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EXECUTIVE SUMMARY

Introduction

This year marks the tenth anniversary of the Correctional Medical Authority's (authority) surveys of both the medical and mental health care provided in Florida's prisons. During this decade, the Department of Corrections (department) implemented major changes to better ensure inmates received a basic level of care. The authority assisted in many of those activities and also made funding recommendations to the Governor and the Legislature. The interaction between the authority and the department has developed into a system of checks and balances, ensuring inmates in Florida receive a constitutionally adequate level of care consistent with minimum standards accepted in the community at large.

This year the authority continued to improve the processes by which it surveys prison facilities. Survey instruments were reviewed and updated to better assess the health care system. Additionally, as a part of the Osterback revised offer of judgment, the authority completed its first year of oversight of facilities designated to house inmates whose classification is close management.

FY 2002-2003 Surveys

A critical element of the authority's statutory direction is the comprehensive review and assessment of health care services provided at each of Florida's prisons. The authority conducted 19 surveys of institutional health care during FY 2002-2003. At eight institutions, the private sector provided health care services.

Health care surveys are divided into three components: medical, dental and mental health care. All components include reviews of clinical care, supportive systems, and related administrative functions. Individual institutional survey reports may be found on the authority's website at: http://www.doh.state.fl.us/cma/reports.

Upon receipt of the formal survey report, statutes require the department to prepare a corrective action plan. The plan must identify the corrective action the institution plans to take to address the findings identified in the survey report. Generally about seven months after the survey, the authority conducts a site visit to review the progress made toward correcting the deficiencies identified in the survey report. Issues that are not corrected remain open pending further review. The authority continues to monitor those issues through on-site or off-site evaluation until they are resolved, or until the next formal survey of the facility.

During FY 2002-2003, the authority encountered numerous institutions that could not provide evidence of correction of cited deficiencies during the first, second or even third corrective action assessment. Only one institution corrected all survey findings by the first assessment. One institution surveyed during FY 2000-2001 required six assessments before all outstanding issues were adequately addressed. Only fifty percent of institutions involved in the corrective action process were determined to have corrected all deficiencies during the fiscal year so that follow-up monitoring by the authority could be discontinued. At half of the remaining institutions, multiple evaluations were conducted. One institution remains open after four assessments. The need to re-monitor institutions with uncorrected survey findings resulted in the authority's conducting 46 corrective action evaluations during the fiscal year. The authority believes the necessity for repeated reviews represents an ineffective use of both authority and institutional resources. The authority recommends the department implement a process whereby institutions successfully remedy cited deficiencies at the first review.

Topics of Concern

This section of the report discusses areas of concern identified through the survey process or other oversight activities. Topics are outlined briefly below. More information may be found in the body of the report.

Episodic Care

There is no departmental requirement or process that ensures a review of the decisions made by lower level health care providers at sick-call and emergency encounters. The authority recommends a higher-level clinician conduct a clinical and documentation review of the health care encounters performed by correctional medical technicians and licensed practical nurses. That review should be documented.

Medication Administration

Authority surveys found deficiencies in the process of administering medication that include: failure to document medication orders by signature, date, and time; failure to transcribe medication orders by the end of the shift during which they were ordered; and failure to conduct oral cavity checks when administering medication. The authority recommends the department place greater emphasis on documentation requirements for medication orders and performance of oral cavity checks. These checks must be conducted by a staff person, whether security or health care, who is in close proximity to the inmate and on the same side of the pill window as the inmate.

Intrasystem Transfers

To ensure continuity in care, a coordinated process for transferring inmates among institutions is necessary. Almost one-third of surveyed institutions presented deficiencies in documenting the exchange of clinical information. Compliance with intrasystem transfer requirements needs to be an area of enhanced administrative review.

Sick-Call Triage

The department's sick-call procedure outlines two processes by which an institution can implement sick-call. The authority believes there is an alternative method for sick-call sign-up, triage and scheduling that would be more coordinated and efficient and would result in better resource management. The authority recommends the department consider the alternative detailed in the body of this report.

Inmate Co-Payment

The authority believes co-payments for episodic (sick-call) treatment of symptoms related to chronic illnesses should be eliminated. The authority believes it would be more effective and less costly to waive assessment of the co-payments for symptomatic complaints related to the chronic condition.

Department staff indicate inmates in a chronic illness clinic who initiate a sick-call visit, even for symptoms related to the chronic condition, are assessed a co-payment, since the sick-call encounter is a self-initiated contact. They further indicate the co-payment may be waived if the inmate files an appeal and it is determined the sick-call encounter was a result of the chronic illness.

The authority continues to recommend the department pursue legislative modification of the statutory co-payment language to allow waiver of the co-payment for a self-initiated visit directly related to a chronic illness. Additionally, the authority will continue to monitor this issue and review appeals of the sick-call co-payment to determine if this is an effective resolution.

Structured Activity on Inpatient Units

Treatment practice does not meet department policy for seriously mentally ill inmates housed in inpatient units. That policy requires 12 hours of planned therapeutic activities per week for Crisis Stabilization Unit (CSU) patients and 17 hours per week for Transitional Care Unit (TCU) patients. At least two hours must be offered during weekend hours. This lack of therapeutic activities results in almost constant in-cell confinement for some mental health patients. Isolation is not conducive to a therapeutic treatment milieu normally associated with inpatient mental health settings. The authority continues to recommend prioritization of the provision of therapeutic activities for patients housed in a mental health inpatient unit.

Offender-Based Information System

Frequently, surveyors discover instances where information documented in the medical record is not congruent with information in the medical information database. In addition, interviews with health care staff indicate the dwindling availability of support staff and problems with computer access severely affect the input of data. Of primary concern to the authority is the apparent lack of a functional system designed to ensure that accurate, reliable information is entered into the OBIS database.

The initial analysis of, and changes to, an individual's medical, physical, mental and dental status play an important role in housing and job assignments, as well as the inmate's overall welfare. The system to ensure accurate information is entered into the OBIS database lacks consistency. This may be due in part to reductions in the number of clerical support staff. These staff reductions subsequently require clinicians to enter their own data. Very often, there is not an identified staff person at each institution responsible for ensuring that information entered is accurate.

The authority recommends the OHS develop a more reliable system of entering inmate health information into the OBIS database. The plan should include a system of checks and balances to improve OBIS data accuracy and ensure consistency with other methods of documentation.

Health Policies and Procedures

In its last two annual reports, the authority recommended the department develop a cross-reference tool for rules, policies and procedures. This recommendation is based on national correctional recommendations (Anno, 2001, p. 309). The department has numerous documents that set forth its policies and procedures including, but not limited to, administrative code, department procedures, health services technical instructions, and health services administrative memorandums. For example, information on sick-call is found both in department procedure and health services technical instructions. The same is true for provision of services to inmates in special housing. Again the authority recommends the department develop a cross index by key word, indicating all the references where information pertinent to the key word may be found.

Body Cavity Searches

The authority once again raises concerns regarding departmental policy that calls for health care staff to be available for conducting security-related body cavity searches. National correctional health care standards and American Public Health Association standards prohibit body cavity searches that can compromise therapeutic relationships between clinicians and their patients.

The authority recommends the department explore alternatives to its existing body cavity search policy. Other state correctional systems have implemented successful in-house and off-site alternatives that preclude the involvement of institutional health care staff. Examples include using trained security personnel to conduct such searches, using off-site health care personnel or off-site health care facilities, and using "dry cells" for inmate isolation and subsequent identification of contraband when passed through the intestinal tract.

Institutional Staffing Levels

During the time frame in which the department was involved in a federal lawsuit concerning the provision of health care (1972 – 1993), the department published various staffing guidelines. The first was in 1978. In 1991, the Florida Legislature directed the department to develop uniform staffing standards for health services that took into consideration staffing standards in other state's correctional systems and comparable sized Florida community hospitals. That directive led to the department's last publication of staffing standards for health services in January 1992. Since that date, the department has not published its staffing guidelines or patterns.

Since 1992 numerous changes in the department have affected the OHS and its provision of services. The most obvious are the increase in the number of institutions, the dramatic increase in population, and the privatization of health care in region 4. There are numerous other changes, however, that have affected staffing levels.

Authority surveyors over the past two fiscal years more frequently identified areas where insufficient staffing appeared to affect the provision of adequate care and/or the documentation of that care in sufficient detail. These observations were particularly apparent in the mental health area. Staff at institutions housing inmates with severe mental illness carried caseloads well beyond what could reasonably be expected for provision of adequate treatment. While institutions with lower acuity inmates are not overstaffed per se, the staffing assigned appears disparate based on institutional mission and the number of inmates served, when other institutions are struggling with burdensome caseloads.

The authority recommends the Governor and Legislature again require the department to evaluate its staffing needs, consider realignment of existing staff, including administrative support positions, and provide specific justification for additional staff, where warranted. The development of a basic staffing pattern that can be modified according to institutional mission and the medical and mental health needs of patients is essential. While recognizing there are budgetary constraints facing the state, the authority believes an investment in sufficient staff is more cost effective than the potential liability arising from providing inadequate care that does not meet constitutional standards. The leaner staffing patterns become, the more likely it is this will eventually occur.

Mandatory HIV testing

Per statutory directive, the department has implemented the mandatory testing of inmates for HIV as they are being discharged from the prison system. Although the program has been successfully implemented, approximately eight percent of the inmates leaving the system are not tested prior to release. While supportive of pre-release testing, the authority prefers mandatory HIV testing upon admission. Many inmates do not know their HIV status upon entering the system. Testing upon admission would provide an opportunity to assess this status and begin appropriate clinical monitoring. Accurate clinical information can beneficially affect treatment decisions and use of resources over the long term.

Automatic External Defibrillators

Since 1998-1999 the authority has recommended the department purchase automatic external defibrillators (AEDs). However, the department has continued to purchase non-automatic defibrillators that require advance cardiac life support (ACLS) training, even though few staff have this training.

Currently of concern to the authority, as this issue is addressed yet again this year, is a presumed reluctance by the OHS to acknowledge the use of AEDs as a community standard. As indicated in last year's annual report, the American Heart Association now includes AED training as a part of basic life support instruction,

and AEDs are commonplace in other state facilities, as well as in restaurants, airlines, sport facilities, hotels, etc. Additionally, as the department struggles with budgetary issues, staffing shortages, and employing and/or retaining ACLS trained nurses and physicians, the use of emergency equipment operable by minimally trained staff is more fiscally and clinically advisable than the continued purchase of equipment that can only be operated by fully ACLS trained staff.

Use of Chemical Agents

The use of chemical agents in the areas of confinement and close management has been of significant concern to the authority over the past several years. Generally, these concerns have surfaced as the result of specific incidents where oleoresin capsicum, or pepper spray, has been used in apparently inappropriate ways with serious medical and/or mental health consequences. These consequences have included serious chemical burns and, in one instance, exacerbated mental health symptomatology followed by the inmate's suicide.

During FY 2002-2003 authority staff reviewed policies available from ten states including Florida and the federal Bureau of Prisons in an attempt to answer some of the policy questions surrounding the use of chemical agents to gain behavioral control over inmates. Of particular interest from this review were the federal Bureau of Prisons' confrontation avoidance procedures.

To the department's credit, Florida's policies in regard to the use of chemical agents are more explicit than many other states. This is particularly the case where policy specifies the nature of medical and mental health staff involvement when chemical agents are used in non-emergency situations. Still, there is room for continued improvement in certain areas.

Budget and Personnel

FY 2002-2003

The General Appropriations Act for FY 2002-2003 provided nearly $267 million and initially placed the OHS in a better financial position than in prior years. This funding, however, was equivalent to year-end FY 2001-2002 expenditures. Thus, at the beginning of FY 2002-2003, the department projected an approximate $4 million deficit for the upcoming year. However, by January 2003 it was necessary to revise the projection and the OHS estimated a deficit of $13 million. This deficit was predicated on numerous factors including (1) the Criminal Justice Estimating Conference's projected increases in average daily population, (2) the projection of sick and annual leave payouts for employees reaching a mandatory June 30 retirement date, (3) continued need for medical staff supplied by private health care agencies, (4) necessary revisions to the Wexford contract and (5) the increased cost of purchasing pharmaceuticals, community hospital and physician services and other medical/ancillary services and supplies.

Over the past 10 years the department has made numerous changes in its operations that resulted in significant cost containment. These were discussed in detail in previous annual reports. The budget and personnel committee believes while some modifications of these efforts may generate additional small pockets of cost avoidance, major cost avoidance efforts have been exhausted. In order for the department to recover from its consistent deficit status, legislative appropriations will have to be sufficient to address the costs of producing and purchasing health care services in Florida.

While there is always concern that health care expenditures for inmates are extreme, an interesting comparison is the cost of providing health care coverage for state employees. The authority first made this comparison in its April 1989 report. The department's premium includes dental coverage as well as mental health crisis and inpatient coverage. Thus, the cost of providing health care to inmates may not be out of line with the cost of an insured employee's purchase of health care services.

FY 2003-2004 and beyond

It is unlikely that the $289 million funded by the 2003 Legislature for FY 2003-2004 will be sufficient to cover the cost of providing medically necessary care, once again leaving the OHS in a deficit posture. Since medically necessary care cannot be denied regardless of budgetary appropriations, this places the department in the position of transferring funds from other budget entities to supplement the under-funded OHS portion of the budget. As it has in previous reports, the authority expresses concern about this necessity and urges the Legislature to adequately fund the department's provision of health services.

The authority is also concerned about continued insufficient funding as it relates to several issues that will affect the cost of medical care in upcoming years. In particular, the treatment of Hepatitis C, geriatric and end-of-life care, as inmates with long-term sentences age and expire in the system, will impact future expenditures.

Mental Health

During FY 2002-2003, the Mental Health Committee focused on the adverse impact of budget reductions that all state agencies have experienced and the impact these cuts have had on the mental health services provided to Florida's inmate population. Data provided by the department have consistently demonstrated rising caseloads for clinicians. Many authority survey findings were linked to staff shortages.

The committee also requested workload and budget data for region 4, the region operated by the private company Wexford Health Sources (Wexford), in addition to the data requested for state run facilities. Wexford has not met this request to date, resulting in the committee's inability to review the information during FY 2002-2003. The committee is interested in reviewing any ways in which Wexford has implemented innovative practices to reduce cost, as this was highlighted as a benefit of the privatization endeavor.

In addition to reviewing the effects of budget reductions, the committee reviewed several continuing issues affecting the mental health care provided to inmates. These topics included:

- **Practitioners covering multiple institutions**
- **Continued use of locum tenens psychiatrists**
- **Restoration of psychiatric consultant position**
- **Proposed reductions in service delivery logs**
- **Examination of the ranges in caseload sizes**
- **Implementation of s2p program**
- **Cognitively impaired inmate pilot program**
- **Group case management concept**
- **Reductions in substance abuse programs**
- **Use-of-force**
- **DC Procedure 403.007: Medication Administration and Missed Medication**
- **Psychiatric medication availability**
- **Changes to statute governing the Corrections Mental Health Institution**
- **Staffing**

As in past years, this fiscal year has been characterized by reductions in budgetary resources. Despite the committee's continued recommendations that additional funding be sought to alleviate the unmanageable workload placed on mental health staff, the department has sought no such funding. Until efforts are made to reduce workload, it is likely that serious deficiencies in care will abound.

Quality Management

Quality Management Survey Findings

At eight institutions surveyed during FY 2002-2003, the QM program was functioning at less than an optimal level. A common survey finding at those institutions centered on quality management meeting minutes that were not descriptive enough to reflect the committee's discussion and analysis of QM data in terms of patterns, trends, unusual events or concerns. Information about committee action and improvement interventions was also not detailed in the minutes.

Another finding at those institutions was lack of evidence of development and submission of a required trending report and discussion of the improvement plan for each standard scoring <80% during the annual clinical quality review. Department policy requires intervention and monitoring of standards scoring <80% until a score of 80% is achieved and sustained for at least three months.

A third finding where survey results for the QM program were less than optimal involved the lack of clinical peer review for all credentialed practitioners. However, during FY 2002-2003, the department instituted a peer review component as part of the annual clinical quality review, and the authority does not anticipate future deficiencies in this area.

Authority Assessment of the Clinical QM Program

Quality management programs commonly encompass three general areas: (1) a means to measure the quality of care, generally referred to as quality assessment or improvement; (2) utilization management; and (3) credentialing and recredentialing. Other areas commonly addressed by the health care community include infection control and risk management. The department's inmate health care clinical QM program encompasses seven components. Policies and procedures for each area are delineated in Health Services Bulletins/Technical Instructions. The authority's QM committee expects all health care QM policies to be complete, up-to-date and based on current QM practices.

Quality Assessment Component

The quality assessment component has successfully transitioned to a program based on specific performance indicators. This activity returns data at the institutional level that, when combined with the authority's survey findings, provides staff sufficient information to formulate necessary intervention to improve performance. Follow-up monitoring and reporting of data during QM committee meetings should reveal successful compliance with administrative procedures and improvement in documentation and provision of quality care.

Risk Management Component

After several years of consistent under-reporting in the risk management area, participation increased dramatically as more institutions in regions 1–3 reported data during FY 2002-2003. Improvement in participation was seen in all regions except region 4, where Wexford provides health care.

Several years ago the authority recommended rate-based reporting of risk management data and this change was made temporarily. The authority again recommends rate-based reporting and encourages a return to a rate-based method of comparing data at the statewide level.

Credentials Review Component

During the current year, the credentialing process continued to operate smoothly. Generally, credentials packets are submitted and reviewed, and privileges are granted in a timely manner. For several years the authority has contended that the credentialing program should include a practitioner-profiling component. The Medical Peer Review policy is slated to include a section requiring an annual clinical peer review, but it remains unclear to the authority how this peer review will link with the credentialing process.

Mortality Review Component

Mortality review is a process of retrospectively reviewing documentation in the medical record to evaluate the quality and appropriateness of the health care provided. The purpose of mortality review is to improve the quality of service, while providing for professional growth and development. The department's mortality review program has multiple levels of review. Outside reviews consistently surface issues that were overlooked or not addressed by the institutional review. Historically, over two-thirds of all cases with care deficiencies were identified at the outside review level.

The authority's quality management committee also reviews a selected number of mortality cases where deficiencies in care were identified. The authority's quality management committee continues to find some institutional reviews focus only on care surrounding the terminal event, and do not objectively evaluate the overall care of the patient that may have led to the terminal event. For this reason, for the past two annual reports the authority made two recommendations for enhancements to the mortality review program. The authority reiterates those recommendations in this report. Implementation of these two recommendations could lead to earlier identification of deficiencies in care or shortcomings in the systems processes at the institutional level, and, thus, earlier intervention.

Authority Case Reviews

The authority's quality management committee reviews a limited number of mortalities where deficiencies in care have been previously identified. This review focuses on the effectiveness of the department's mortality review process. During FY 2002-2003, the authority's QM committee reviewed 17 cases. The committee determined the peer review process was effective in nine (53%) of the cases. In the remaining eight cases, the committee determined the peer review process was not adequate.

Case Closure

Case closure is the process of ensuring that all steps of the mortality review process have been completed and all documentation with respect to any corrective action required has been received by central office for inclusion in the mortality review file. In its last two annual reports, the authority noted the department needed to improve its time frames for closing mortality cases. During the current fiscal year, the department's clinical quality management program made admirable progress in closing cases, including three long-term cases. All but one of FY 2000-2001 cases are closed. Ninety percent (90%) of FY 2001-2002 cases are closed, and nearly 50% of FY 2002-2003 cases are closed.

Mortality Data

During FY 2002-2003, 207 deaths occurred in the state system. Of those, 65% (135) were attributable to three conditions; 29%, cancer; 23% cardiac related conditions; and 13% HIV/AIDS. During this fiscal year, deaths attributable to HIV/AIDS have shown a slight increase over previous years. Also, after a slight decline in the previous fiscal year, deaths per thousand returned to the rate reflected since the 1998-1999 fiscal year, 2.7 deaths per thousand inmates.

Utilization Management

The department operates a statewide utilization management program at Reception and Medical Center. The department provides health services under a managed care model and the utilization management program processes pre-approvals for scheduled hospitalizations, ambulatory surgeries and specialty consultations. It also provides retrospective review for emergency hospitalizations. Possibly unique to the department, its utilization management program also coordinates patient transfers from non-contract hospitals to ones with which it has contracts, or from contracted facilities to intrasystem facilities such as the department's hospital at Reception and Medical Center or an institutional infirmary setting. This system of internal transfers results in cost avoidance related to both health care and security. During FY 2002-2003, the department projected it avoided expenditures for hospitalization and related security costs and for step-down care of approximately $4 million. Data also show the majority of hospital admissions occur at hospitals with which the department has contracts for reduced fees.

Program Evaluation

Last year's report noted a renewed emphasis on program evaluation and the undertaking of a review of the quality assessment component, specifically the clinical quality review process and its associated instruments. Performance improvement initiatives were developed for the CQR process. The authority encouraged the department to undertake an evaluation of each of the QM program components. Unfortunately, this did not occur. Once again it was necessary for staff to assist in other health care related initiatives. In this year's case it was development and implementation of policies and procedures to comply with the Health Information Portability and Accountability Act (HIPAA).

Pharmacy Component

Statutes require pharmacies to maintain a continuous quality improvement program. Prior to the current fiscal year, pharmacy quality management data was reported only to the department's Pharmacy and Therapeutics Committee. Beginning in FY 2002-2003, the department began reporting information with respect to dispensing errors to the statewide clinical QM program. This current fiscal year focused on improving the reporting of information to central office and clarifying what information is required by statute. The authority recommends the department continue its efforts to encourage its pharmacies to more accurately report pharmaceutical quality-related events.

Medical Peer Review

An annual clinical review for specified health care providers is an expectation of national correctional organizations and is also common practice in the community setting. After discussion of this issue last year, the authority and the department agreed a specific document would be developed for the authority's review during the survey process. Survey results with respect to clinical peer reviews were inconsistent during FY 2002-2003. Some institutions were able to produce a document outlining the specific records reviewed for each clinician. This documentation is acceptable to the authority. Other institutions produced a memorandum stating peer reviews had been conducted for specified practitioners. The authority does not deem this adequate. The authority encourages the department to release a policy revision that specifically sets forth the requirements for annual clinical review and to develop a common format for peer reviewers to use during the annual CQR process.

Health Education

The department continues to be an accredited provider for continuing medical education (CME) credits for physicians and continuing education units (CEUs) for nursing and mental health staff. Numerous training activities are presented each year, and the department is improving tracking of these activities and is also improving the link between QM mortality review findings and CME course offerings.

Nursing Shortage And Staffing Solutions

There is a well-documented shortage of nurses in the United States. The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) projects a shortage of over 61,000 RNs in Florida or a need for 33% more nurses than will be available (HRSA, 2000).

Today's nursing shortage is different from years past and is related to several factor including workforce competition, impending retirement of existing nursing personnel, and the exodus of women from the profession. There have been many private and governmental efforts to help alleviate the nursing crisis. However, to date there is no definite solution to remedy the situation. Several approaches for easing the nursing shortage within Florida's correctional facilities are presented in the body of the report.

Health Care of Aging Inmates

Each year the authority provides information on the status of elderly inmates. The percentage of inmates in the system over the age of 50 continues to steadily increase. In 1991 that percentage was about 5%, this year it is about 10%, and the projection for 2015 is roughly 19%. This data demonstrates slight increases over last year's projections.

Inmates over 50 continue to disproportionately account for those assigned to medical grade 3 and above (representing the more serious and most acute/chronic medical conditions). Inmates over the age of 60 also were disproportionately represented in the group of inmates with severe mental impairment.

While the population of inmates over age 50 is approximately 10%, this population is disproportionately represented in the cost of providing care. This group accounts for 26% of community inpatient episodes, 25% of outpatient surgery episodes, 14% of outside emergency room visits, 26% of ancillary care episodes and 25% of specialty care episodes.

River Junction Work Camp was established by the Legislature as a geriatric facility for generally healthy elderly inmates. It functions well in that respect, but there remains an enormous need for the department to develop a comprehensive plan to meet the varied needs of other segments of the aging population, especially those inmates with long-term chronic conditions who will age and expire in prison. These inmates will require a full range of geriatric services, including but not limited to assistance with activities of daily living, nursing home type care and hospice/end-of-life care.

As noted in previous reports, the department does not have the capability of identifying cost data by age for key components of its operation, including health care. The authority continues to recommend a data collection, retrieval and analysis system. It also continues to recommend the department conduct a research study on health-related concerns of aging and elderly inmates.

RECOMMENDATIONS

Follow-up Monitoring
- Emphasize successful closure of Corrective Action Plans at the first review.
- Implement a process by which central office monitors institutional progress toward closing survey findings.

Episodic Care
- Conduct clinical reviews of the work performed by correctional medical technicians (CMT) and licensed practical nurses (LPN) and require documentation of that review.

Medication Administration
- Place greater emphasis on documentation requirements for medication orders and performance of oral cavity checks.

Sick-call Triage
- Implement a more coordinated, efficient process for sick-call sign-up, triage and scheduling.

Inmate Co-payment
- Pursue a legislative modification of the statutory co-payment language to allow waiver of the co-payment for a self-initiated visit directly related to a chronic illness.

Structured Activity on Inpatient Units
- Prioritize the provision of therapeutic activities for patients housed in a mental health inpatient unit.

Psychiatric Restraints
- Consider any form of restraint that restricts the movement of four limbs a 4-point restraint and address it in policy.
- Include assessment of competency in the application of restraints in the psychiatric restraint training module.
- Require 15-minute observations for psychiatric restraint be conducted by healthcare staff.
- Require one-to-one observation if seclusion and restraint are used together.
- Within 24 hours after release from restraints, require the patient and staff members to discuss the incident leading to the use of restraints and how the use of restraints could have been avoided.

Offender Based Information System
- Develop a more reliable system of entering inmate health information into the OBIS database. The plan should include a system of checks and balances to improve OBIS data accuracy and ensure consistency with other methods of documentation.

Health Policies and Procedures
- Develop a cross index of policies and procedures by keyword, indicating all the references where information pertinent to the keyword may be found.

Body Cavity Searches
- Modify the existing body cavity search policy.

Institutional Staffing Levels
- Evaluate staffing needs, consider realignment of existing staff, including administrative support positions, and provide specific justification for additional positions, where warranted.

Automatic External Defibrillators
- Develop a replacement schedule for outdated defibrillation equipment, and include an issue in the Legislative Budget Request for the purchase of automatic external defibrillators.

Use of Chemical Agents
- Revise the "Chemical Agents Risk Assessment", form DC4-650B, for clarity per authority recommendations.
- Expand the list of conditions that may be exacerbated by chemical agents and electronic restraining devices (ERDs) per authority comments previously provided.
- Require that the level of health care provider completing the chemical agents risk assessment without a higher-level review be at least a registered nurse.
- Reinstate videotaping of non-emergency use of chemical agents and ERDs through use of permanent fixed-mounted camera systems in confinement and close management units.
- Expand the requirement for a face-to-face evaluation by mental health staff following chemical agent or ERD use to include inmates of all psychological grades.
- In the event of repeated administration of chemical agents or ERD use within a short time period (e.g., 24 hours), conduct a mandatory mental health evaluation that day or as soon as possible the next working day, regardless of inmate psychological grade.
- Consider adopting the confrontation avoidance procedures utilized by the federal Bureau of Prisons.
- Emphasize non-confrontational communication styles during correctional officer training as the easiest and most effective means of avoiding the need to use force.

Continued Use of Locum Tenens Psychiatrists
- Address the lack of competitive salaries for correctional psychiatrists.

Examination of the Ranges in Caseload Sizes
- Analyze workload data and reallocate resources in areas of critical need.

Reductions in Substance Abuse Programs
- Pursue restoration of adequate funding for substance abuse programs.

Psychiatric Medication Availability
- Develop a psychiatric emergency medication kit at each major institution.

Changes to Statute Governing the Corrections Mental Health Institution
- Use non-departmental staff on any administrative panel authorizing involuntary placement in an inpatient psychiatric facility or involuntary medication. Include specific patient rights in statute rather than only in administrative rule.

Quality Assessment Component
- Adopt thresholds for clinical indicators that are specifically linked to the potential impact on continuity of care.
- Develop mental health indicators that reflect clinical outcomes.

Risk Management Component
- Use a rate-based method for comparing risk management events at the statewide level.

Mortality Review Component
- Develop an inservice education program for physicians specifically designed to provide information on how to conduct an effective, objective case review of the provision of care.
- Consider a process by which a department physician, possibly from another institution, who was not involved in the provision of care conducts the mortality review.
- Provide physicians with a systematic way to ensure recommended approaches to common ailments are addressed and considered.

Program Evaluation Component
- Extend the program evaluation process to each quality management component.

Pharmacy Component
- Require accurate reporting of pharmaceutical quality-related events.

Medical Peer Review
- Release a policy revision that specifically sets forth the requirements for annual clinical review and also develops a common format for peer reviewers to use during the annual clinical quality review process.

Healthcare of Aging Inmates
- Implement a data collection, retrieval, and analysis system that will ensure reliable age-based data regarding health care utilization and costs.
- Conduct a methodologically sound research study on the health-related concerns of aging and elderly Florida inmates. Present recommendations to the Legislature for current and future management of this population.
- Explore the expansion of the Conditional Medical Release Program to include appropriate older inmates.
- Pursue agreements with Florida's medical, criminology and social work schools to augment the care of older inmates, and provide training opportunities for students.
- Pursue research on recidivism rates for Florida's state correctional system, with a focus on inmates 50 and older.
- Pursue research on the characteristics and needs of female inmates, with a focus on inmates 50 and older.

INTRODUCTION

This year marks the tenth anniversary of the Correctional Medical Authority's (authority) surveys of both the medical and mental health care provided in Florida's prisons. The authority's efforts over the past ten years have also focused on facilitating the development of the Department of Corrections' (department) quality management program. This partnership heralded the end of twenty years of litigation through the federal courts. It also produced major cost containment initiatives, standardized health care policies and procedures, internal and external monitoring processes and, most of all, resulted in significant improvements in the health care delivery system.

Much has changed in the last ten years as a result of the interaction between the authority and the department's Office of Health Services (OHS). During this decade, major changes were implemented to better ensure inmates were receiving a basic level of care. The authority assisted in many of those activities to include developing policies and procedures, assisting with the implementation of standards, monitoring quality assurance measures, reviewing critical incidents, and recommending needed policy changes. The authority also made funding recommendations for the OHS budget to the Governor and Legislature. The interaction between the authority and the department has developed into a system of checks and balances, ensuring inmates in Florida receive a constitutionally adequate level of care consistent with minimum standards accepted in the community at large.

This year, the authority continued to improve the processes by which prison facilities are surveyed by reviewing and updating all survey instruments to better assess the inmate health care system. Additionally, as a part of the Osterback Revised Offer of Judgment, the authority has entered into the second year of oversight of facilities designated to house inmates whose classification is close management.

FY 2002-2003 SURVEYS

Overview

A critical element of the authority's statutory direction is the comprehensive review and assessment of health care services provided at each of Florida's prisons. As required, surveys are conducted on triennial cycles unless circumstances call for more frequent reassessment. The authority conducted 19 surveys of institutional health care during FY 2002-2003. At eight institutions, the private sector provided health care services.

Privatized health care in Florida's prison system falls under one of two contracting arrangements. In one, the department contracts directly with private vendors for provision of care. Wexford Health Sources, Inc. (Wexford) holds the largest such contract for prisons, providing health care services to all state-operated institutions in region 4 (South Florida). Wexford provided care at four institutions surveyed this cycle. Prison Health Services holds the contract at one institution, and it too was surveyed this cycle.

The second contracting format involves instances in which the Correctional Privatization Commission (CPC) contracts with a vendor for operation of an entire facility. Three institutions surveyed this cycle were CPC facilities. At one, Wackenhut Corporation held the contract, and Corrections Corporation of America held the other two.

Health care surveys are divided into three components: medical, dental and mental health care. All components include reviews of clinical care, supportive systems, and related administrative functions. In the medical and dental areas, the administrative review includes evaluation of the quality management and infection control programs. Clinical audits include sick-call, emergencies, infirmary care, preventative care, outside consultations and chronic illness clinics. With respect to the mental health area, clinical audits evaluate handling of episodic care such as psychological emergencies and self-injury/suicide prevention, as well as routine care such as assessment, treatment planning, case management, individual and group therapy, and medication management. All survey components are combined into a single formal report. Individual institutional survey reports may be found on the authority's website at: http://www.doh.state.fl.us/cma/reports.

Upon receipt of the formal survey report, statutes require the department to prepare a corrective action plan (CAP). The CAP must identify the corrective action the institution plans to take to address the findings identified in the survey report. A more detailed review of the CAP assessment process is provided in a later section of this document.

Medical and Dental Health Care

Similar to last year's report, there were no major areas of concern identified with the provision of dental services. The table below outlines areas of medical care where statewide data reflected significant trends and where improvements in providing care are necessary.

Area of Review	Area of Concern
Chronic Illness Clinics • Asthma • Diabetes • Immunity • Seizure • General Medicine	• Failure to address disease-specific elements during physical examinations conducted upon enrollment in the clinic • Failure to address disease-specific elements in the medical histories obtained upon enrollment in the clinic
Chronic Illness Clinics • Diabetes	• Untimely review of abnormal diagnostic studies • Influenza vaccine not offered as required
Chronic Illness Clinics • Immunity	• Untimely adjustment of medications for viral rebound situations
Chronic Illness Clinics • Seizure	• Failure to consider tapering of seizure medications when indicated
Preventative Care	• Failure to document rectal examinations and fecal occult blood testing (or presence of a signed refusal in the chart) during annual/biennial examination
Episodic Care • Infirmary Care	• Failure to document daily on-site and/or weekend telephone rounds by the physician or clinical associate • Incomplete admission nursing assessments and patient education/orientation
Episodic Care • Physician Follow-up Care	• Inadequate coordination between security and health care staff for identifying and rescheduling patients failing to show for appointments
Medication Administration	• Failure to consistently include signatures, dates, and times on medication orders • Failure to transcribe medication orders during the shift on which they were written • Failure to conduct oral cavity checks following medication administration
Intrasystem Transfers	• Continuity of care affected by lapses in the exchange of clinical information between transferring institutions, including current prescriptions and pending medical appointments and consultations

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Policy/Department Issues	• Special housing inmates were not provided one hour of exercise per day, outside the cell, five days per week • Lack of review of clinical encounters performed by correctional medical technicians or licensed practical nurses by a higher-level clinician • Failure to demonstrate annual peer review of the CHO and other licensed health care practitioners • No policy addressing elective medical or surgical procedures and how inmates may pursue any elective medical or surgical procedure the department declines to provide • No policy prohibiting the medical staff from participating in gathering forensic information and participating in body cavity searches for forensic purposes • No evidence of reviews of monthly facility and food service area sanitation inspection reports by health services staff

Mental Health Care

The table below outlines where statewide data reflected significant trends and where improvements in care are necessary. Due to the authority's triennial survey cycle, only five of the 24 institutions housing inmates receiving psychotropic medications (S3 inmates) were surveyed. Additionally, only one reception center and only two of the seven mental health inpatient facilities were surveyed in this cycle.

Area of Review	Area of Concern
Access to Mental Health Services	• Lack of consideration of patient's history of mental health treatment and past suicide attempts in responding to psychological emergencies • Lack of tracking system for psychological emergencies • Lack of administrative review of request log
Inpatient Mental Health Treatment	• Lack of timely initial nursing assessments • Inadequate clinical staffing • Inadequate security staffing • Inadequate therapeutic activities offered • Risk assessments for violence not conducted • Lack of timely and appropriate treatment plans
Intellectual Functioning	• Intelligence testing not completed as required • Lack of appropriate pre-release (end-of-sentence) planning
Outpatient Mental Health Treatment	• No written and verbal orientation to services within 24 hours • Inadequate clinical staffing • Lack of timely and appropriate treatment plans • Sufficient treatment groups not offered • Lack of appropriate pre-release (end-of-sentence) planning
Psychiatric Restraint	• Incomplete initial physician orders • Warden or designee not informed of incidents • Respiration and circulation checks not completed as required • Vital signs not taken as required • Patient's limbs not exercised as required • New physician orders not obtained every 4 hours • Restraints not removed after 30 minutes of calm behavior • Medical and security staff not adequately trained in restraint application
Psychotropic Medication Practices	• Physician orders not dated and timed • Medication lines not held at appropriate times • Patients not observed swallowing medications • Proper informed consent not documented • Annual physical assessments not conducted • Appropriate laboratory studies not conducted • Lack of appropriate follow-up by psychiatrist after initial prescription
Reception/Intake Process	• Lack of continuity of psychotropic medications for inmates newly received from county jails. • Psychiatric referrals not made for newly received inmates having prior psychiatric hospitalizations and/or recent psychotropic medication usage • Past treatment records not requested if inmate at reception center more than 30 days
Self-Injury/Suicide Prevention	• Physician admission orders or verbal orders not countersigned; • Status not re-ordered every 24 hours • Lack of daily counseling by mental health staff • Lack of daily physician rounds • Patients not observed at the ordered frequency • Lack of adequate post-discharge follow-up
Sex Offender Services	• Treatment groups not offered • Treatment refusals not signed or witnessed • Treatment summary or termination group note not documented • Lack of pre-release (end-of-sentence) planning
Special Housing	• Incomplete mental status evaluation tracking systems • Periodic mental status evaluations (30/90-day confinement evaluations) not completed • Clinically inappropriate responses to adjustment problems
Other Administrative Issues	• Administrative review of logs not occurring
Mortality - Suicides	• Lack of appropriate follow-up care following discharge from mental health observation • Inappropriate risk level assigned • Order for suicide observation status not implemented • Deaths by overdosing suggest serious contraband medication problem

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In addition to quality of care issues previously noted, surveys also identify written departmental policy and/or practices that conflict with standards endorsed by the authority.

- Suicidal patients not observed at least every 15 minutes
- Physicians discharge patients from the infirmary without personally examining them
- Current self-injury/suicide prevention and 23-hour observation policy provides inadequate guidance to clinical staff
- Inadequate psychiatric staffing resulting in delays in evaluations and treatment
- Hour-of-Sleep (HS) medications administered too early in the day
- Insufficient allocated mental health positions
- Retrospective review by appropriate healthcare and administrative staff for critical events not required (i.e., psychiatric restraint use or suicidal incidents)

Policy/Department Issues

While the following issues from the prior year's annual report were not specific findings in survey reports for this year, they are continuing issues of concern:

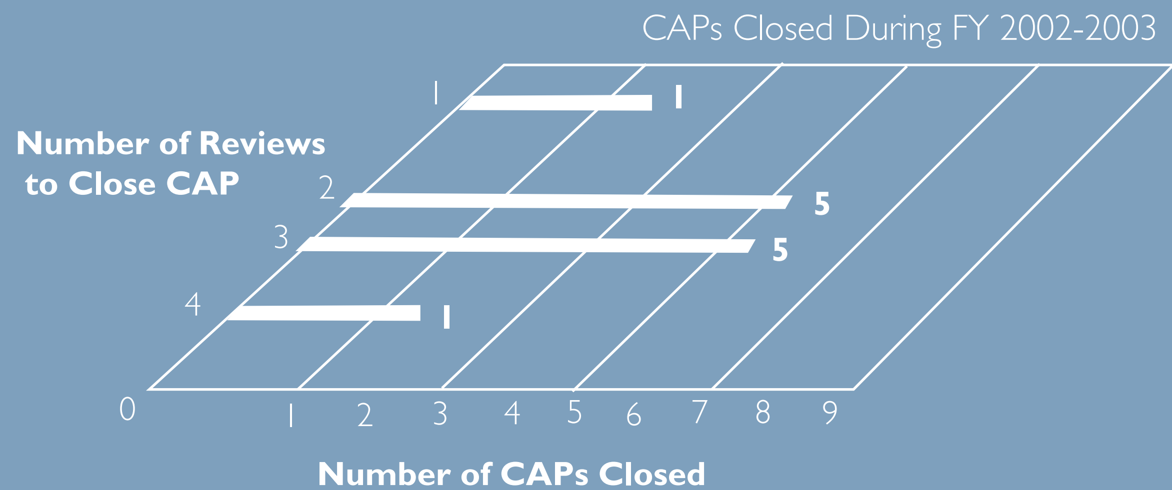
- Lack of annual psychiatrist peer review
- No documentation regarding legality of use of electronic medical password as an electronic signature for physician orders
- Clinical staff lacking computer and inter/intranet access
- Lack of formal policy and training for medical and mental health staff to report allegations of inmate abuse
- Lack of policy clarity for guiding medical staff in providing information to security prior to use of chemical agents

Follow-up Monitoring

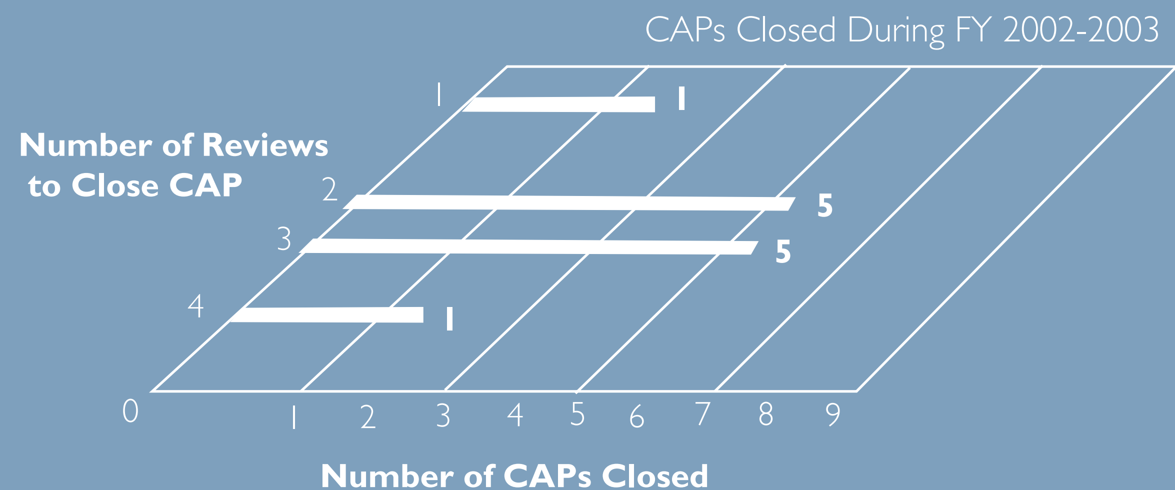
The department is statutorily required to develop corrective action plans (CAP) to address findings set forth in the authority's survey reports and submit them to the authority within 30 days of the publication of the report. These CAPS are usually constructed with the assistance of regional and central office staff. Generally about seven months after the survey, the authority conducts a site visit to review the progress made toward correcting the deficiencies identified in the survey report. Issues that are not corrected remain open pending further review. The authority continues to monitor those issues through on-site or off-site evaluation until they are resolved, or until the next formal survey of the facility.

Only one institution provided evidence of correction of survey deficiencies at the first authority assessment.

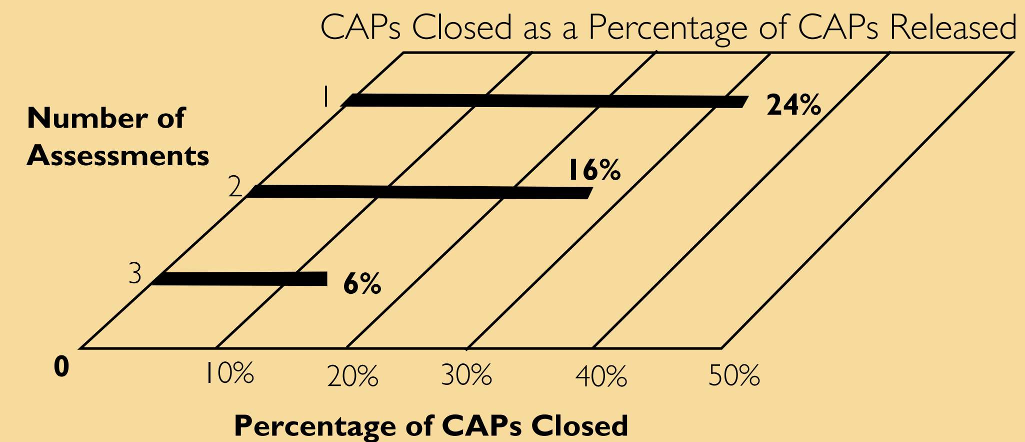
During FY 2002-2003, 24 institutions had open CAPs requiring review. Four open CAPS were for institutions surveyed during FY 2000-2001, 15 during FY 2001-2002 and 5 during the current survey cycle. The authority encountered numerous institutions that could not provide evidence of correction of cited deficiencies during the first, second or third CAP assessment. Only one institution corrected all survey findings by the first CAP assessment. While eleven of the 24 institutions finalized correction by the third CAP assessment, a few continued to have uncorrected deficiencies. One institution surveyed during FY 2000-2001 required six assessments before all outstanding issues were adequately addressed. For institutions involved in the CAP process, Figure 1 demonstrates the number of CAPS the authority closed after its corrective action assessment reviews and the number of reviews required to close the CAP. (Figure 1)



At the close of the fiscal year, as shown in Figure 2, 12 institutional CAPs remained open. All institutions had been reviewed at least once. One institution remains open after four reviews.



The need to re-monitor institutions with uncorrected survey findings resulted in the authority's conducting 46 CAP evaluations during the fiscal year. The authority believes the necessity for repeated CAP reviews represents an ineffective use of both authority and institutional resources. For the 46 CAP assessments released by the authority, Figure 3 demonstrates the cumulative percentage of CAP reviews that resulted in closure.



Monitoring of the CAP process by regional or central office staff to ensure cited deficiencies are addressed with an effective intervention appears limited. The authority recommends that the department place emphasis on successful closure of CAPs at the first review. The authority also recommends the department implement a process by which central office monitors institutional progress toward closing survey findings.

TOPICS OF CONCERN

Survey-based Concerns

Episodic Care

Certified correctional medical technicians (CMT-C) and licensed practical nurses (LPN) work under the supervision of registered nurses (RN). At most institutions these individuals serve as the initial medical contact during sick-call and after-hours emergencies. They assess and treat common medical complaints through the use of clinical guidelines and nursing assessment forms. There is no departmental requirement or process that ensures a review of the decisions made at these clinical encounters. The authority previously recommended that a higher-level clinician review the clinical decisions made by CMT-Cs and LPNs, and document that review. Although some facilities have implemented such a review, most have not. At surveyed institutions, 82% of state-operated institutions and 38% of privately operated facilities failed to meet this standard. The authority continues to recommend a clinical review of the health care encounters performed by correctional medical technicians (CMT) and licensed practical nurses (LPN) and documentation of that review.

Medication Administration

The medication administration process, or pill line, ensures that inmates appropriately receive prescribed medications that they are not allowed to keep on their persons. Problem areas identified in the authority's previous annual report were again noted during the past year's reviews. They include: failure to document medication orders by signature, date, and time; failure to transcribe medication orders by the end of shift; and failure to conduct oral cavity checks when administering medication. The authority recommends the department place greater emphasis on documentation requirements for medication orders and performance of oral cavity checks. These checks must be conducted by a staff person, whether security or health care, who is in close proximity to the inmate and on the same side of the pill window as the inmate.

Intrasystem Transfers

Although improved results were noted during the past year, there still remain deficiencies in the process for intrasystem transfers of inmates. A coordinated transfer process is necessary for ensuring the transmission of clinical information between sending and receiving institutions. That process is a crucial component of continuity of care within a correctional health care system. Almost one-third of surveyed institutions presented deficiencies in documenting the exchange of clinical information. Compliance with intrasystem transfer requirements should be an area of enhanced administrative review.

Nearly one-third of surveyed institutions failed to adequately document the exchange of clinical information during intrasystem transfers.

Sick-Call Triage

The department's sick-call procedure specifies an inmate should sign up for sick-call on an "Inmate Sick-Call Sign Up" form at a location designated by the institution. Upon arriving at the medical unit the inmate then completes an "Inmate Sick-Call Request" form and provides it to medical staff. Although the authority finds this an acceptable method of accessing sick-call, it does not believe it is the most efficient way to organize the sick-call process for medical staff or the inmate.

The sick-call procedure outlines an alternative method of accessing care that the authority believes could be modified to become a best practice. The current alternative method makes "Inmate Sick-Call Request" forms available for inmates to complete and place in a secured box that only health services staff can access. Medical staff retrieve the request form and triage the requests. When inmates report at the next scheduled sick-call, they are seen in priority order according to the seriousness of their complaints.

The authority suggests a variation of the alternative method described above that would allow medical staff to prioritize requests and schedule inmates during sick-call according to the nature of the request. This method would result in better resource management. In implementation of this method, all prescription renewals or requests for information or passes would be scheduled at a specific time. Requests for non-urgent health care would be triaged in order of importance by presenting symptoms. This method also has the potential to divert unnecessary movement of inmates for administrative, pharmaceutical or other reasons not necessarily related to sick-call. The authority recommends this as a more coordinated, efficient process for sick-call sign-up, triage and scheduling.

The authority suggests the department evaluate its sick-call process to attain greater efficiency.

Inmate Co-payment

The authority has advocated for the elimination of co-payments for episodic (sick-call) treatment of symptoms related to chronic illnesses. An inmate wishing to avoid co-payment may delay accessing treatment until the next scheduled chronic illness clinic visit or may wait until the condition becomes an emergency. The authority believes it would be more effective and less costly to waive assessment of the co-payments for any symptomatic complaints related to the chronic condition.

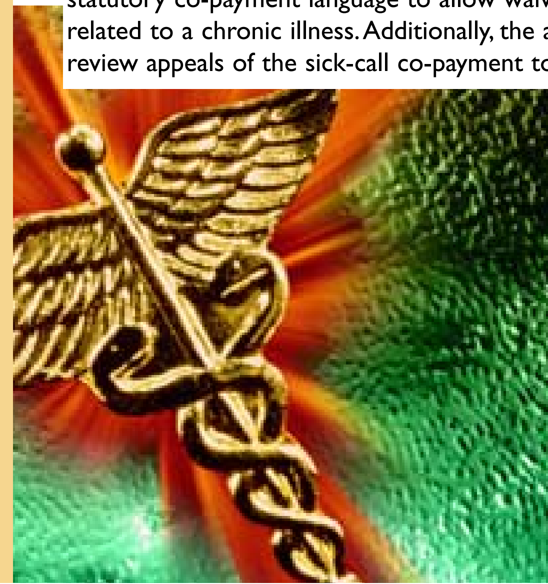
A draft of the inmate handbook, due for distribution, contains wording that may address the authority's concerns. It states:

"If you have a chronic medical problem and are in a special clinic, there is no co-payment for these clinic visits or sick-call visits determined by the clinician to be related to chronic conditions."

Verbal discussion with department staff, however, revealed inmates in a chronic illness clinic who initiate a sick-call visit, even for symptoms related to the chronic condition, will be assessed a co-payment, because a sick-call encounter is a self-initiated contact. Staff also indicated the co-payment may be waived if the inmate files an appeal and it is determined the sick-call encounter was a result of the chronic illness.

The authority continues to recommend the department pursue legislative modification of the statutory co-payment language to allow waiver of the co-payment for a self-initiated visit directly related to a chronic illness. Additionally, the authority will continue to monitor this issue and review appeals of the sick-call co-payment to determine if this is an effective resolution.

The authority continues to recommend pursuit of Legislative modification of the co-payment requirement.



Structured Activity on Inpatient Units

Departmental policy requires 12 hours of planned therapeutic activities per week for Crisis Stabilization Unit (CSU) patients and 17 hours per week for Transitional Care Unit (TCU) patients. At least two hours must be offered during weekend hours. As in previous years, this policy is not being met. Survey findings and corrective action plan assessments confirm that insufficient therapeutic activities are offered. In addition to the most critically mentally ill patients not receiving the required level of group treatment, limited group interaction also results in almost constant in-cell confinement for some mental health patients. This isolation is not conducive to a therapeutic treatment milieu normally associated with inpatient mental health settings. The authority continues to recommend prioritization of the provision of therapeutic activities for patients housed in a mental health inpatient unit.

Limited group interaction results in almost constant in-cell confinement.

Psychiatric Restraints

Surveys identified problems related to psychiatric restraints at eight institutions during FY 2002-2003. All indicated a need for thorough training of staff members involved in the application of the restraints, to include medical staff, mental health staff, and security staff. In many of the institutions at which restraints were applied, deficiencies in compliance with departmental policy were identified. Refer to the following survey reports for detailed findings: Washington, Tomoka, Broward, Union, Hardee, Columbia, Calhoun, and Madison Correctional Institutions.

Revisions need for psychiatric restraint policy.

The authority recommended a training module on the use of psychiatric restraints be developed and offered as part of the required annual training for employees. The department complied with this recommendation. Not all employees have participated in this training as they have yet to reach their date for annual training. At many institutions
where lack of training was identified during the survey, employees have been trained as a component of the CAP.

The use of psychiatric restraints has received a great deal of attention from the mental health community in recent years due to adverse events occurring following improper use. As a result, several organizations have developed standards guiding usage, including the federal government, JCAHO, APHA, ACA, and NCCHC. In response to findings issued during FY 2002-2003, the authority reviewed available standards to ensure the department's policy governing the use of psychiatric restraints was adequate for safe usage. As a result, several recommendations have been developed:

Any form of restraint that restricts the movement of four limbs is considered 4-point restraint.

- The department's current policy differentiates between 4-point restraints in which a restraint bed is in use and leather restraints in which all four limbs are restrained without the use of a bed. In this policy, the leather restraints require a lesser standard of assessment and monitoring. It is the position of the authority that any form of restraint that restricts the movement of four limbs is considered 4-point restraints and should be addressed as such in policy.
- All staff involved in the application of restraints must receive training and demonstrate competency in the use of restraints (JCAHO). Although the department has made strides in the development of a training module, assessment of competency is not a component of this training.
- Required 15-minute observations should only be conducted by healthcare staff (NCCHC).
- If seclusion and restraint are used together, a staff person must be assigned one-to-one for observation (Federal guidelines).
- Within 24 hours after release from restraints, the patient should meet with staff members to process the incident and discuss how the use of restraints could have been avoided (JCAHO, Federal, and ACA).

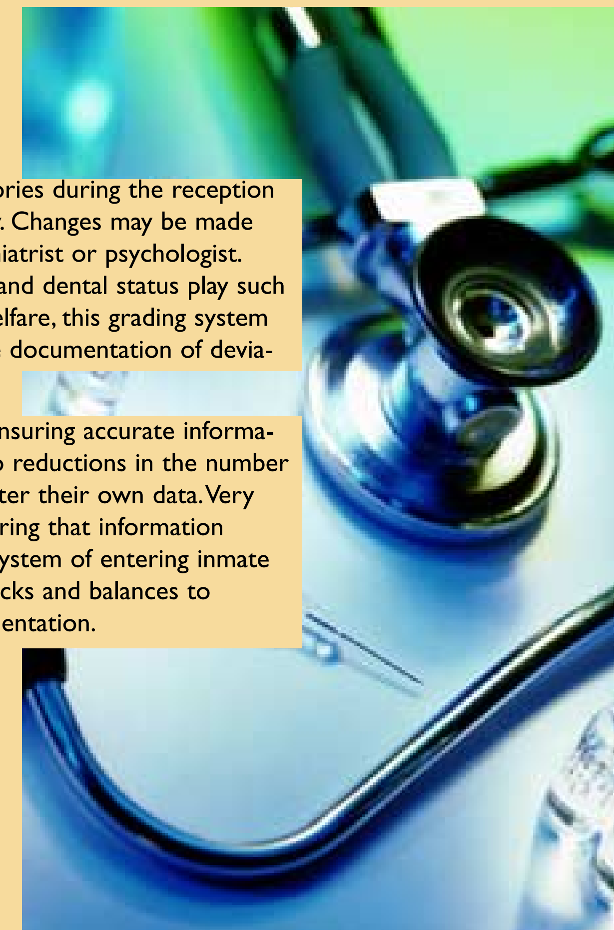
Offender-Based Information System

A concern surfaced in several institutional reports over the past two years is the accuracy and reliability of the data entered into the department's offender based information system (OBIS). Frequently, surveyors discover instances where information documented in the medical record is not congruent with information in the OBIS database. In addition, interviews with health care staff indicate the dwindling availability of support staff and problems with computer access severely affect the input of data. Of primary concern to the authority is the apparent lack of a functional system designed to ensure that accurate, reliable information is entered into the OBIS database.

One example of erroneous information is the Inmate IQ Report (OBIS report MHS 96). Prior to embarking on a survey, mental health analysts request preplanning information from the institution. One of the items requested is a list of inmates with low scores on IQ tests. Often, institutional staff will provide the OBIS generated list. The scores on the list often fail to match the information documented in the medical record. This example demonstrates an area where incorrect OBIS data may impact clinical functioning.

Another example frequently cited as problematic during surveys is incongruent grading of inmate functioning levels or grades (PULHESDXTI) in medical records versus the OBIS database. Accuracy is critical when documenting initial and updated functioning levels represented by the PULHESDXTI acronym list:

P – physical capability
U – upper extremities
L – lower extremities
H – hearing
E – vision
S – mental functioning
D – dental
X – functional capacity
T – transportation demand
I – impairment



The department initially assigns a numerical functioning grade to each of the categories during the reception process, considering various internal organs, systems, and integral parts of the body. Changes may be made only by a physician, or in the case of a psychological grade ('S' category), by a psychiatrist or psychologist. Since the initial analysis of, and changes to, the individual's medical, physical, mental and dental status play such an important role in housing and job assignments, as well as the inmate's overall welfare, this grading system must be assigned, input and updated with the greatest care, with clear and accurate documentation of deviations from the norm.

Unlike many other organized systems within the department, the system in place ensuring accurate information is entered into the OBIS database lacks consistency. This may be due in part to reductions in the number of clerical support staff. These staff reductions subsequently require clinicians to enter their own data. Very often, there is not an identified staff person at each institution responsible for ensuring that information entered is accurate. The authority recommends the OHS develop a more reliable system of entering inmate health information into the OBIS database. The plan should include a system of checks and balances to improve OBIS data accuracy and ensure consistency with other methods of documentation.

Topical/General Concerns

Health Policies and Procedures

In its last two annual reports, the authority recommended the department develop a cross-reference tool for rules, policies and procedures. This recommendation is based on national correctional recommendations (Anno, 2001, p. 309). The department has numerous documents that set forth its policies and procedures including, but not limited to, administrative code, department procedures, health services technical instructions, and health services administrative memorandums. For example, information on sick-call is found both in department procedure and health services technical instructions. The same is true for provision of services to inmates in special housing. Again the authority recommends the department develop a cross index by key word, indicating all the references where information pertinent to the key word may be found.

Body Cavity Searches

The authority once again raises concerns regarding departmental policy that calls for health care staff to be available for conducting security-related body cavity searches. This issue also was identified in our previous annual report. Using health care staff to perform searches for forensic purposes poses a threat to the therapeutic relationship between clinician and patient. National correctional health care standards and American Public Health Association standards prohibit body cavity searches that can compromise therapeutic relationships between clinicians and their patients.

It is understood that situations arise in which medical concerns necessitate using health care staff for body cavity searches. The authority concurs with exceptions to search restrictions in circumstances that represent immediate threats to an inmate's health.

Many departmental health care staff have advised that they would refuse to conduct body cavity searches for security-related purposes. None reported having to perform such searches. However, the existing departmental policy could force health care staff to choose between disobeying orders or jeopardizing a therapeutic relationship and compromising clinical principles.

The authority recommends the department explore alternatives to its existing body cavity search policy. Other state correctional systems have implemented successful in-house and off-site alternatives that preclude the involvement of institutional health care staff. Examples include using trained security personnel to conduct such searches, using off-site health care personnel or off-site health care facilities, and using dry-cells for inmate isolation and subsequent identification of contraband when passed through the intestinal tract.

Institutional Staffing Levels

During the time frame in which the department was involved in a federal lawsuit concerning the provision of health care (1972–1993), the department published various staffing guidelines. The first was in 1978, the last in January 1992. Since that date, the department has not published its staffing guidelines or patterns. The following chart outlines the published staffing patterns and the basic staffing recommended in each. FTE refers to one full-time position.

Document	Institution Size	Total Staffing	Medical Staffing	Mental Health Staffing	Dental Staffing	Administrative Staffing
Comprehensive[1] Health Services Plan June 1982[2]	600 Beds	24.8 FTE	12 FTE	9.5 FTE	3.3 FTE	Not specifically identified
Comprehensive[3] Health Services Plan June 1987	"Major Institution"	32 FTE	21 FTE	1 Psychiatrist and 1 Secretary/500 Inmates 5 psychological staff FTE	4 FTE	Not specifically identified
Comprehensive[4] Health Services Plan May 1989	600 Beds 1500 Beds	27 FTE 49 FTE	21 FTE 37 FTE	4 FTE 5 FTE	2 FTE 7 FTE	Not specifically identified Not specifically identified
Staffing Standards for Health Services January 1992	900-1100 Beds	28 FTE	19 FTE	2 FTE	3 FTE	4 FTE

[1]**Identified factors to increase or decrease staffing. Specified Reception Medical Center Hospital and reception processing staffing.**

[2]**Specified population levels at which additional staff were to be added.**

[3]**No provision for other factors except reception processing.**

[4]**Specified prototype staffing: base, variable, and specialty factors to increase or decrease staffing.**

In 1991, the Florida Legislature directed the department to develop uniform staffing standards for health services that took into consideration staffing standards in other state's correctional systems and comparable sized Florida community hospitals. That directive led to the department's last publication of staffing standards for health services in January 1992.

In 1992, there were 48 institutions and 61,000 beds to house inmates for whom the department provided care. The department was the care provider for all institutions with the exception of South Florida Reception Center (SFRC), which contracted with EMSA for provision of health care services. An inmate's assignment to an institution was primarily determined by security considerations, with little recognition given to an inmate's medical condition and the attendant health care ramifications. Since the federal court required extensive nursing coverage for chronically ill inmates housed in an infirmary setting, the manner in which the security function controlled population movement resulted in the need for every institution to be staffed to handle a broad spectrum of health care requirements.

