Table of Contents

Page

Executive Summary 1

Recommendations 6

Budget and Personnel Committee Report 10

Survey Findings 16

- Physical Health Services 17
- Mortalities 21
- Dental Services 23
- Mental Health Services 24
- Special Populations 27
- Follow-up Monitoring 30
- Institutional Evaluations of Survey Process 31

Mental Health Committee Report 33

Quality Management Committee Report 39

Miscellaneous 46

- Survey Instrument Revision 46
- Central Florida Reception Center HIV Facility 46
- HIV Inmate Peer Education Program 47

Appendices

Authority Assessment of Quality of Care .... A

Authority Assessment of Mortality Cases Reviewed .... B

Percent of Level I and Level II Citations Corrected at CAP Assessment C

Summary of Survey Findings by Correctional Institution .... D

Apalachee Correctional Institution D1

Avon Park Correctional Institution D1

Baker Correctional Institution D1

Brevard Correctional Institution D2

Corrections Mental Health Institution D2

Dade Correctional Institution D2

Gainesville Correctional Institution D3

Hamilton Correctional Institution D3

Lake Correctional Institution D3

Lawtey Correctional Institution D4

Liberty Correctional Institution D4

New River Correctional Institution D4

North Florida Reception Center D5

Okeechobee Correctional Institution D5

Polk Correctional Institution D6

Putnam Correctional Institution D6

Quincy Correctional Institution D6

River Junction Correctional Institution D6

Santa Rosa Correctional Institution D7

Walton Correctional Institution D7

Glossary .... E

Correctional Medical Authority Citizen Volunteers .... F

Authority Members F1

Budget and Personnel Committee Members F2

Mental Health Committee Members..F2

Quality Management Committee Members F3

Executive Summary

Executive Summary

Introduction

In July 1986, while the State's prison health care system was under the jurisdiction of the Federal Court, the Florida Legislature established the Correctional Medical Authority (authority). Because Florida had demonstrated a long history of providing inadequate health care to inmates, the authority was directed to assist the Department of Corrections (department) in the delivery of health care services by making recommendations for improvement.

The department's Office of Health Services (OHS) is responsible for developing a comprehensive health care delivery system and promulgating all department health care standards. Florida Statutes charge the authority with responsibility for determining whether those health care standards conform to minimum standards. Minimum standards are defined in the authority's statute as the standard of care generally accepted in the professional health community at large. Otherwise stated, the authority has the responsibility for determining whether constitutionally adequate care is being provided to Florida's prison inmates. The authority meets this mandate by conducting comprehensive surveys of the health care system at each major correctional institution. These surveys determine whether the department's health care standards and community standards are met.

The authority has submitted ten previous reports to the Governor and the Legislature outlining recommendations for improvements in the health care delivery system. Included in those reports were strategies for containing health care costs. OHS administrators have implemented many of the authority's previous recommendations. In addition, the status of those recommendations is provided in this report. This report summarizes activities conducted by the authority during fiscal year 1997-98, and reflects the authority's assessment of the OHS' health care program.

The authority is pleased to report that its submission of survey reports to the department is up-to-date and timely. Likewise, corrective action plan assessment visits are up-to-date with timely reporting of findings.

Budget and Personnel Committee Report

Oversight of the financial and management activities of the OHS is assigned to the authority's budget and personnel committee. The committee consists of seven citizen volunteers whose backgrounds include health care financing and consulting, hospital administration, and governmental accounting, budgeting, and personnel. The OHS has successfully controlled growth of health care expenditures over the past several years. Over the past five fiscal years, the inmate population has increased nearly 20% from 53.2 thousand to 63.8 thousand. Actual health care expenditures per inmate have increased from $8.69 per day to $9.87 per day over the same five-

year period, an increase of 13.5%. Four percent of that increase was directly attributable to expenditures related to HIV/AIDS. When compared to the 20% increase reflected in the medical care component of the Consumer Price Index (CPI) for that same five-year period, the OHS' success in controlling health care expenditures is evident. Expenditures for AIDS have increased from a per diem of $0.38 in FY 1993-94 to $0.77 during FY 1997-98. This increase is directly attributable to triple drug treatment regimens, which are the minimum standard of care, and more specifically to the cost of drugs, especially protease inhibitors. Despite the efforts of the OHS to contain costs, the treatment of HIV/AIDS is a significant drain on resources.

The committee commends the OHS for its continued cost containment efforts. Utilization management, contract negotiations, and consolidation of services generate significant cost avoidance for the department. The OHS continues to explore alternative methods of providing services, expanding the use of the North Florida Reception Center by providing additional services through that institution.

Survey Findings

During fiscal year 1997-98, the third year of this triennial survey cycle, the authority's staff visited 40 of the department's 60 major institutions. Twenty institutions were visited as part of the triennial survey process. Thirty-two individual physical and mental health corrective action assessments were conducted for 20 institutions as a part of follow-up monitoring.

Of the 20 institutions surveyed during fiscal year 1997-98, four experienced their first authority survey—Gainesville, Okeechobee, Quincy, and Santa Rosa. At one department facility, health care services were provided by the private sector—EMSA Correctional Care at Okeechobee Correctional Institution. Additionally, three institutions providing care to special populations were among those surveyed—Corrections Mental Health Institution, an inpatient psychiatric hospital for male and female inmates; Gainesville, a residential drug treatment facility; and Brevard, which houses male youthful offenders. The remaining institutions surveyed house adult males.

As noted in previous years, the authority found the department demonstrated an adequate structure for the delