedicine. **We disagree at CNMCF psychiatric care is provided by Wexford via telemedicine.**

Recommendation- The statement that at CNMCF-“psychiatric care is provided by Wexford via telemedicine” is not accurate. At CNMCF all psychiatrists are on-site psychiatrists. There are no telepsychiatry clinics at the CNMCF facility.

Finding-Better Coordination of Care between Mental Health staff and Psychiatry staff. **We agree partially, such as LCCF and GCCF facilities where the Department has found a need to improve the coordination of psychiatric and mental health care.**

Recommendation- Mental Health staff is to attend telepsychiatry encounters with the telepsychiatrists, each session, usually before and after the telepsychiatry session. These meetings are to occur frequently and regularly for case staffing, treatment planning and discussion of difficult cases. Facilities, which have on-site psychiatrists, the psychiatrists and the mental health staff, hold regular meetings in person to coordinate patient care. At the Mental Health Treatment Center, Mental Health and Psychiatry staff meets weekly on Tuesdays from 9am to 12 pm for treatment team meetings to coordinate care of all patients.

LCCF has had compliance issues with Geo Mental Health staff attending telepsychiatry encounters with the telepsychiatrists. Problems of this nature have been noted before during psychiatry audits. Recently the Geo Mental Health staff and Wexford medical staff at LCCF and GCCF have been reminded of the need for better coordination of care. The change in the next contract to mandatory site visits every three months by the telepsychiatrists and in-state telepsychiatrists will improve greatly the coordination or care between Geo Mental Health staff and psychiatrists.

Quality improvement issues with Psychiatry and Mental Health are coordinated and reviewed jointly at the NMCD Central Office level by the NMCD Clinical Director of Psychiatry and the NMCD Mental Health Bureau Chief. The NMCD Clinical Director of Psychiatry and the NMCD

Mental Health Bureau Chief are graduates of the same post-doctoral training program and have an excellent working relationship.

Finding –“The department has not effectively monitored the cost of medical services or enforced key contract provisions such as staffing requirements”. **We disagree regarding the psychiatry contract monitoring portion.**

Recommendations- Psychiatry services provided by Wexford have been closely monitored. Psychiatry physician and psychiatry nurse FTE reports with vacancies and specific type of staff positions vacant or filled, not simply aggregate FTEs, have been received monthly from Wexford for every month since the beginning of the contract.(Since July 1, 2004) These forms are placed in a binder at Central Office.

Meetings with the Clinical Director of psychiatry and Wexford Corporate and Regional Office staff are documented in writing using the NMCD Psychiatry Contract Monitoring form which documents compliance or problems with the following key areas: FTE or staffing issues (Psychiatrists/Nurses), Clinical issues, Corrective action plans, Pharmacy/psychotropic medications, Therapeutic restraint/seclusion, Telepsychiatry, CQI, and the Alternative Placement Area. These forms are placed in a binder at Central Office.

The Department fined Wexford \$35,000 for Psychiatrist staffing vacancies early in the contract when this occurred which significantly improved the overall psychiatry staffing for the remainder of the contract.

Finding-“The department lacks adequate staff to oversee a complex and expensive medical system that serves over 6,500 inmates across ten facilities.” **We agree regarding the NMCD Clinical Director of Psychiatry position.**

Recommendation- The position for the NMCD Clinical Director of Psychiatry will increase from 0.75 FTE to full time starting June 4, 2007.