In its January 1992 report, the department developed staffing recommendations that attempted to provide flexibility for staffing adjustments should the medical makeup of an institution's population change due to inmate movement based on custody and classification decisions. A basic staffing prototype of 28 positions was recommended for a 900-1100 bed institution. Modifications reducing or increasing the prototype staffing were recommended based on what was defined as base factors, variable factors and specialty factors. These factors, when applied to most of the institutions in the 900-1100 bed range, generated recommended staffing of 32–35 FTE. Institutions with specific missions, such as inpatient mental health services, generated the need for additional FTE.

The staffing study also recommended that regional health services staff be allowed the ability to temporarily shift staff among institutions as needed, whenever security's movement of inmates resulted in an imbalance in health care staffing. A further recommendation involved positions vacant over 180 days. It was recommended central office staff coordinate with regional staff to assist in recruitment efforts or reassign the vacant position elsewhere in the state as deemed appropriate by central office management.

The 1992 staffing study presented to the Legislature documented a need for 2,340 positions or 202 FTE more than existing authorized positions. region 4 accounted for 558 of those positions. SFRC, which at that time was contracted to EMSA, accounted for 134 of the documented FTE and nearly 2,000 beds.

Since 1992 numerous changes in the department have affected the OHS and its provision of services. Among them are:

- **transfer of inpatient psychiatric hospitalization and staff from the former Department of Health and Rehabilitative Services specifically for provision of inpatient care;**
- **staffing specifically designated for provision of mental health services to inmates housed in close management status;**
- **increase in the number of institutions and inmate population;**
- **increase in the number of single cells and close management beds;**
- **consolidation of five regions into four and privatization of provision of health care services in region 4;**
- **collaboration with the security function to define medical missions of institutions and the type of medical conditions that can be assigned to an institution depending upon its medical staffing configuration;**
- **legislative elimination of positions that remained vacant for a specific time. These vacancies were generally due to inability to recruit staff either because of insufficient personnel in the profession or non-competitive salaries. This has been especially evident in the nursing and mental health areas;**
- **increased reliance on medical staffing agencies to provide temporary staff, especially in nursing and mental health areas;**
- **increase in percentage of inmates exhibiting signs and symptoms of mental illness;**
- **increase in inmates with chronic medical conditions;**

Currently, as previously mentioned elsewhere, all heath care in region 4 state-operated institutions is contracted through Wexford. The authority reviews institutional staffing for those facilities as part of its survey process. The authority has requested information from Wexford regarding its staffing patterns, but as yet has not received that information. For institutions contracted with the CPC, the CPC and the contracted provider determine staffing configurations. The authority also reviews staffing at those institutions as part of its survey process. All state-operated facilities in regions 1 – 3 are staffed by state employees, with the exception of Taylor Correctional Institution at which Prison Health Services provides health care.

Chart 2 below compares the number of institutions and inmates in the system in 1992 and 2003. Population in regions 1 – 3 has increased by 67% because of the 7 institutions constructed in those regions since 1992.

Chart 2

Year	Number of Institutions			Number of Inmates		
	Total	Regions 1 – 3	Region 4	Total	Regions 1 – 3	Region 4
1992	48	38	10	46,967	35,133	11,833
2003	57	45	12	75,276	58,695	16,581

Chart 3 compares the actual staffing that existed in 1992, the staffing recommended in the staffing plan, and current staffing. Staffing for regions 1–3 and central office has increased by 154 FTE or 17%. However, nearly half of those increased positions (72 FTE) were designated for the close management programs at Florida State Prison and Santa Rosa Correctional Institution. This means that since 1992 only 82 positions have been provided beyond the recommended level. The 1992 basic staffing prototype of 28 FTE applied to each of the 7 new institutions in regions 1–3 would generate 196 FTE, well above the 82 FTE remaining to provide other health care after adjusting for the close management mission. Additionally, this projected 196 FTE does not consider any specialized mission at any of the 7 added institutions, such as a significant number of chronically ill or mentally ill patients.

Chart 3

Year	Total	Regions 1 – 3 and Central Office	Region 4
1992 Actual	2,138	1,649	489
1992 Staffing Plan	2,340	1,782	558
2003 Actual	1,941	1,936	5*

*** Contract Monitoring Team for Wexford Health Sources contract** **Chart 2**

Authority surveyors over the past two fiscal years more frequently identified areas where insufficient staffing appeared to affect the provision of adequate care and/or the documentation of that care in sufficient detail. Documentation remains the key component of substantiating the medically necessary treatment options that were considered by the provider and offered to the patient. In this respect, the common prevailing community standard is, if the treatment planning, clinical care and patient education provided are not documented, they have not occurred.

At some facilities surveyed over the past two years, staffing patterns appeared insufficient based on the significant acuity level of the medical or mental health conditions of inmates housed at the institution. At these facilities, documentation of care was often cursory and did not adequately describe the encounter. At other facilities, staffing patterns appeared adequate based on the medical and mental health acuity levels of the inmates served, and surveyors found the provision and documentation of care non-problematic. These institutions were usually ones with lower medical and psychological grade inmates.

Care of severely mentally ill is compromised by inadequate treatment.

These observations were particularly apparent in the mental health area. Staff at institutions housing inmates with severe mental illness carried caseloads well beyond what could reasonably be expected for provision of adequate treatment. While institutions with lower acuity inmates are not overstaffed per se, the staffing assigned appears disparate based on institutional mission and the number of inmates served, when other institutions are struggling with burdensome caseloads.

The authority requested an updated staffing pattern numerous times over the past several years, but has not received information on the department's basic staffing pattern or criteria used for specific institutional adjustments. Thus, the authority recommends the Governor and Legislature require the department to evaluate its staffing needs, consider realignment of existing staff, including administrative support positions, and provide specific justification for additional staff, where warranted. The development of a basic staffing pattern that can be modified according to institutional mission and the medical and mental health needs of patients is essential. While recognizing there are budgetary constraints facing the state, the authority believes an investment in sufficient staff is more cost effective than the potential liability arising from providing inadequate care that does not meet constitutional standards. The leaner staffing patterns become, the more likely it is this will eventually occur.

Mandatory HIV Testing

Per statutory direction, the department implemented the mandatory testing of inmates for HIV as they are being discharged from the system. The law requires that all inmates whose HIV status is unknown to the department be tested within sixty days of discharge.

Mandatory HIV testing: at admission or discharge?

For all HIV positive inmates, the department is required to notify the county health department of planned residence and is required to provide necessary transitional assistance.

Although the program has been successfully implemented, approximately eight percent of the inmates leaving the system are not tested prior to release. Some inmates invoke their legal right to refuse treatment as a means of refusing testing. The authority feels that this exclusion misses the intent of the legislation and would like to see remedies implemented to ensure that, when applicable, all inmates are tested prior to release.

While supportive of pre-release testing, the authority prefers mandatory HIV testing upon admission. Many inmates do not know their HIV status upon entering the system. Testing upon admission would provide an opportunity to assess this status and begin appropriate clinical monitoring.

Symptoms of HIV infection are often mistaken for other diseases or for a minor self-limited illness (Brown and Herbert, 2002, p.1). Accurate clinical information can beneficially affect treatment decisions and use of resources over the long term. Currently, there are approximately 3,000 known HIV positive inmates in the Florida prison system or about four percent of the status population.

Automatic External Defibrillators

AEDs save lives.

Appendix H of the authority's 1998-1999 annual report, Report on the Health Care Delivery of the Florida Department of Corrections, entitled, "Correctional Medical Authority Position Statement on Emergency Cardiopulmonary Resuscitative Procedures," summarized the authority's position on the use of automatic external defibrillators (AED) in Florida correctional institutions. The authority made several recommendations regarding staffing and training of medical personnel assigned to institutions that housed inmates at increased risk of significant emergent cardiac events. Also included was a recommendation the department "purchase AEDs for each of its prisons where the full crash cart was not historically used to its capacity and where sufficient advanced cardiac life support (ACLS) trained staff was not available." The department responded that it had completed a detailed feasibility study and received and reviewed the National Commission on Correctional Health Care (NCCHC) position statement on AEDs. The department further noted a project was in the planning phase, but funding was the major barrier to overcome.

In the authority's 1999-2000 annual report, the issue of AED placement was again addressed by recommending, "on-going training programs related to cardiac care, and placement and use of AEDs in institutions." The department's response detailed various training programs related to the identification and treatment of cardiac disease, but no reference to the purchase and use of AEDs.

The issue of the use of AEDs was once again addressed in the authority's next annual report (2000-2001). In this report, the authority recommended the "statewide placement of AEDs in institutions" and that the department "include an issue in its Legislative Budget Request (LBR) for the purchase of AEDs." The authority was provided no specific information as to whether these recommendations were considered or acted upon.

In December 2002, in the authority's 2001-2002 annual report, the use of AEDs in correctional institutions was reiterated. The authority recommended the OHS develop a "schedule for replacing outdated defibrillation equipment with AEDs." The department responded it had purchased 15 defibrillators in June 2002, and another defibrillator was scheduled for replacement as funds became available. In this case, the OHS response referenced the purchase of non-automatic defibrillators, not AEDs as recommended.

Currently of concern to the authority, as this issue is addressed yet again this year, is a presumed reluctance by the OHS to acknowledge the use of AEDs as a community standard. As indicated in last year's annual report, the American Heart Association now includes AED training as a part of basic life support instruction, and AEDs are commonplace in other state facilities, as well as in restaurants, airlines, sport facilities, hotels, etc. Additionally, as the department struggles with budgetary issues, staffing shortages, and employing and/or retaining ACLS trained nurses and physicians, the use of emergency equipment operable by minimally trained staff is more fiscally and clinically advisable than the continued purchase of non-automatic equipment that can only be operated by fully ACLS trained staff.

The authority continues to recommend the department develop a replacement schedule for outdated defibrillation equipment, and again recommends the inclusion of an issue in its Legislative Budget Request (LBR) for the purchase of AEDs.

Use of Chemical Agents

The use of chemical agents in the areas of confinement and close management has been of significant concern to the authority over the past several years. Generally, these concerns have surfaced as the result of specific incidents where oleoresin capsicum, or pepper spray, has been used in apparently inappropriate ways with serious medical and/or mental health consequences. These consequences have included serious chemical burns and, in one instance, exacerbated mental health symptomatology followed by the inmate's suicide. The reader is referred to reports of the following authority surveys for details: Okeechobee Correctional Institution, April 2001; Wakulla Correctional Institution, April 2002; Washington Correctional Institution, July 2002.

During FY 2002-2003 authority staff reviewed policies available from ten states including Florida and the federal Bureau of Prisons in an attempt to answer some of the policy questions surrounding the use of chemical agents to gain behavioral control over inmates. (See Appendix A). Of particular interest from this review was the federal Bureau of Prisons' confrontation avoidance procedure, which is described as follows in Title 28, Section 552.23, Code of Federal Regulations:

> **"Prior to any calculated use of force, the ranking custodial official (ordinarily the Captain or shift Lieutenant), a designated mental health professional, and others shall confer and gather pertinent information about the inmate and the immediate situation. Based on their assessment of that information, they shall identify a staff member(s) to attempt to obtain the inmate's voluntary cooperation and, using the knowledge they have gained about the inmate and the incident, determine if use of force is necessary."**

Such an approach may be advantageous in that it brings relevant and informed parties together to strategize alternatives to the use-of-force. Certainly, it may lend increased defensibility to any decision to proceed or not proceed with the use-of-force.

Other results of this review suggest that Florida's policies in regard to the use of chemical agents are more explicit than many other states. This is particularly the case where policy specifies the nature of medical and mental health staff involvement when chemical agents are used in non-emergency situations. The level of detail in Florida's policy most likely reflects foresight on the part of department decision-makers as well as authority advocacy for explicit policy language where staff and inmate health and safety is at risk. Still, there is room for continued improvement in certain areas. The following recommendations are made to the department (several of these recommendations appeared in the prior year's authority annual report and, to date of this writing, have not been acted upon by the department):

- **the form entitled, "Chemical Agents Risk Assessment", DC4-650B, should be revised for purposes of clarity per authority comments previously provided;**
- **the list of conditions that may be exacerbated by chemical agents and electronic restraining devices (ERDs) should be expanded as per authority comments previously provided;**
- **the level of health care provider allowed to complete the risk assessment without a higher-level review should be at least a registered nurse;**
- **the department should reinstate videotaping of non-emergency use of chemical agents and ERDs through use of permanent fixed-mounted camera systems in confinement and close management units;**
- **the requirement for a face-to-face evaluation by mental health staff following chemical agent or ERD use should be expanded to include inmates of all psychological grades;**
- **in the event of repeated administration of chemical agents or ERD use within a short time period (e.g., 24 hours), a mental health evaluation should be mandatory that day or as soon as possible the next working day, regardless of inmate psychological grade;**
- **the department should consider adoption of the confrontation avoidance procedures utilized by the federal Bureau of Prisons;**
- **training of correctional staff should continuously emphasize non-confrontational communication styles as the easiest and most effective means of avoiding the need to use force.**

These recommendations are offered in the spirit of a goal the authority shares with the department - ensuring a safe environment for both staff and inmates through reducing the need for force and eliminating potentially serious medical and mental health consequences for all involved.

Suicidal and Self Injurious Behaviors

In four prior annual reports, the authority recommended the department implement a policy requiring observation intervals no greater than 15 minutes for inmates placed on suicide/self-injury prevention status. Current policy describes a protocol, SOS II, in which inmates are observed at 30-minute intervals. In June 2002, the department presented a draft policy for review that incorporated the authority's recommendation. However, this policy has not yet been adopted. Once more, the authority urges the department to comply with national correctional and community standards in ensuring that observations for inmates at risk for self-harm do not exceed 15 minutes.

The authority advocates out-of-cell exercise beginning the first day of confinement.

Exercise in Special Housing

For the third consecutive year, the authority recommends revision to departmental procedures that do not permit adequate out-of-cell exercise for inmates in confinement. Current procedures require a 30-day waiting period before three hours of exercise per week is allowed. Based on the ACA standards, the authority advocates out-of-cell exercise of one hour per day, five days per week for all inmates in special housing units, beginning the first day of confinement. Failure to provide this exercise has medical and psychological implications as well as potential legal ramifications.

BUDGET AND PERSONNEL

The authority's budget and personnel committee provides financial oversight of the department's health care services related expenditures and management processes. Additionally, the committee reviews the OHS legislative budget request and provides recommendations for funding the OHS budget to the Governor and Legislature.

The committee is comprised of a group of citizen volunteers whose backgrounds include a variety of expertise, including health care financing and consulting, hospital administration, and governmental budgeting and accounting.

FY 2002-2003

The General Appropriations Act passed in the Spring of 2002 for FY 2002-2003 provided nearly $267 million and initially placed the OHS in a better financial position than in prior years. This funding, however, was equivalent to year-end FY 2001-2002 expenditures. Thus, at the beginning of FY 2002-2003, the department projected an approximate $4 million deficit for the upcoming year. However, by January 2003 it was necessary to revise the projection and the OHS estimated a deficit of $13 million. This deficit was predicated on numerous factors including (1) the Criminal Justice Estimating Conference's projected increases in average daily population, (2) the projection of sick and annual leave payouts for employees reaching a mandatory June 30 retirement date, (3) continued need for medical staff supplied by private health care agencies, (4) necessary revisions to the Wexford contract and (5) the increased cost of purchasing pharmaceuticals, community hospital and physician services and other medical/ancillary services and supplies.

Over the past 10 years the department has made numerous changes in its operations that resulted in significant cost containment. These were discussed in detail in previous annual reports and include such approaches as:

- **developing a utilization management program for retrospective and current review and length-of-stay case management;**
- **reducing the number of institutions at which inmates with serious medical conditions are housed;**
- **reducing the number of dentists and increasing the use of dental assistants;**
- **closing all but four pharmacies, one each in regions 1 – 3 and one at Reception Medical Center Hospital (RMC);**
- **contracting for laboratory and radiology services;**
- **centralizing chemotherapy services at RMC;**
- **negotiating contracts with hospitals and physicians;**
- **contracting with the private sector for provision of health care in specific institutions and in region 4; and**
- **installing a mobile surgery unit at RMC for outpatient surgery.**

The budget and personnel committee believes while some modifications of these efforts may generate additional small pockets of cost avoidance, major cost avoidance efforts have been exhausted. For the department to recover from its consistent deficit status, legislative appropriations will have to be sufficient to address the costs of producing and purchasing health care services in Florida.

While there is always concern that health care expenditures for inmates are extreme, an interesting comparison is the cost of providing health care coverage for state employees. The department acts in effect as the insurer for inmates. In fact, the authority first made this comparison in its April 1989 report. At that time the department's average costs for providing care ($2,500 per inmate) were more than twice that of the average of state health plan options ($1,000 per employee).

For FY 2002-2003, with total expenditures of $281 million, the "insurance premium" for the average daily population of 75,276 inmates is approximately $3,700 per inmate. For the same time period, the average cost of individual coverage for a state employee (state and employee contribution) totaled $3,490 per employee. While the inmate costs appear higher, other factors must be considered.

The department's premium includes dental coverage as well as mental health crisis and inpatient coverage. State employees also incur additional costs in the form of co-pays for office visits and prescription medications and/or deductibles. It is conceivable the annual cost of these items would bring the totals more nearly in line. Another consideration is the state employee pool may generally be a healthier population than the incarcerated population. It is generally accepted in correctional arenas that inmates have more chronic conditions and age more rapidly than their counterparts in the community. Thus, one must consider that the cost of providing health care to inmates may not be out of line with the cost of an insured employee's purchase of health care services.

FY 2003-2004 and beyond

It is unlikely that the $289 million funded by the 2003 Legislature for FY 2003-2004 will be sufficient to cover the cost of providing medically necessary care, once again leaving the OHS in a deficit posture. Since medically necessary care cannot be denied regardless of budgetary appropriations, this places the department in the position of transferring funds from other budget entities to supplement the underfunded OHS portion of the budget. As it has in previous reports, the authority expresses concern about this necessity and urges the Legislature to adequately fund the department's provision of health services.

Despite inadequate funding, medically necessary care cannot be denied.

The authority is also concerned about continued insufficient funding as it relates to several issues that will affect the cost of medical care in upcoming years. In particular, the treatment of Hepatitis C, geriatric and end-of-life care, as inmates with long-term sentences age and expire in the system, will impact future expenditures.

MENTAL HEALTH

During FY 2002-2003, the Mental Health Committee focused on the adverse impact of budget reductions that all state agencies have experienced and the impact these cuts have had on the mental health services provided to Florida's inmate population. Data provided by the department have consistently demonstrated rising caseloads for clinicians. Many authority survey findings were linked to staff shortages. The committee recommended the department request additional funding to provide the minimal amount of staff necessary for appropriate services; however, no such changes have been reflected in the LBR.

To fulfill its statutorily prescribed role of oversight of clinical and budgetary functions, the committee requested workload and budget data for region 4, the region operated by the private company Wexford, in addition to the data requested for state run facilities. Wexford has not met this request to date, resulting in the committee's inability to review the information during FY 2002-2003. The committee is interested in reviewing any ways in which Wexford has implemented innovative practices to reduce cost, as this was highlighted as a benefit of the privatization endeavor.

In addition to reviewing the effects of budget reductions, the committee reviewed several issues affecting the mental health care provided to inmates. These topics are described below.

Topics from the FY 2001-2002 Mental Health Committee Report

Practitioners Covering Multiple Institutions

Several surveys conducted during the FY 2001-2002 cycle generated findings related to a lack of adequate staffing and on-site supervision. The practice of having psychologists and psychological specialists responsible for two or more institutions was linked to these deficiencies. Continued monitoring of this issue during FY 2002-2003 indicated that this practice is still utilized in regions 3 and 4. Insufficient staffing resources play a significant role in the inability of the department to resolve this problem.

Continued Use of Locum Tenens Psychiatrists

Reliance on temporary psychiatric staffing, known as locum tenens, continues to plague the department and leads to concerns with continuity of care. Despite attempts by the department to recruit qualified, full-time physicians, locum tenens make up a significant portion of the psychiatrists working in Florida's prison system. Although the committee identified lack of competitive salaries as one contributing factor to the problem, no attempts to address salary concerns for correctional psychiatrists were identified.

Locum tenens–a significant portion of prison system psychiatrists.

Restoration of Psychiatric Consultant Position

The committee recommended the position of psychiatric consultant be reinstated to allow for appropriate training and peer review of psychiatrists in the department. This function is of critical importance due to the high number of locum tenens employed. Although the OHS assigned a psychiatrist to this position, the placement is not full-time. Additionally, the psychiatric consultant has also been named the Regional Medical Executive Director for region 3. As a result, the ability to conduct the training and peer reviews recommended by the committee is limited.

Proposed Reductions in Service Delivery Logs

In an attempt to locate areas of potential workload reduction in light of rapidly dwindling staffing resources, the department chose to eliminate several service delivery logs that were required at the institutional level. In FY 2002-2003, the list of required logs was reduced from 13 to 6. The authority will continue to monitor the practice throughout the next fiscal year.

Examination of the Ranges in Caseload Sizes

A primary concern identified during FY 2001-2002 was the growing caseload sizes for psychiatrists and psychological specialists, particularly at S-3 institutions. The committee recommended that an analysis of workload data be completed for the reallocation of resources in areas of critical need. This recommendation has not been implemented, and FY 2002-2003 brought soaring caseloads at a greater number of S-3 institutions.

Implementation of S2P Program

A pilot program housed at Polk Correctional Institution permitted a limited number of inmates to self-administer keep-on-person psychotropic medications under the supervision of a general medicine practitioner with psychiatric consultation. A survey of Polk Correctional Institution in July 2003 confirmed the S2P program had been discontinued.

Cognitively Impaired Inmate Pilot Program

A policy directive provided for the development of a specialized program for offenders identified as cognitively impaired. During FY 2002-2003, however, this policy was abolished, as were any further plans for this program. A lack of resources and the lack of appropriate program participants were cited as reasons for discontinuation of the program. The committee expressed concern that many inmates with limited cognitive functioning were unidentified in the population and might benefit from such a program.

Group Case Management Concept

Introduced at several institutions in response to limited staffing resources, the provision of case management in group settings was a controversial topic during FY 2001-2002. Although members acknowledged the benefits of group processes, concerns regarding the maintenance of confidentiality and availability of individual contact if needed were voiced. During FY 2002-2003, no further expansion of this approach was identified during surveys.

FY 2002-2003 Committee Topics

Reductions in Substance Abuse Programs

During the August 16, 2002, meeting, a representative from the department's Substance Abuse Program described the budget cuts experienced by the department in the area of substance abuse treatment. Although these cuts were made in the previous fiscal year, they resulted in a decrease during FY 2002-2003 of the number of treatment beds available. The $10 million dollar cut resulted in the then available 6,646 beds being reduced to 1,512 beds to serve the entire inmate population. The committee encouraged the department to pursue restoration of adequate funding.

Use-of-force

Throughout FY 2002-2003, the attention of the committee was drawn to the issue of use-of-force and the involvement of mental health staff in the process. During the August meeting, committee members expressed concern that escalation of inmate behavior to a level resulting in the use of chemical agents or the electronic restraining device might be related to insufficient mental health services for inmates suffering from a mental health disorder. Changes in policy to require increased contact with mental health staff were discussed. The Director of Mental Health Services reported that department staff were scheduled to attend training by the National Institute of Corrections that might help alleviate concerns.

However, during the January 2003 meeting, the Director reported that no recommendations resulted from this training. The committee once again expressed concern regarding the use-of-force with inmates suffering from a mental health disorder, particularly in light of reports that significant force may be used in the event of verbal disturbances posed by these inmates without a threat of harm to themselves or others. Discussion continued to the May 2003, meeting, during which the Director presented a policy modification in draft form requiring mental health staff to complete a mental status examination by the next working day for S-2 and S-3 inmates. This issue will continue to be followed in the next fiscal year to ensure that adequate services are provided to the mentally ill population.

DC Procedure 403.007: Medication Administration and Missed Medication

Issued April 2001 and reviewed August 2002, DC Procedure 403.007 standardizes the medication administration times for all institutions to 7 a.m. and 4 p.m. It also delineates a procedure for the refusal of medication. The committee members expressed concern that this procedure compromises the prescribing practices for psychotropic medications, many of which should be given at the hour of sleep. Additionally, committee members expressed concern that the procedure for refusal of medication is unduly punitive and is not in the best interest of the patient. The procedure requires inmates who do not come to the medication administration line of their own accord to be brought to medical for the purpose of signing a refusal. However, if at that time the inmate indicates a desire to take the prescribed medication, it is not made available and the inmate is required to sign the refusal form. The committee expressed concern that misleading blood level monitoring and reappearance of psychiatric symptoms could result.

At the May meeting, the department presented a draft of a policy revision. This revision contained language that permitted practitioners to prescribe outside of the standardized times. However, no change was made to the procedure for medication refusals. At the time of this report, the draft revision has not yet been adopted.

Psychiatric Medication Availability

Committee members requested clarification from the department regarding those medications available at all institutions in the event of a psychiatric emergency. It was determined that there is no standardized requirement for stock medications to be kept for this purpose. The committee recommended that a psychiatric emergency medication kit be developed and disseminated to each major institution. This kit was not developed during FY 2002-2003.

Changes to Statute Governing the Corrections Mental Health Institution

Correctional Mental Health Institution (CMHI) is the inpatient mental health facility located at Zephyrhills Correctional Institution that permits involuntary placement and medication. Admission to CMHI and subsequent involuntary treatment requires an order of the court if the inmate does not submit to these procedures voluntarily. Additionally, no other facility in the state (e.g., Crisis Stabilization Units and Transitional Care Units) is permitted to administer ongoing medication without consent.

Departmental staff reported that numerous problems exist surrounding the use of CMHI. Of utmost significance is inaccessibility of the court system in several South Florida counties. Due to lack of timely court hearings, there have been significant delays in providing treatment to those inmates in desperate need. Furthermore, once an inmate has been stabilized on medication, he/she is returned to an institution unable to continue the use of involuntary medication, resulting in frequent readmissions to CMHI.

In an effort to ameliorate these problems, the department submitted a proposal to the Legislature that would change the statute governing CMHI in two significant ways. It would create an internal administrative panel that would replace the court system for approval of placements to CMHI and, secondly, the panel would also provide approval for involuntary psychotropic medication. At the time of this report, no action had been taken on this issue.

Committee members expressed several concerns about the use of an administrative panel. Recommendations included the use of non-departmental staff on the panel to avoid bias and the inclusion of specific patient rights in the statute rather than only in administrative rule.

An additional approach to reorganizing the system for involuntary psychiatric commitment presented by the department is to distribute the CMHI beds to CSUs throughout the state. By doing so, the department could lessen the burden on local court systems. Committee members expressed concern that this approach could lower the degree of programming and treatment provided to inmates needing the highest level of care.

Staffing

Grave concerns continued to surface during the committee meetings about the department's ability to provide adequate mental health treatment to those inmates in need, due to its dwindling human resources. Recent data provided to the committee from the department revealed, at several S-3 institutions across the state, caseloads for therapists exceeded 100 patients and caseloads for psychiatrists were estimated over 250. Inpatient mental health units reviewed in the past year did not offer the required level of services to their patients, and the majority of S-3 institutions surveyed resulted in significant findings.

In response to these reports, at the committee's request, the authority corresponded with the Secretary regarding those concerns. Nevertheless, as discussed earlier, the department did not request additional funding for mental health staff in its LBR.

Summary

As in past years, this fiscal year has been characterized by reductions in budgetary resources. Despite the committee's continued recommendations that additional funding be sought to alleviate the unmanageable workload placed on mental health staff, the department has sought no such funding. Until efforts are made to reduce workload, it is likely that serious deficiencies in care will abound.

QUALITY MANAGEMENT

Quality Management Oversight

Statutes require the authority to appoint and maintain a medical review committee to provide oversight for the department's inmate health care quality management (QM) program. This committee reviews amendments to the department's QM program prior to their implementation by the department. The committee also assesses the overall organizational plan, program objectives and processes for the inmate health care clinical QM program. Functioning of the QM program at the institutional level is assessed during the survey component of the authority's mission.

Quality Management Survey Findings

At eight institutions surveyed during FY 2002-2003, the QM program was functioning at less than an optimal level. A common survey finding at those institutions centered on quality management meeting minutes that were not descriptive enough to reflect the committee's discussion and analysis of QM data in terms of patterns, trends, unusual events or concerns. Information about committee action and improvement interventions was also not detailed in the minutes.

Another finding at those institutions was lack of evidence of development and submission of a required trending report and discussion of the improvement plan for each standard scoring <80% during the annual clinical quality review. Department policy requires intervention and monitoring of standards scoring <80% until a score of 80% is achieved and sustained for at least three months.

A third finding where survey results for the QM program were less than optimal involved the lack of clinical peer review for all credentialed practitioners. However, during FY 2002-2003, the department instituted a peer review component as part of the annual clinical quality review, and the authority does not anticipate future deficiencies in this area.

Authority Assessment of the Clinical QM Program

Quality management programs commonly encompass three general areas: (1) a means to measure the quality of care, generally referred to as quality assessment or improvement, (2) utilization management and (3) credentialing and recredentialing. Other areas commonly addressed by the health care community include infection control and risk management. The department's inmate health care clinical QM program encompasses seven components. Policies and procedures for each area are delineated in Health Services Bulletins/Technical Instructions. The authority's QM committee expects all health care QM policies to be complete, up-to-date and based on current QM practices.

The chart below identifies QM policies currently in place and their effective dates

HSB/TI	Title	Effective Date
15.09.01	Clinical Quality Management	2/10/2003
15.09.02	Infection Control Reporting to the Department of Health	4/7/2003
15.09.03	Infection Control Program	1/4/1999
15.06.04	Utilization Management Program	7/18/2000
15.09.05	Credentialing and Privileging Procedures	10/3/2001
15.09.06	Medical Peer Review Committee	11/7/2000
15.09.07	Clinical Quality Assessment Program	4/7/2003
15.09.08	Clinical Risk Management Program	10/15/2001
15.09.10	Mortality Review Program	4/26/2002
15.09.11	Management of Central Office Confidential Clinical Quality Management Materials	4/1/2003

The Medical Peer Review Committee policy was routed for review during the previous fiscal year, and has not yet been finalized and disseminated. Revisions included in this policy address the annual clinical peer review for credentialed practitioners as part of the annual clinical quality review process. The authority recommends the department finalize the policy and distribute it to the field expeditiously.

The Infection Control policy guidelines are now more than four years old. The OHS has indicated review of this policy is in process. The authority encourages the department to submit this document for comment and finalize and distribute it in as timely a manner as possible.

Quality Assessment Component

The shift in the QM program's measurement of quality of care provided from one centered on focused studies to one centered on quality indicators is now complete. The clinical quality assessment component of the clinical QM program is structured around a system where an annual clinical quality review (CQR) is conducted at each institution between July 1 and October 31. Instruments containing performance indicators are applied to the institution's implementation of statewide administrative policies and procedures and also to documentation contained in individual medical records to identify areas where performance does not meet expectations.

An institution scoring below a specified level on an indicator is expected to implement an intervention to improve performance and monitor the indicator monthly. If monthly data fails to show improvement in meeting the standard, the institution is expected to undertake an investigative study to determine the cause(s), and initiate further corrective action or intervention to successfully meet the standard. Currently the QM program applies a benchmark of below 80% before requiring monitoring of an indicator or implementing any intervention to improve performance.

In the physical health area, three years of data is available for many indicators. The March 2003 statewide clinical QM meeting included a presentation of data that compared thresholds over the three-year time frame and highlighted increases or decreases in statewide performance. During the upcoming year, QM program staff will evaluate the current instruments and available data to create instruments for use in the next CQR cycle from July through October 2004 that have a more clinical focus and reflect current practice standards. As a part of that revision, the authority recommends the QM program adopt thresholds for clinical indicators that are specifically linked to the potential impact on continuity of care. For example, there is an accepted standard of care that clinicians always address abnormal diagnostic or laboratory test results. Thus, the threshold would be 100%.

The shift to clinical indicators is now complete. The department should now evaluate indicators for their impact on continuity of care and determine acceptable performance thresholds accordingly.

The mental health indicators were significantly revised for FY 2002-2003 and also will be reviewed for additional revision for development of the FY 2004-2005 instruments. A focus on development of indicators that reflect clinical outcomes is recommended.

In summary, the quality assessment component has successfully transitioned to a program based on specific performance indicators. This activity returns data at the institutional level that, when combined with the authority's survey findings, provides staff sufficient information to formulate necessary interventions to improve performance. Follow-up monitoring and reporting of data during QM committee meetings should reveal successful compliance with administrative procedures and improvement in documentation and provision of quality care.

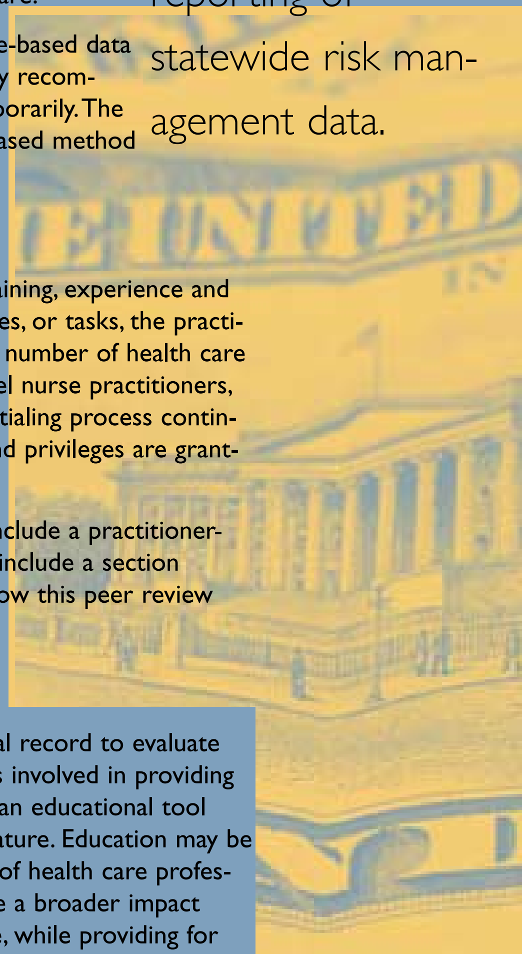
Risk Management Component

The risk management component of a QM program is intended to help identify, investigate and analyze where practices occur that could lead to an adverse outcome. These programs are generally intended to protect patients from harm and the agency from foreseeable or preventable loss. The risk management program gathers data on (1) patient injury that occurs while a patient is under the care or control of health services personnel, (2) medication errors whether or not they require intervention and (3) other high risk or sentinel events, including bloodborne pathogen exposure. Sentinel events are those that involve an unexpected occurrence of death or serious physical or psychological injury, or the risk thereof, and signal the need for immediate investigation and response.

After several years of consistent under-reporting in the risk management area, participation increased dramatically as more institutions in regions 1-3 reported data during FY 2002-2003. While the data reported demonstrates increases in the number of patient injuries and medication errors, this is likely attributable to the increased number of institutions reporting. Improvement in participation was seen in all regions except region 4, where Wexford provides health care.

The authority recommends rate-based reporting of statewide risk management data.

During the current fiscal year, the OHS briefly discussed the feasibility of reporting rate-based data to the statewide committee, rather than numerical data. Several years ago the authority recommended rate-based reporting of risk management data and this change was made temporarily. The authority again recommends rate-based reporting and encourages a return to a rate-based method of comparing data at the statewide level.



Credentials Review Component

Credentialing is the process by which an organization verifies a practitioner has the training, experience and licensure necessary to perform the functions of a position, and determines the privileges, or tasks, the practitioner can perform based on those qualifications. The department credentials a limited number of health care professionals. Among them are all physicians, physician assistants, dentists, advanced level nurse practitioners, and doctoral and master's level mental health staff. During the current year, the credentialing process continued to operate smoothly. Generally, credentials packets are submitted and reviewed, and privileges are granted in a timely manner.

For several years the authority has contended that the credentialing program should include a practitioner-profiling component. As mentioned earlier, the Medical Peer Review policy is slated to include a section requiring an annual clinical peer review. However, it remains unclear to the authority how this peer review will link with the credentialing process.

Mortality Review Component

Mortality review is a process of retrospectively reviewing documentation in the medical record to evaluate the quality and appropriateness of the health care provided. The administrative systems involved in providing care are also reviewed during this process. Mortality review is intended to function as an educational tool when areas of deficiency are identified, whether they are clinical or administrative in nature. Education may be limited to the health care professional that provided the care, or extended to a group of health care professionals where a systems deficiency existed or the deficiency is one that is likely to have a broader impact than one provider. The purpose of mortality review is to improve the quality of service, while providing for professional growth and development.

The department's mortality review program has multiple levels of review. All deaths are reviewed at the institutional level. Usually the physician that provided the care heads the mortality review team that conducts the review. A second independent review is conducted by a contracted physician and also by a psychiatrist in the event of a suicide. This review is commonly referred to as the "outside review." Whenever deficiencies are identified, further action is necessary. If identified at the institutional level, immediate corrective action is undertaken. If identified at the outside review level, an additional review is undertaken at the regional or central office level to determine if corrective action is warranted. Outside reviews consistently surface issues that were overlooked or not addressed by the institutional review. Historically, over two-thirds of all cases with care deficiencies were identified at the outside review level..

The authority's QM committee also reviews a selected number of mortality cases where deficiencies in care were identified. The authority's QM committee continues to find some institutional reviews focus only on care surrounding the terminal event, and do not objectively evaluate the overall care of the patient that may have led to the terminal event. For this reason, for the past two annual reports the authority made two recommendations for enhancements to the mortality review program. The authority reiterates those recommendations in this report.

The first recommendation involves development of an inservice education program for physicians specifically designed to provide information on how to conduct an effective, objective case review of the provision of care. This would involve education on evaluating all components of care and the administrative systems surrounding the provision of that care. The authority's QM committee's review of mortalities often identifies systems issues that impact care, such as incompletely or inaccurately completed health information upon transfer from institution to institution; delays in scheduling appointments with a specialist, thus delaying diagnosis, or after diagnosis of a life-threatening condition, delay in scheduling appropriate required treatment, thus exacerbating the condition and limiting or reducing the prognosis for effective treatment and recovery. The authority believes a training program focused on conducting a thorough objective mortality review could be effective in ensuring identification of possible care and systems deficiencies at the outset, prior to identification by a contracted outside reviewer or the authority's QM committee.

The authority's second recommendation centers on the premise the physician providing care to the patient may not be able to conduct the most objective review of that care. The authority again suggests the department consider a process by which a department physician, possibly from another institution, who was not involved in the provision of care, conduct the mortality review. The department's usual practice is to include a physician at the institution as a member of the institutional mortality review team. At some institutions with only one physician, this results in a physician reviewing his/her own provision of care. Additionally, the institutional team normally consists of other non-physician or non-clinical health care staff, such as the dentist, nursing supervisor, medical records supervisor, psychologist, dentist, and the health services administrator. The authority questions whether these members have the clinical ability to discuss care provided and implications of diagnostic tests or failure to order diagnostic testing. The authority also is aware non-clinical members of the team might be hesitant to question the physician.

Implementation of these two recommendations could lead to earlier identification of deficiencies in care or shortcomings in the systems processes at the institutional level, and, thus, earlier intervention. The authority believes the mortality review process should be one designed to identify areas where systems processes affect adequacy of care provided and also to identify areas where clinical education might be beneficial not only to a specific provider but other health care providers as well.

A recent study published in the New England Journal of Medicine revealed it is not uncommon for physicians to fail to follow the treatment guidelines recommended for many common ailments. The numerous treatment changes and advances in medicine over the past years have made it difficult for physicians to remember the dozens of guidelines and hundreds of recommendations for every medical condition. These advances in medicine make it incumbent upon the department to identify those areas where continuing education needs to be provided. The department also should provide its physicians with a systematic way to ensure recommended approaches to common ailments are addressed and considered.

Authority Case Reviews

As mentioned previously, the authority's QM committee reviews a limited number of mortalities where deficiencies in care have been previously identified. This review focuses on the effectiveness of the department's mortality review process. This process first involves a review of the medical record to determine whether the authority's physician reviewer concurs with the institutional and/or outside review. It is not uncommon for the authority's reviewer to identify either care or systems issues not previously identified by prior reviewers. After reviewing the record for care and systems issues, the authority's reviewer summarizes his review and the mortality review conducted by the department and any corrective action resulting from that review for the committee. During FY 2002-2003, the authority's QM committee reviewed 17 cases. The committee determined the peer review process was effective in nine (53%) of the cases. In the remaining eight cases, the committee determined the peer review process was not adequate. In six of those cases, the institution did not identify deficiencies in care or systems, thus no corrective action was undertaken. In the remaining two cases, the committee determined the documentation that recommended corrective action had occurred was insufficient.

Case Closure

Case closure is the process of ensuring that all steps of the mortality review process have been completed and all documentation with respect to any corrective action required has been received by central office for inclusion in the mortality review file. In its last two annual reports, the authority noted the department needed to improve its time frames for closing mortality cases. Three cases were in excess of two years old. While this year the department has more open cases in the one-to-two year range, much of this is attributable to the several months' vacancy in the deputy director of clinical services' position.

Insert "pull-out/highlight box" with the following: The department made admirable progress in closing mortality cases.

However, despite that vacancy, the clinical QM program made admirable progress in closing cases, including the three long-term cases. All but one of FY 2000-2001 cases are closed. Ninety percent (90%) of FY 2001-2002 cases are closed, and nearly 50% of FY 2002-2003 cases are closed. With the deputy director's position now filled, the authority's QM committee expects an improvement in prompt closing of mortality cases. For peer review to be an effective educational tool, necessary corrective action for involved staff must be implemented, completed and documented without delay. In addition, cases where identified deficiencies may have a broader impact should be referred to the continuing medical education committee for future educational offerings. For example, during the current fiscal year, the clinical QM program conducted a special review of deaths over the past three years from colon cancer. This study revealed one-half of the deaths had a delay in diagnosis, and a CME course on diagnosis of colon cancer was offered.

Mortality Data

The MR program is also the repository for data about the numbers and causes of deaths that occur within the state prison system.

During FY 2002-2003, 208 deaths occurred in the state system. Of those, 65% (135) were attributable to three conditions: 29% cancer, 23% cardiac related conditions, and 13% HIV/AIDS. During this fiscal year, the number of deaths attributable to HIV/AIDS has remained similar to previous years.

Also, after a slight decline in the previous fiscal year, deaths per thousand returned to the rate reflected since the 1998-1999 fiscal year, 2.7 deaths per thousand inmates.

Infection Control

The infection control program (IC) defines the parameters for required reporting of infectious diseases within the correctional system to the Florida Department of Health and collects surveillance data on other infectious diseases and conditions. Data on bloodborne pathogens, infection related to dialysis procedures, and infection resulting from surgery at the mobile surgical center at RMC are also collected and analyzed. Current year data demonstrates a continued increase in the number of institutions reporting data to the central office IC coordinator.

Last year's report noted a special project was undertaken based on inconsistent reporting of dialysis infection data by the contracted vendor providing dialysis at RMC. Reporting of data continued to be problematic over the course of the current fiscal year. Turnover in the vendor's staff resulted in lapses in data or inaccurately reported data and required repeated intervention and training by central office staff.

Utilization Management

Utilization management (UM) is a function of quality management that is designed to manage the use of limited resources to maximize the effectiveness of care provided. Written clinical practice guidelines promote fair and consistent use of services. Generally UM programs include preauthorization, concurrent review, discharge planning, retrospective review, and case management. UM decisions should be made in a fair, impartial and consistent manner and all patients should have equitable access to care across the system.

The department operates a statewide utilization management program at RMC. The department provides health services under a managed care model and the UM program processes pre-approvals for scheduled hospitalizations, ambulatory surgeries and specialty consultations. It also provides retrospective review for emergency hospitalizations. Possibly unique to the department, its UM program also coordinates patient transfers from non-contract hospitals to ones with which it has contracts, or from contracted facilities to intrasystem facilities such as the department's hospital at RMC or an institutional infirmary setting. This system of internal transfers results in cost avoidance related to both health care and security. During FY 2002-

2003, the department projected it avoided expenditures for hospitalization and related security costs and for step-down care of approximately $4 million. Data also show the majority of hospital admissions occur at hospitals with which the department has contracts for reduced fees.

Like last year, primary admission diagnoses continue to be (1) circulatory or cardiac related conditions, (2) digestive conditions including liver failure, and (3) injury and/or poisoning. This category includes clotted or infected grafts of dialysis patients, self-mutilation and overdoses. The latter two categories are generally related to suicide gestures or attempts. During the fiscal year, injury and/or poisoning accounted for nearly 20% of all admissions.

Program Evaluation

Not unlike the QM program evaluating the effectiveness of the provision of health care, program evaluation is the measurement of the effectiveness of the QM program. Periodically each program component should be reviewed to ensure the data is useful for making management decisions to improve the provision of care. Program evaluation is a process of assessing existing efforts and refining data collection to ensure staff and management have the information necessary to affect improvement interventions that will result in a better quality of care.

The program evaluation component of the department's OHS has been fraught with obstacles over the years. The authority originally recommended the department contract with a consultant to measure the effectiveness of its QM program. Due to budgetary constraints, an internal evaluation program was envisioned. Although in existence for more than five years, that internal evaluation component is not yet fully developed. Several times during its history, the program evaluation function has been suspended and its staff assigned to other projects.

Last year's report noted a renewed emphasis on program evaluation and the undertaking of a review of the quality assessment component, specifically the clinical quality review process and its associated instruments. Performance improvement initiatives were developed for the CQR process. The authority encouraged the department to undertake an evaluation of each of the QM program components. Unfortunately, this did not occur. Once again it was necessary for staff to assist in other health care related initiatives. In this year's case it was development and implementation of policies and procedures to comply with the Health Information Portability and Accountability Act (HIPAA).
Although the authority recognizes quality management staff occasionally must be assigned to other projects, it urges the department to extend its evaluation process to each QM component.

Pharmacy Component

Statutes require pharmacies to maintain a continuous quality improvement program. The department currently operates four pharmacies that dispense medications to patients in the prison system. These pharmacies are required to report quality related events involving inappropriate dispensing or administration of a prescribed medication. These events involve dispensing errors that are a variation from the prescriber's prescription order or a failure by the pharmacy to identify and manage instances of prescribing errors that may affect the patient, for example, therapeutic duplication or drug-disease contraindication/interaction.

Department pharmacies should accurately report the occurrence of quality-related events.

Additionally, non-dispensing pharmacies exist at the remaining institutions for storing and administering prescribed medication at specified pill line times. Medication administration errors resulting from this interaction are generally reported through incident reports to the risk management program. Examples are the wrong medication being given to a patient or an incorrect dosage of the appropriate medication being given.

Prior to the current fiscal year, pharmacy quality management data was reported only to the department's Pharmacy and Therapeutics Committee. Beginning in FY 2002-2003, the department began reporting information with respect to dispensing errors to the statewide clinical QM program. This current fiscal year focused on improving the reporting of information to central office and clarifying what information is required by statute. For instance, during the first quarter, one pharmacy reported no dispensing errors, a recognized impossibility, especially given the volume of medications dispensed. As a result, central office staff met with institutional staff and learned, for example, that an institution receiving incorrectly dispensed medication returned it to the pharmacy prior to it being administered to the patient. Since the error had been identified, the pharmacy incorrectly did not count the error. The pharmacy director is continuing to monitor this area and while the percentage of reported quality-related events is less than might be minimally expected, over

the course of the fiscal year, improvement in reporting is evident.

The authority recommends the department continue its efforts to encourage its pharmacies to more accurately report pharmaceutical quality-related events until the percentage of reported quality-related events more closely resembles what is actually occurring and what might reasonably be expected when compared to the community-at-large.

Medical Peer Review

An annual clinical review for specified health care providers is an expectation of national correctional organizations and is also common practice in the community setting. After discussion of this issue last year, the authority and the department agreed a specific document would be developed for the authority's review during the survey process. This document would identify the practitioner and the records reviewed with respect to that practitioner's provision of care. The department indicated it would incorporate this annual clinical review component in its annual CQR process and include this change in the medical peer review policy. The department indicated it planned to release the revision to that policy during the first quarter of FY 2002-2003. As of the beginning of FY 2003-2004, an update has not been released.

Responding to an inquiry from the authority, the department indicated it had instructed institutions via an administrative memorandum to conduct clinical peer reviews for clinicians in specified health care classes during the annual CQR audits. Survey results with respect to clinical peer reviews were inconsistent during FY 2002-2003. Some institutions were able to produce a document outlining the specific records reviewed for each clinician. This documentation is acceptable to the authority. Other institutions produced a memorandum stating peer reviews had been conducted for specified practitioners. The authority does not deem this adequate.

The authority encourages the department to release a policy revision that specifically sets forth the requirements for annual clinical review and also develops a common format for peer reviewers to use during the annual CQR process.

Other Areas

While not specifically QM components, health education and the inmate grievance process are indirectly linked to the QM process.

Health Education

The department continues to be an accredited provider for continuing medical education (CME) credits for physicians and continuing education units (CEUs) for nursing and mental health staff. Numerous training activities are presented each year, and the department is improving tracking of these activities.

The department is also improving the link between QM mortality review findings and CME course offerings. This year several areas were identified for which statewide CME presentations on appropriate work-up and treatment strategies are planned. These include asthma, anemia, and clinical signs and symptoms of AIDS. Evaluation of Thrombocytopenia and liver function tests are also planned.

Grievances

Information gained from analyzing the category and number of inmate grievances related to medical care can be used to improve service provision. For this reason the authority has encouraged the department to consider this data and link it to its performance improvement efforts.

The grievance data currently provided the QM program by other department program areas is not useful in this respect. The authority continues to recommend the OHS work with other departmental program areas to obtain data in a useful format for development of QM indicators or focus studies, when warranted.

NURSING SHORTAGE AND STAFFING SOLUTIONS

There is a well-documented shortage of nurses in the United States. The following discussion examines some options to aid in the recruitment and retention of nurses within Florida's correctional system.

Background

A 29% shortage of RNs by 2020 is estimated by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), in a report projecting the supply, demand and scarcity of RNs if the current nursing shortage and trends are not addressed. The study further projects a shortage of over 61,000 RNs in Florida or a need for 33% more nurses than will be available (HRSA, 2000).

The November 2001 Monthly Labor Review published by the U.S. Bureau of Labor Statistics (cited in The American Association of Colleges of Nursing (AACN) Nursing Shortage Fact Sheet) indicated more than one million new and replacement nurses will be needed by 2010. A 21% increase in the need for nurses nationwide was projected by the U.S. Department of Labor from 1998 to 2008 (AACN, 2002). Even though Florida has the highest percentage of elderly in the nation, it ranks 31st in the number of RNs per 100,000 population. Pennsylvania with the second highest percentage of elderly in the nation is 28% above Florida's supply of RNs (FHA, 2001).

Health Care's Human Crisis: The American Nursing Shortage by Kimball and O'Neil for the Robert Wood Johnson Foundation states that today's nursing shortage is different from years' past and is related to several factors. As the population ages, it is probable that the demand for nursing care will increase and further strain the health care system. There are fewer younger workers entering the workforce creating intense competition for staff. The aging nursing workforce will also impact the shortage. The average age of nurses is 44, and it is likely that many will retire within the next decade. The physically demanding nature of nursing prevents many individuals from working in nursing much past their mid-50's. Also, the present racial and ethnic makeup of the nursing profession does not mirror that of the increasing diversity of the United States. To make nursing more reflective of society and attract necessary new nurses, recruitment from minority groups must become a priority. Another problem exacerbating the nursing shortage is the many women that have left nursing for other professions. Additionally, an insufficient number of men have entered the profession. The prime source of young workers (Generation X) does not view nursing as a desirable profession. Lastly, the increased demands stemming from diminished resources have resulted in workplace dissatisfaction among nurses (Kimball & O'Neil, 2002).

Solutions/Alternatives

It is obvious that without some change health care is heading for trouble if the nursing shortage is not addressed. Fortunately, there have been many private and governmental efforts to help alleviate the nursing crisis. However, to date there is no definite solution to remedy the situation. The following ideas are presented as possible approaches to help ease the nursing shortage within Florida's correctional facilities.

One possible solution/alternative is the promotion of "teacher hours" for nurses, or working nine months while distributing salary over twelve months. A grant funded by the Robert Wood Johnson Foundation is currently studying the effectiveness of this strategy. In line with the teaching model, nurses seeking to earn additional income could request to work the extra three months or the amount of time they desire to help fill staff vacancies (Robert Wood Johnson Foundation, 2003).

To cover temporary vacancies, correctional facilities and hospitals could consider recruiting school nurses that are not employed for the summer. This could be promoted as an opportunity to earn additional income while enhancing clinical skills and remaining up-to-date with current medical practice.

Health Care's Human Crisis: The American Nursing Shortage by Kimball and O'Neil for the Robert Wood Johnson Foundation also examined a group of national reports aimed at addressing the nursing shortage and summarized the recommendations as follows:

- **Expand the supply of nurses through more effective recruitment.**
- **Expand educational capacity and opportunity to increase the number of nurses.**
- **Enhance supply and retention of nurses by treating them as strategic assets and making positive changes in the work environment.**
- **Increase the visibility of the importance of nurses' contribution to the quality of health care.**
- **Increase career options and improve compensation for nurses.**
- **Work on strengthening nursing leadership (Kimball & O'Neill, 2002).**

The Florida Hospital Association report, Florida's nursing shortage: It is here and getting worse, recommended undertaking the following efforts to address the nursing shortage:

- **Enhance the image of nursing.**
- **Improve the work environment for nurses.**
- **Increase funding to nursing education programs.**
- **Attract more students to the field of nursing.**
- **Shorten the amount of time required to obtain a Florida license for out-of-state RNs (FHA, 2001).**

Nursing shortage suggestions.

Streamlining the endorsement process for licensure for out-of-state nurses and promoting Florida's environment could serve to increase the nursing population. Marketing campaigns in northern states focused on relocating to Florida for the winter may possibly turn seasonal employment into permanent employment.

Another important and often overlooked resource for nursing is the male population. Heavy emphasis on recruiting males could help to offset the loss of females from the profession. The flexibility and mobility in nursing and its relative job security could be stressed. In these difficult economic times when other employers are trimming their ranks, this flexibility and mobility could be influential in luring males into the nursing profession. Easy employability has encouraged many people to switch careers midstream (Towns, 2002).

Yet another cost effective way for facilities to recruit nurses is to pursue nursing students as part-time employees to cultivate future employee prospects and to promote awareness of correctional nursing within nursing schools and the community. Also, recruitment of retired nurses to work on a part-time basis as a way to remain involved with nursing and earn extra income in retirement is a way to help solve some of the staffing issues. Offering flexible hours and scheduling, such as variable shifts, could also help with recruitment and retention.

Solutions Specific to Correctional Facilities

The authority recommends consideration be given to a number of strategies to lessen the nursing vacancies with the department. These include:

- **Salary increases that would help put department recruitment and retention efforts in a more competitive position. The Florida Hospital Association reported average med/surg RN salaries as $42,286. By comparison, the 160 Senior RNs employed by the department averaged $38,070, or 11% less.**
- **Initiate media campaigns that correct misconceptions regarding working in the prison setting. Campaigns should promote the diverse caseloads, a clinic-type setting (vs. acute care), greater stability, more manageable shifts, and a strong public health mission (Shimkus, 2001).**
- **Provide bonuses or a chance to win a bonus through a drawing for nurses who have perfect attendance within a set time frame to help prevent staffing shortages due to excessive use of sick days (Shimkus, 2001).**
- **Offer bonuses for years of completion and stages of attainment as another incentive for retaining and recruiting nurses. Advancing up a clinical ladder could include financial incentives offered as rewards for the additional work.**
- **Offer a shadowing program for people who are interested in correctional nursing but still have doubts. Compensate potential employees for attendance where they follow and observe staff nurses. If they are still unsure, offer to hire on at the correctional facility as per diem workers (Shimkus, 2001).**
- **Place advertising in regional nursing publications that extols the various aspects and benefits of correctional nursing and state employment. Feature the high–risk retirement benefit package.**
- **Establish mentoring programs for new correctional employees. Partner new nurses with experienced nurses who can provide assistance and encouragement long after traditional orientation has ended.**
- **Emphasize monthly staff programs as opportunities to address staff concerns and provide open communication. Retention should improve if staff feel their concerns are appropriately addressed.**

- **Provide equal retirement benefits for LPNs and RNs by adding LPNs to special risk membership retirement class (Chapter 121.0515(2)(f), F.S.).**
- **Empower administrators and supervisors to apply innovative solutions that meet their particular needs.**

CLOSE MANAGEMENT MONITORING

In December 2001, the department entered into a revised offer of judgment in a lawsuit entitled Osterback v. Moore. In this case, the plaintiffs argued that placement in a special housing unit called close management could lead to significant deterioration in mental status for those inmates at risk for mental health problems. In the offer, the department set forth a wide range of environmental and mental health treatment changes designed to lessen the effect of any adverse conditions. As part of the agreement, the authority was charged with monitoring the implementation of these changes. During FY 2002-2003, the authority conducted monitoring visits at two of the prisons designated to house close management inmates: Florida State Prison (FSP) and Lowell Correctional Institution (LOWCI).

FSP was surveyed in November 2002. Despite the challenges of developing a new program, survey findings were generally positive. Increased correctional officer and mental health staffing was allocated to meet the programmatic needs. Increased mental health treatment modalities, greater access to out-of-cell activities, and a wider range of privileges were all hallmarks of the new program.

Significant obstacles also accompanied the program. Increased staffing and the high influx of S-3 inmates created a need for higher-level on-site clinical leadership. This included coordinating the activities of over 30 newly hired treatment staff. Delays in completion of required documentation, such as behavioral risk assessments and individual service plans, were evidence of this need. Also, there was a need for additional training in the appropriate completion of this documentation. The authority recommended a clinical supervisor position be created.

The authority returned to FSP in May 2003 for a CAP assessment. As recommended, a clinical supervisor position was created, as well as an Assistant Director of Mental Health position to serve FSP and Union CI. Despite these appointments, however, a great number of the survey findings remained uncorrected six months after the survey. In some instances, corrective action had only been attempted days before the scheduled assessment.

Also in May 2003, the authority conducted a monitoring survey at LOWCI, the only institution housing female inmates assigned to close management. With 34 inmates at the time of the survey, LOWCI offered increased treatment and programming primarily through one dedicated psychological specialist and the correctional officers assigned to the dormitory, which also housed confinement and general population inmates. Survey findings did not reveal any pervasive problems, but rather reflected the difficulties in developing a new program with limited resources. In addition to the CM program,

> The authority has repeatedly expressed concern regarding high mental health caseloads at LOWCI.

LOWCI is a large institution comprised of a main unit and annex that also serves as a reception center. The authority has repeatedly expressed concern regarding the extremely high mental health caseloads at this institution. Placement of the CM program at LOWCI without additional resources has further contributed to the problem. A CAP assessment for LOWCI is planned.

HEALTH CARE OF AGING INMATES

Introduction

The Florida Legislature instructed the authority to report yearly on healthcare issues related to aging inmates. To accomplish this task, the authority requested statistical information regarding the aging population from the department's Bureau of Research and Data Analysis and cost data from the Office of Health Services (OHS) to provide an update of last year's third annual report on aging inmates. Data is provided as of June 30, 2003, unless otherwise specified.

The data gathered for this report was shared with the Florida Corrections Commission (FCC) as the FCC is also charged by the Legislature with the task of providing an annual report on the aging offender. The FCC will report separately on elder trend data, including admissions and projected admissions to the department, as well as special programs and policies in other states. In addition, the FCC will report on the status of the department's recent efforts to address the Commission's previous recommendations regarding elder inmates.

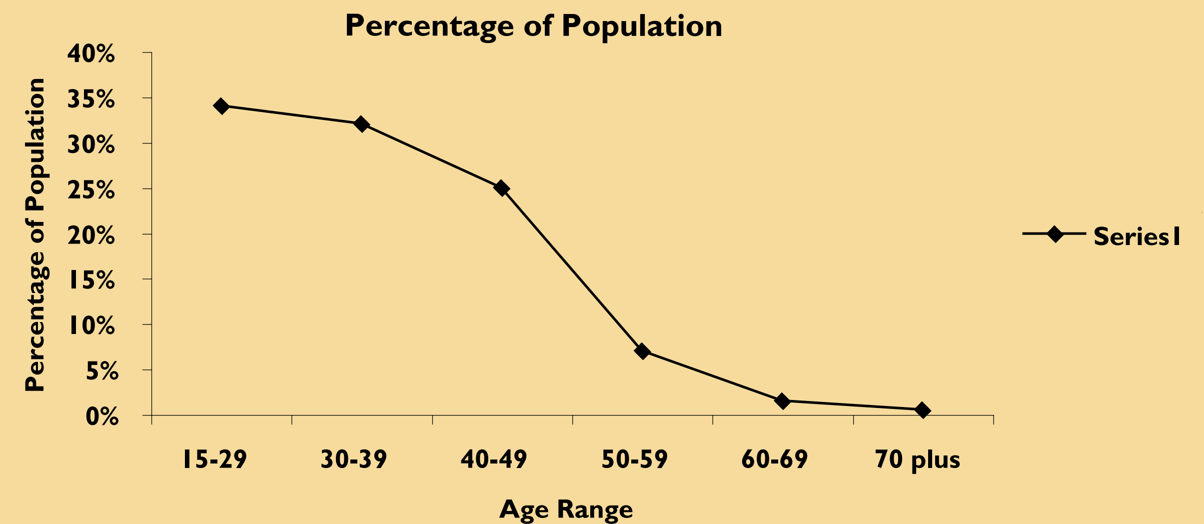
The results of a site visit to River Junction Work Camp (RIJWC), the only institution specifically designated by the department to house inmates over the age of 50, are reported below. Developments in addressing the aging inmate population and the authority's recommendations regarding the aging inmate population are presented.

Elderly and Aging Inmate Profile

Attempting to describe a typical aging inmate in the Florida system remains an elusive task. An individual initially arrested late in life may pose different health care challenges than an inmate who has aged while incarcerated. In its 1999 annual report, the FCC recommended the adoption of age 50 as the defining factor for declaring an inmate elderly secondary to lifestyle, medical care, and environment. The department suggested age 59 for defining elderly inmates. Regardless of the outcome of this debate, incarcerated individuals are generally accepted as aging faster than individuals in the community.

Percentage of Inmate Population by Age

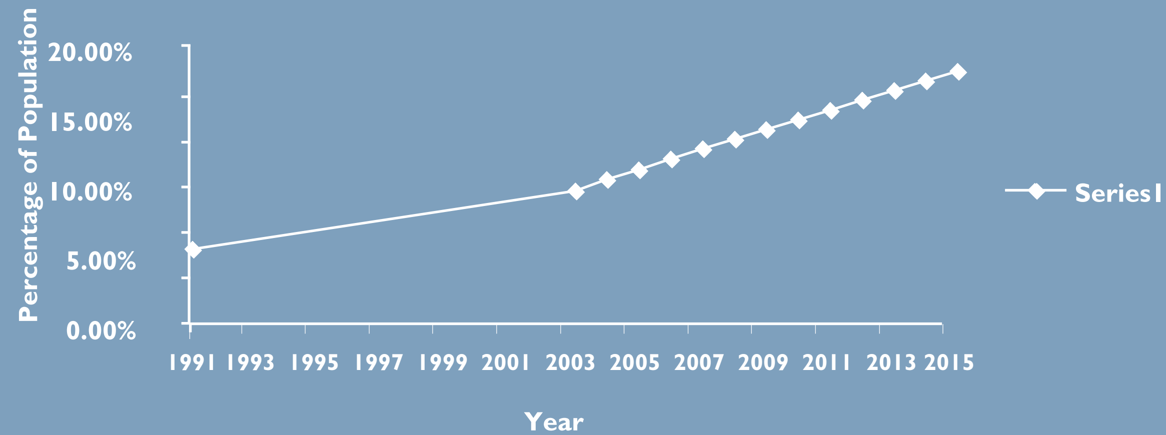
During FY 2002-03, 1,577 inmates 50 and older were admitted to the department. Of those admitted during FY 2002-03, 82% were 50-59 years old upon admission, 15% were 60-69 years old, and 2% were 70 and older. As of June 30, 2003, the percentage of the total inmate population 50 and older was nearly 10%. The average inmate age in FY 2002-03 was 35 years. The following chart displays the percentage of the inmate population by age as of June 30, 2003.



(Prepared by the Florida Department of Corrections, Bureau of Research and Data Analysis, July 15, 2003. Based on any inmate within the department's custody during FY 2002-2003. Inmate ages calculated based on June 30, 2003 data. Data missing on 46 inmates less than 15 years of age).

Projected Growth of the Aging Inmate Population

The proportion of the population comprised of inmates over 50 has doubled in the previous ten years and continued growth is anticipated. Last year, inmates over the age of 50 represented 9.3% of the total inmate population. On June 30, 2003, inmates over 50 comprised 9.9% of the total inmate population. The following chart demonstrates the growth through 2015 based on projections by the department's Bureau of Research and Data Analysis.



(Prepared by the Florida Department of Corrections, Bureau of Research and Data Analysis, July 21, 2003 1991-2007 data provided by Criminal Justice Estimating Conference 2008-2015 data provided by Department of Corrections).

Aging Female Inmates

Females 50 and over represented 4.2% of the total 50 and older population in June 2003. Currently, there is very little research on the needs of elderly women in state and federal prisons.

Literacy Levels

On June 30, 2003, approximately 39.5% of the 50 and older inmate population, for whom data were available, demonstrated basic literacy skills (grades 4 through 8). One-fourth of the 50 and older population had less than basic literacy skills (grades 1 through 3) and over one-third of the 50 and older population had only functional literacy skills (grades 9 through 12). These data have remained relatively constant since reported in the authority's 2001 annual report.

Common Primary Offenses and Length of Sentence

For the 3,545 inmates system-wide on June 30, 2003, whose incarcerations were initiated at 50 or older, the primary offenses in descending order by frequency of occurrence were: sexual/lewd behavior, drugs, murder/manslaughter, other violent offenses, property/theft/fraud/damage, burglary, "other", robbery, and weapons. Of these 3,545 inmates, 11 (0.31%) received death sentences. A further 405 (11.43%) received life sentences. Approximately 62% of these inmates received sentences up to ten years in length. Approximately 15% received sentences between 12 and 24 years. Approximately 2% received sentences between 30 and 50 years.

Of the 8,639 inmates serving a life sentence system-wide on June 30, 2003, 2,252 (26%) were 50 and older and 6,387 (74%) were under the age of 50. Of the 4,149 inmates serving a life without parole sentence on June 30, 2003, 494 (12%) were 50 and older and 3,655 (88%) were under the age of 50.

Housing Location

On June 30, 2003, 44 of the 72 state correctional institutions housed 50 or more inmates over the age of 50. Eight of the 44 institutions housed 200 or more inmates over the age of 50. Of these, Union Correctional Institution and RMJWC housed the greatest concentration of inmates older than 50 with 968 and 354 inmates respectively. There were no discernable patterns in the housing of inmates 50 and older. Currently, these inmates appear to be largely mainstreamed throughout the system. In correspondence dated July 29, 2003, the department's American with Disabilities Act (ADA) Coordinator stated that all institutions housing disabled inmates have been surveyed for compliance with the ADA in FY 2002-03. The ADA Coordinator also reported that all applicable institutions were found by the department to be substantially in compliance with regard to programs and physical accessibility.

Recidivism

The United States Department of Justice, Bureau of Justice Statistics Special Reports dated 1989 and 2002 examine the recidivism of prisoners released in 1983 and 1994 respectively. The earlier study was based on a sample drawn from 11 states including Florida. The later study was based on a sample drawn from 15 states including Florida. Both studies suggested that recidivism was inversely related to the age of the inmate at the time of release: the older the inmate, the lower the rate of recidivism. The authority understands that the department's Bureau of Research and Data Analysis is interested in researching the indicators of recidivism among elderly Florida inmates. The authority concurs that this would be a useful area for study in Florida.

Health Status

The Bureau of Research and Data Analysis documented that inmates over 50 continue to disproportionately account for those assigned to medical grade 3 and above (representing the more serious and most acute/chronic medical conditions). Data from FY 2001-02 also indicated that inmates over the age of 60 were disproportionately represented in the group of inmates with severe mental impairment (psychiatric grade 4).

Medical Service Utilization and Cost Data for Community Care Episodes

The department's information system, OBIS, contains cost data for health care delivered in community facilities. Currently, the department's system does not have the capability of compiling cost data internal to its operations by age or function, such as health services or the operational and educational components of incarceration. In studies carried out in other states, however, the cost of providing housing, programs and medical care to elderly inmates has been estimated at twice that of younger inmates.
As of June 30, 2003, 35 inmates over the age of 50 were assigned inmate assistants. During the prior year, 244 inmates over age 50 were provided inmate assistants. The assistants' duties included pushing wheelchairs, guiding, reading, and sign language.

Of the 207 inmate mortalities that occurred in FY 2002-2003, 114 (55.07%) were among the 50 and older inmate population. The primary causes of death were cancers and diseases of the circulatory system.

Cost Data for Community Care Episodes

The OHS provided FY 2002-2003 cost data for community care episodes. A summary of the FY 2002-2003 data follows. The department's Bureau of Research and Data Analysis recorded this data for FY 2002-2003 as of July 15, 2003. As there is billing and data entry delay, numbers for FY 2002-2003 may increase in the following months.

Community Inpatient Care

The use rate for community inpatient care episodes (overnight hospitalization), showed an overall increase with age. Community inpatient episodes for the 50 and older population represented 26% of the total in FY 2001-2002.

Community Ambulatory Surgery Episodes

These are outpatient single-day surgery episodes (no overnight stays). In this category, inmates over 50 represent 25% of the total ambulatory surgery episodes.

Non-Department (Community) Emergency Room Visits

Inmates over 50 represent 14% of the total non-department emergency room visits. The department's Bureau of Research and Data Analysis prepared this data for FY 2002-2003 as of July 15, 2003. There was also billing and data entry delay that may result in increased numbers for FY 2002-2003.

Community Ancillary Care Episodes

These services include laboratory, radiology, and optometry, physical and respiratory therapy provided on-site by external providers under contract to the Department. Inmates over 50 represent 26% of total.

Community Specialty Care Episodes

Specialty care episodes describe outside (the department) consultations. Inmates over 50 represent 25% of the total.

The chart below shows a comparison between the percentage of the inmate population over 50 and the percentage of the community care for that population by category. Inmates over 50 continue to consume a disproportionate amount of the services for community care episodes, and these numbers are increasing.

Need a chart titled "Inmates over 50, Percentage of Population as Compared to Percentage of Community Care Episodes FY 2002-2003":

Inmates Over Age 50	Percentage
Percentage of Total Inmate Population	**9.90%**
Percentage of Total Community Care Episodes-Ambulatory Surgery	**25%**
Percentage of Total Community Care Episodes-Emergency Room Visits	**14%**
Percentage of Total Community Care Episodes-Ancillary Services	**26%**
Percentage of Total Community Care Episodes-Specialty Care	**25%**

(Prepared by the Florida Department of Corrections, Bureau of Research and Data Analysis, July 15, 2003).

River Junction Work Camp

RIJWC, established by Senate Bill 2390 opened on June 23, 2000. Chapter 944.804 of the Florida Statutes intended that the institution be a geriatric facility for generally healthy elderly inmates. Specifically, the intent was to develop a preventive wellness/fitness program designed to maintain the mental and physical health of elderly inmates, including a diet that would specifically meet the needs of these inmates. Two additional components of the program were to be training of institutional staff to supervise elderly inmates and detect physical and mental changes warranting medical attention and an emphasis on measures that would offset medical costs associated with an elderly inmate population. The Legislature was also interested in how these activities could be generalized to the remaining system. Based on the facility tour conducted on July 31, 2003, and interviews with staff, reported below, there is no evidence to date that the department has significantly addressed the intent of the Legislature other than developing a training curriculum titled Aging Inmate Supervision. It is clear that while the environment at RIJCI could contribute to maintaining the health of relatively well and mobile inmates 50 and older by involving them in work and recreational activities and providing adequate health care, RIJCI is not a true geriatric facility. Furthermore, there remains an enormous need for the department to develop a comprehensive plan to meet the varied needs of the aging inmate population in as cost effective manner as possible. Ideally, this planning would be based on a public health model that considers primary, secondary and tertiary levels of care within and outside the correctional system as appropriate, given the mission and responsibilities of the department. For example, it may be possible to provide some chronic medical care in a community setting for appropriate elderly inmates.

On June 30, 2003, RIJCI housed 58 community custody level inmates, 116 medium custody inmates, and 218 minimum custody inmates for a total of 398 inmates. Approximately 54% of the inmates were described as having normal physical stamina or minimal medical problems. The remaining 46% had moderate medical problems. None of the inmates had identified psychological problems; all were assigned a psychological grade of 1 (S1). On June 30, 2003, approximately 80% of the 398 inmates were 50-59; approximately 10% were 40-49; and approximately 10% were 60 and older. Seven inmates were 65-69 and two were 70 and older. The inmates do not have first-degree murder, sex, or violent offenses.

On July 31, 2003, authority staff accompanied by FCC staff toured the institution and reviewed some randomly selected medical records.

Findings

A tour of the medical unit was conducted and several staff were interviewed. The facility was clean and well organized. Staff are assigned to Apalachee Correctional Institution (APACI) and posted to the work camp. Routine health care staffing allocations at the work camp include a registered nurse (RN) who works Monday through Friday from 7:00 am until 3:00 pm. This represents a decreased level of nursing coverage than noted in the authority's last review. At that time nursing coverage spanned from 6:00 am until 11:00 pm. An advanced registered nurse practitioner visits from APACI each week. The RN is also required to provide nursing service coverage at APACI when needed due to ongoing nursing personnel position vacancies.

During the visit a sample of medical records was reviewed. Care appeared to be timely and responsive to presenting conditions. The medical conditions of patients enrolled in chronic illness clinics seemed to be in good control. Problematic symptoms were addressed promptly and thoroughly. Sick-call care was timely and responsive. Some adverse clinical events resulted in transfers to APACI for further monitoring in the infirmary and for higher-level clinical assessment. The department's Offender Based Information System (OBIS) indicated the following chronic illness clinic data for RIJCI as of July 28, 2003: fourteen inmates were seen in the asthma clinic; 15 in the diabetes clinic; 59 in the hypertension clinic; 23 in the TB/INH clinic; and 87 in the general medicine clinic. At that time, one S3 inmate and one HIV-positive inmate were temporarily housed at the institution.

There were no emergency events identified in the record review. Staff indicated that emergencies were addressed by having on-site staff contact medical personnel at APACI for instructions or by calling 911 directly, as indicated by the presenting situation. The authority previously identified concerns regarding emergency care and they continue to date. Limited on-site health care coverage, an older inmate population, and location in an outlying area of the county, are factors that raise apprehension regarding the potential for bad outcomes in the event of cardiac arrest. The authority has recommended installing Automatic External Defibrillators (AEDs) in all prisons, similar to other public buildings in Florida. However, the minimal on-site health care staff and the older inmate population certainly elevate the need for an AED in this institutional setting. The institution is not designed to meet the needs of physically impaired inmates. All inmates 57 and older are housed in the lower level dormitory.

Facility areas formerly used for educational and vocational training were toured. Only a part-time literacy program was offered at the time of the tour. Recent budget reductions resulted in elimination of the other educational programs, including the GED program and all of the vocational programs. Both program areas are in good repair and are well equipped for their indicated activities should they resume.

The visiting park includes a relatively new building with pleasant accommodations for visitors. The grounds are well maintained although the space available within the facility's fenced enclosure offers a limited area for recreational activities. Currently, there is not an indoor recreation area for use in inclement weather. That limitation is an increased concern given the additional inmate idleness following the elimination of educational and vocational programs. Approximately one-third of the population is assigned to the squads that work outside the fenced compound. The outside work squads are responsible for many of the maintenance and physical plant support functions of Florida State Hospital.

Correctional officers assigned to RIJCI indicated that they had received training on supervising elderly inmates.

Recommendations

Given Florida's demographics, and national and state laws mandating longer prison sentences, the physical health, psychological health, and social needs of elderly and aging inmates continues to result in increasingly important management and budget decisions for the Legislature and prison administrators. It is likely Florida will require a range of policy and program options to manage the population as it ages, including segregated services for the aged and infirm and programs that support elderly inmates more suited to living in the general prison population.

However, sound policy and programmatic decisions cannot be made without reliable information. In this regard, two areas of significant concern remain. First, the department does not have the capability of identifying internal cost data by age for key components of its operation including health services. Second, most existing research information on older prisoners is based on unrepresentative samples and does not examine the relationship between age, ethnicity, gender, and race. Sound research is needed as a basis for managing the aging inmate population in Florida. Therefore, the recommendations of the previous three years stand:

- Implement a data collection, retrieval, and analysis system that will ensure reliable age-based data regarding health care utilization and costs. (The authority is prepared to support the department's requests for resources to implement such a system).

- Conduct a methodologically sound research study on the health-related concerns of aging and elderly Florida inmates. Present recommendations to the Legislature for current and future management of this population. The authority is prepared to assist in the design, implementation, and analysis of a study on the health-related concerns of aging and elderly inmates in Florida. To date, the authority has developed a draft mental health survey instrument exploring the needs of elderly inmates.

Status of Previous Recommendations

During FY 2002-03, the department's Bureau of Research and Data Analysis worked in conjunction with the Research Triangle Institute to revise and resubmit to the National Institute of Justice (NIJ) the grant proposal discussed in last year's annual report on aging. The current proposal, similar to last year's, is to conduct a methodologically sound study on several aspects of health care delivery in the state's correctional institutions. This grant would allow the department to meet many of the recommendations the authority and FCC have put forth regarding health care and aging inmates. The intent is to examine the impact of the co-payment system on health care demand and cost and to develop a methodology for modeling and projecting correctional healthcare demand and costs. The study will provide information as to the relative cost of health care and the health care needs of elderly inmates versus younger inmates, and males versus females. Additionally, combining the historical demand and cost information with inmate population projections by age and gender groups will provide reliable estimates on the types, levels, and costs of health care services that will be needed in the future. The authority provided a letter in support of the grant proposal dated March 3, 2003. The authority commends the continued attention of the Bureau of Research and Data Analysis to this task. E-mail correspondence from the Bureau dated July 21, 2003, indicated the grant proposal continued to be under review by the NIJ.

Current Issues

During the past year the authority staff, FCC staff and department staff have met a number of times to discuss budget and programmatic issues facing Florida in managing the aging inmate population. Meetings were conducted in January, May, June and July of 2003. In May 2003, the authority hosted a presentation on the Medical, Psychological, and Social Considerations Facing Older Prisoners, by Dr. John K. Kerbs, Assistant Professor, Florida State University School of Criminology and Criminal Justice. Invitations were extended to the department, Elder Affairs staff, and other interested organizations. The presentation was very well attended and Dr. Kerbs has remained available to work with the department, the authority and FCC in addressing aging inmate issues. In July 2003, a meeting was conducted between authority staff and the department's new Office of Health Services (OHS) management team, including the Director of Health Services and the deputy directors of clinical and administrative functions. The Deputy Director for Administration indicated that he is developing a work plan to address aging issues that are the responsibility of OHS. The authority is encouraged that OHS management is interested in taking a leadership role in this area.

One area that may be useful to further explore is the viability of potential parole or some expansion of the Compassionate Medical Release Program to include appropriate older inmates; for example, older inmates seriously disabled by illness. Relevant research questions in this regard would have to establish the age of eligibility, types of offenses allowed, amount of sentence served, disciplinary histories, and recidivism rates for different groups of older inmates, as well as projections of eligibility pools over time. Dr. John Kerbs raised this area of study to the group following meetings with the department, authority and FCC staff in January, May, and June of 2003.

FY 2002-03 Recommendations

In addition to the previous recommendations, which are still relevant, the authority recommends the following:

- **Begin to explore the expansion of the Conditional Medical Release Program to include appropriate older inmates.**

- **Pursue agreements with Florida's medical, criminology and social work schools to augment the care of older inmates, and provide training opportunities for students (the FCC has made a similar recommendation in past years).**

- **Pursue research on recidivism rates for Florida's state correctional system, with a focus on inmates 50 and older.**

- **Pursue research on the characteristics and needs of female inmates, with a focus on inmates 50 and older.**

REFERENCES

Anno, B., (2001). Correctional health care: Guidelines for the management of an adequate delivery system, **pp.47-48, 74-75.**

American Association of Colleges of Nursing. (2003). Nursing shortage fact sheet. **Retrieved July 8, 2003 from http://www.aacn.nche.edu/Media/Backgrounders/shortagefacts.htm**

Brown, K. and Herbert, E. (2002). Health status report: Infectious diseases in corrections. **HEPP Report, vol. 5 (10), p.1.**

Correctional mental health care: Standards & guidelines for delivering services. **(1999). Chicago, IL: National Commission on Correctional Healthcare.**

Florida Hospital Association. (2001). Florida's nursing shortage: It is here and it is getting worse. **Retrieved July 9, 2003 from http://www.fha.org/acrobat/nursingshortage01.pdf**

Health Resources and Services Administration. (2002). Projected supply, demand, and shortages of registered nurses: **2000-2020. Retrieved July 8, 2003 from ftp://ftp.hrsa.gov/bhpr/nationalcenter/rnproject.pdf**

Kimball, B., O'Neil, E. (2002). Health care's human crisis: The American nursing shortage. The Robert Wood Johnson Foundation. **Retrieved July 8, 2003 from http://rwjf.org/publications/publicationsPdfs/nursing_report**

McGlynn, E.A., Asch, S.M., Adams, J., Keesey, J., Hicks, J., DeCristofaro, A., & Kerr, E.A. (2003). The quality of health care delivered to adults in the United States. The New England journal of medicine: **348, 2635-2645.**

National Commission on Correctional Health Care - Correct Care. (2001). Rx for RN Shortages. **Retrieved July 7, 2003 from http://www.ncchc.org/pubs/CC_archive/rnshortage.html**

Performance-based standards for correctional health care in adult correctional institutions. **(2002). Lanham, MD: American Correctional Association.**

Restraint and seclusion. (2001). 2001-2002 Standards for behavioral health care (pp. 103-112). Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations.

The Robert Wood Johnson Foundation. (2003). Evaluation of a pilot program to retain hospital-based registered nurses in the labor force. **Retrieved July 8, 2003 from http://rwjf.org/programs/**
Standards for health services in correctional institutions. (2003). Washington, DC: American Public Health Association.

Title 42/3, Section 483.376. (2002). (42CFR483.376). Washington, DC:
U.S. Government Printing Office.

Towns, W. (2002). Examining the role of men in nursing: Recommendations for action. Florida Center for Nursing. **Retrieved July 8, 2003 from http://www.flcenterfornursing.org/**

Appendix A

Survey of State Policies on Use-of-Force with Chemical Agents*

State	Who authorizes?	Medical consulted?	Medical input prevents?	Post exposure shower?	Post-exposure medical exam?	Use in segregation cells?	Use with MH patients?	Videotaped?	Refer to MH?
California	Lieutenant or higher	Policy not explicit	Inpatient MH units: psychiatrist must approve unless emergency	Policy not explicit	Policy not explicit	Policy not explicit	Inpatient MH units: psychiatrist must approve unless emergency	Policy not explicit	Policy not explicit
Connecticut	Shift supervisor	Yes--"whenever possible"	Policy not explicit	Yes	Yes	Policy not explicit	Policy not explicit	Policy not explicit	Policy not explicit
Florida	Warden or duty warden	Yes, indirectly - Lieutenant or s hift supervisor reviews a form completed by medical	Policy not explicit	Yes	Yes	Yes (when verbal control efforts fail)	Yes--but not on inpatient MH units unless emergency	No	Yes--only for those inmates already on MH caseload (S2 & S3 inmates)
Massachusetts	Warden or designee	Yes	Policy not explicit	Policy not explicit	Yes	Policy not explicit	Policy not explicit	Policy not explicit	Policy not explicit
Minnesota	Shift supervisor	No	N/A	Yes	Yes	Yes (when verbal control efforts fail)	Policy not explicit	Yes	Policy not explicit
Montana	Warden or designee	Yes	Policy not explicit	Yes	Yes	Policy not explicit	Policy not explicit	Policy not explicit	Policy not explicit
New York	Warden or designee	Yes	Yes (except emergencies)	Yes	Yes	Policy not explicit	Policy not explicit	Policy not explicit	Policy not explicit
Oklahoma	Regional director (except emergencies)	Yes	Policy not explicit	Yes	Yes	Yes (when verbal control efforts fail)	Policy not explicit	Yes	Policy not explicit
Oregon	Officer in charge	Policy not explicit	Policy not explicit	Yes	Yes	Policy not explicit	Policy not explicit	Policy not explicit	Policy not explicit
Wisconsin	Warden or designee	Policy not explicit	Policy not explicit	Yes	No--medical staff are "consulted"	Policy not explicit	Policy not explicit	Policy not explicit	Policy not explicit
Federal Bureau of Prisons	Captain or shift Lieutenant	Yes--mental health staff also consulted	Policy not explicit	Yes	Yes	Policy not explicit	Policy not e xplicit	Policy not explicit	Policy not explicit

*** Limited to non-restricted documents available on official state and federal corrections department websites and/or state administrative rules**

CORRECTIONAL MEDICAL AUTHORITY CITIZEN VOLUNTEERS FISCAL YEAR 2002-2003

Authority Members

Jeannie B. Baker, who served as board Chair for FY 2002-2003, was appointed to the Correctional Medical Authority in April 1996. She is the administrator for an acute care hospital in a rural northeast Florida community. She brings extensive experience in hospital administration to the board. Ms. Baker also serves as liaison to the Budget and Personnel Committee.

Ward Boston, III, was appointed to the board in January 2002. He is the chief executive officer of a west central Florida hospital and brings extensive experience in hospital administration to the board.

William H. Cantwell, M.D., a retired surgeon, was appointed to the board in January 2002. He also served as vice president for medical affairs at a hospital in New York overseeing quality assurance, risk management and credentialing.

H. Rex Etheredge, M.S., was appointed to the board in February 2001. He is the chief executive officer of a large private hospital in Northeast Florida. He has also served in that capacity over the past 12 years at several Florida hospitals. He brings over 30 years of hospital administration experience to the board.

E. Rawson Griffin, III, M.D., F.A.F.P., was appointed to the board in February 2001. He is in private medical practice in central Florida, and is board certified in family practice and geriatric medicine. He currently serves as president of a county medical society. He has served on a district mental health advocacy committee and a Healthy Start Coalition. He is a member of the American Medical Association and the Florida Academy of Family Physicians.

Russell B. Rainey, D.M.D., appointed to the board in February 2001, is in private dental practice in Tallahassee, FL. He has served on the advisory boards for the Headstart and Medicaid Programs and is president of the Leon County Dental Association for 2001-02. He has extensive experience in serving the elderly and Alzheimer's patients and teaches oral health programs at various assisted living facilities and nursing homes.

Barbara S. Russell, R.N., M.P.H., C.I.C., has served, from 1974 to the present, as the director for infection control services for a major Florida hospital. She is a frequent lecturer and/or consultant to local, state and national health care groups, and is an instructor in the department of community mental health at a large Florida university. Since 1994, she has served as president of the National Association for Professionals in Infection Control and Epidemiology, Inc. (APICO). She is also a member of the National and State Association for Practitioners in Infection Control; and an advisory council member for the Florida Consortium of Infection Control. Ms. Russell serves as the authority's representative on the Quality Management Medical Peer Review Committee.

Hospital association representative, vacant.

Mental Health representative, vacant.

Budget and Personnel Committee

James J. Bracher, M.B.A., an insurance regulatory consultant, chairs the budget and personnel committee. He previously served as chief of the bureaus of life and health solvency, managed care, and life and health rates and forms in the Department of Insurance. He brings extensive experience in the financial area to the committee. Mr. Bracher served as executive director of the Health Care Cost Containment Board and of the Florida Health Care Purchasing Cooperative. He also served as vice president for health care of Fringe Benefits Management Company.

Russell A. Arent, M.B.A., is a health care financial consultant, with over twenty years of financial experience in the health care industry. Formerly, Mr. Arent served as chief financial officer of a large southeast Florida health care district and vice president of finance of a large voluntary hospital in southwest Florida.
Jeannie Baker, authority representative.

James Kersey, Jr., C.P.A., M.B.A., F.H.F.M.A., currently serves as vice president for administration and finance, and as the chief financial officer for a large multi-specialty medical group. He brings over 25 years of health care finance experience to the authority. He served on the national Healthcare Committee of the American Institute of CPAs, numerous committees of the Florida Institute of CPAs, and the Healthcare Financial Management Association. He also served as an editorial advisor to the Journal of Accountancy.

Avis Payne, B.S., holds a degree in Accounting from Florida A&M University. She has over 10 years of experience in public and governmental accounting and budget. She served 10 years with the Florida Legislature as legislative analyst and staff director. She currently serves as the bureau chief of medical disability administrative services with the Department of Health, Division of Disability Determinations.

Tom Prevost, B.S., health care consultant, has also served on the budget and personnel committee since its inception. Mr. Prevost was the first director of budget and planning at a major teaching hospital retiring after 25 years of service. He is also a past financial technical advisory panel member to the Health Care Cost Containment Board.

Mental Health Committee

Randy Wilcox, B.S., who served as committee chair, directs governmental regulations for the Florida Council for Behavioral Healthcare. He has been in the field of mental health and drug rehabilitation in a variety of settings for over 30 years.

Marsh Lewis Brown, M.S.W., is the executive director of a mental health center on the Gulf coast of Florida. She was previously a member of the authority and served as committee liaison to the authority.

John Bailey, D. O., is a psychiatrist specializing in delivery of adult psychiatric care. He maintains an active private practice in Tallahassee. He also provided psychiatric consultation services to the Georgia and Florida prison systems.

Wayne Dreggors, M.A., C.M.H.A., is the executive director of a comprehensive community mental health program in central Florida. He has over 25 years experience in community mental health.

Randy K. Otto, Ph.D., M.S., is an associate professor in the Department of Mental Health Law and Policy at the University of South Florida. He also holds adjunct faculty appointments at Stetson University College of Law and other USF departments. He also currently serves as corresponding secretary and member of the Board of Directors for the American Board of Forensic Psychology and president for the American Psychology-Law Society. He previously served as president and vice-president of the American Academy of Forensic Psychology. He has published numerous articles and book chapters in the area of forensic assessment, clinical decision making and violence risk assessment.

Theodore G. Williams, Ph.D., is the clinical director of a Florida mental health counseling and assessment corporation specializing in psychological and forensic services. He is a licensed clinical psychologist with over 12 years of experience. He was a former Senior Psychologist at two Florida correctional institutions and also was a staff psychologist at a major southeast Florida county jail. He has taught undergraduate, graduate and doctoral courses in the United States and Europe.

Quality Management Committee

Bernard Kimmel, M.D., F.A.F.P., who serves as the Chair of the QM committee, is a board certified physician in the field of family practice. Recently retired, Dr. Kimmel brings extensive experience in general medicine to the committee. He also served as a surveyor at department institutions for the Federal court and the authority.

Mollie A. Frawley, R.N., joined the committee in April 2002. She is a legal nurse consultant, board certified in quality assessment and utilization review. She has extensive experience in the public and private sectors. In addition to her clinical nursing background, she brings experience in correctional quality management administration to the committee. Ms. Frawley has also served as a surveyor for the authority.

David V. Glorius, D.O., joined the committee in September 2000. Dr. Glorius works in the field of emergency medicine and also serves a secure facility for youthful offenders. He is a member of numerous professional medical associations including the American and Florida Osteopathic Associations, the American Medical Association, the American College of Emergency Physicians and the American College of Osteopathic Emergency Physicians.

Marilyn Maud, R.N., joined the committee in May 2003. She is an executive community health nursing director for the Department of Health and has extensive background in public health nursing and performance improvement. Ms. Maud is also a licensed health care risk manager.

Barbara S. Russell, R.N., M.P.H., C.I.C., authority representative.

Donna St. Hillier, Ph.D., a licensed mental health counselor in the state of Florida, has extensive experience in school psychology and as an independent psychotherapist specializing in adolescent, adult and relationship issues. She now works extensively in behavioral medicine and death and dying issues. Dr. St. Hillier also serves as a therapist for clients with HIV/AIDS.

David R.W. Simmons, M.D., joined the committee in 2001. He is board certified in Internal Medicine and practices in central Florida.

ACRONYMS

ACLS	Advanced Cardiac Life Support
AED	Automatic External Defibrillator
APACI	Apalachee Correctional Instittition
APHA	American Public Health Association
CAP	Corrective Action Plan
CME	Continuing Medical Education
CMHI	Corrections Mental Health Institution
CMT-C	Correctional Medical Technician - Certified
CPC	Correctional Privatization Commission
CQR	Clinical Quality Review
CSU	Crisis Stabilization Unit
DOH	Department of Health
ERD	Electronic Restraining Device
FCC	Florida Corrections Commission
FSP	Florida State Prison
FY	Fiscal Year
GAA	General Appropriations Act
HSB	Health Services Bulletin
HSTI	Health Services Technical Instruction
IC	Infection Control
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LBR	Legislative Budget Request
LOWCI	Lowell Correctional Institution
LPN	Licensed Practical Nurse
MAR	Medication Administration Report
MDST	Multi-disciplinary Services Team
NCCHC	National Commission on Correctional Health Care
NIJ	National Institute of Justice
OBIS	Offender-Based Information System
OHS	Office of Health Services
QA	Quality Assessment
QM	Quality Management
RIJWC	River Junction Work Camp
RMC	Reception and Medical Center
RMCH	Reception and Medical Center Hospital
RN	Registered Nurse
TCU	Transitional Care Unit
UM	Utilization Management

GLOSSARY

Adequate care/treatment–The process of carrying out an organized, individualized, planned intervention in response to assessed or emergent needs of an inmate with the purpose of identifying and relieving the symptoms of physical or mental illness or emotional disorders, ameliorating physical or emotional pain or enhancing the ability to function in the prison environment.

Adult Facility–Any facility designated to house offenders other than those committed or classified under the Youthful Offender Act.

Chief Health Officer (CHO)–The designated health care physician responsible for the delivery of health care in a major institution. The CHO has direct authority over all health care staff in the institution.

Chronic illness clinic–A medical clinic established to monitor inmates who have chronic medical conditions in one or more of six diagnoses—diabetes, pulmonary, hypertension, seizure disorder, INH therapy, and immunity. Inmates are seen as often as required by their medical condition(s), but not less than every 90 days.

Correctional Medical Authority (authority)–An independent nine member panel created by the Legislature to monitor the delivery of health care services for inmates in the Department of Corrections; to advise the department on the professional conduct of primary, convalescent, dental and mental health care and the management of costs consistent with quality care; and to advise the Governor and the Legislature on the status of the department's health care delivery system. The authority has a staffing complement of 13.

Crisis Stabilization Unit (CSU)–An inpatient facility that provides brief psychological and psychiatric services, the primary objective of which is the rapid alleviation of acute symptoms of mental disorder. Evaluation and treatment services at a CSU are to be brief and length of stay should rarely exceed 90 days.

Custody Level–Determined by a scoring system and professional assessment that reflects the degree of supervision appropriate for an inmate. Factors for consideration include, but are not limited to, severity of offense, length of sentence, characteristics of sentence, criminal history, age and behavior. The four custody levels of inmates are:

- **Maximum Custody**–inmates under a sentence of death.
- **Close Custody**–inmates who must be maintained within an armed perimeter of an institution or be under direct-armed supervision when outside of a secure perimeter.
- **Medium Custody**–inmates who do not require armed supervision when outside the secure perimeter of an institution but do require direct sight and sound supervision if they are outside.
- **Minimum Custody**–inmates who are eligible to be outside of the secure perimeter of an institution without direct sight and sound supervision. (Example - an inmate assigned to a community work squad or an inmate in a work release program).

Disciplinary Report (DR)–A formal method of charging an inmate with a rule violation causing written notice to be served on the inmate, a complete investigation of the allegations, fact-finding by a hearing officer or an impartial team of staff members and, when appropriate, the imposition of sanctions.

Dry Cell– A cell where there is no running water or water has been turned off and drinking water is provided upon request.

Facility Medical Levels

Level 1–Generally medical grade 1 inmates with minimal or no health care problems. These institutions may not have 24-hour coverage or a full-time physician. At most facilities an Advanced Registered Nurse Practitioner (ARNP) will provide immediate medical care. There will not be an infirmary operation. Seriously ill inmates will be transferred to a covering institution. Actual staffing and capabilities will be determined depending on institutional location and needs.

Level 2–Generally medical grades 2, 3, and 4 inmates who are stable, but with chronic health care problems, such as hypertension or diabetes that are well controlled, or an amputee who requires a wheel chair. There will be limited professional medical staff at these facilities, normally one physician and/or an ARNP. There will be 24-hour coverage on an as-needed basis. There will be an infirmary function. Actual staffing and capabilities will be determined depending on institutional location and needs.

Level 3–All medical grades including complex health care problems. Physician or ARNP on-call 24-hours a day. Nursing coverage 24 hours a day. There will be an infirmary function. Generally sick inmates with chronic problems requiring a high level of care. Both significant mental and physical health capabilities will be present. Medical provider complement designed to mirror current inmate medical grade 3 and 4 institutions.

Level 4–Complex health care problems. Will serve as gatekeepers for community provided services. These institutions will be staffed and equipped with an expanded capability to handle most of the highly acute, complex illnesses as well as a measure of custodial care. Planned interactions with medical schools and rotations of various students such as medical residents, nursing students, and psychology interns are expected. Both NFRC and CFRC are designated Centers for Excellence in Correctional Health Care and are staffed, trained and equipped to increase services provided within the system.

Findings–Deviations or departures from department policy, authority standards, or the standard of care generally accepted in the professional health community at large. Findings may arise from a single event or from a trend of similar events. Findings may involve past or present events or trends, which potentially result in the compromise of inmate health care.

Health Services Bulletins or Health Services Technical Instructions (HSBs or HSTIs)–Department of Corrections standards for the provision of care in the institutions.

Housing assignment

Close management–Long-term single cell confinement of an inmate apart from the general population as a result of the inmate's demonstrated inability to live in the general population without abusing the rights and privileges of other inmates or disturbing the security, order or operation of the institution. Secure, self contained cellblock units where each cell includes a lavatory. May be single or double cell housing depending upon level of close management.

Confinement–The removal of an inmate from the general population.
Administrative confinement–Confinement for the purposes of investigation of disciplinary reports, review for protective management, medical or psychiatric reasons, pending classification or for any reason for which the safety of the inmate, other inmates or the security of the institution may be compromised. Generally one or two inmates per cell. May or may not have a lavatory.

Disciplinary confinement–Confinement, which includes the loss of privileges normally afforded other inmates. Housing is in a separate unit designated for confinement purposes. Generally one or two inmates per cell. May or may not have a lavatory.

General population–Housing in open bay dormitory style units or non-secure rooms housing between one to several inmate(s) per cell. Generally without a lavatory.

Institution/Facility Level–Each facility and institution is assigned a facility level based on perimeter security standards, internal housing configuration, security grouping for each level and custody criteria.
Isolation Management Room (IMR) - A single room within the medical infirmary of an institution, which may be used to house acutely mentally disturbed inmates or inmates with suspected or confirmed communicable diseases. An IMR used for suicide observation must be certified for safety standards. These rooms are also referred to as "approved suicide isolation rooms."

Medical grade–Reflects the level of treatment capable of being managed by the facility. An inmate's grade is determined by a health assessment that places an inmate from grade 1, requiring the least level of medical treatment, to 4, requiring the highest level of treatment. The functional capacity of the various organs, systems, and integral parts of the body are considered and assigned a numerical designation. This physical profile provides an index to an overall functional capacity. The functional capacity defines the physical ability of the inmate to adequately function in a work, training or academic capacity or other physical activity. Overall, medical functional grade is based on three factors—physical capacity, mental health status, and functional capacity.

M 1–No demonstrable anatomical or physiological impairment; no work assignment limitation.

M 2–Minimal organic systemic disease; work limitations of a minor nature.

M 3–Moderate organic systemic disease requiring reasonable availability of care; work assignment must consider impact on limiting condition.

M 4–Severe organic systemic disease requiring continuous monitoring; requires strict limits on work assignment.

M 5–Pregnant inmates.

Practitioner Profiling–The process of compiling clinical data to evaluate practice patterns. Data may include, but is not limited to, risk events, quality assessment results, prescribing patterns and mortality review results.

Psychological or S grade–Reflects the level of treatment capable of being managed by the facility. An inmate's grade is determined by a health assessment that places an inmate from grade 1, requiring the least level of psychological treatment, to 5, requiring the highest level of treatment. The S grade provides an index to the inmate's mental status and whether the inmate has any cognitive, emotional and/or behavioral disorders. It also reflects the inmate's adaptive functioning, i.e., the ability to function successfully within the general inmate population without special assistance.

S 1–No disorder or impairment in adaptive functioning.

S 2–Mental disorder in remission, but residual symptoms evident; mild mental retardation, mild impairment in adaptive functioning. The inmate needs periodic case management and/or outpatient counseling.

S 3–Moderate mental retardation or an Axis I disorder that, though fairly well stabilized, produces moderate impairment in adaptive functioning. The inmate needs continuing outpatient case management and treatment. It also reflects the inmate receives psychotropic medication for stabilization.

S 4–Transitional Care Unit housing assignment.

S 5–Crisis Stabilization Unit housing assignment

S-6–Inpatient psychiatric hospitalization housing assignment (CMHI).

SOAP(E)–A method of medical record charting where S documents subjective complaint of the patient, O documents the objective observation of the health care provider, A documents the assessment of the symptoms, P documents the plan for addressing the symptoms, and E documents education provided the patient.

Suicide Observation Status (SOS)–Designation of a level of risk for suicide requiring admission to special housing and minimum levels of observation.

SOS 1 (Severe Risk)–Judgment by appropriate health care staff that the inmate is thinking about suicide or self-injury with active intent. An instance of behavior that could cause serious bodily harm presupposes active intent. Requires admission to an approved IMR or designated alternate housing and observation of the inmate by staff at least every 15 minutes.

SOS 2 (Minimal to Moderate Risk)–Judgment by appropriate health care staff that the inmate is thinking about suicide or self-injury likely to cause serious bodily harm without active intent or specific plans. Requires admission to an approved IMR or designated alternate housing and observation of the inmate by staff at least every 30 minutes.

Transitional Care Unit (TCU)–An inpatient facility that provides psychological and psychiatric treatment in a structured residential setting. May be used as a transition back to general population. Some patients with severe and persistent mental illness may require this level care indefinitely. Transitional care may be indicated for mental and/or intellectual impairment that compromise the ability to adjust within the general population.

Youthful Offender–An inmate between 14 and 24 years of age serving their first felony commitment who is sentenced as such by the court or classified as a youthful offender by the Department (Defined in Chapter 958.03(5), 958.04 and 958.11, F.S.).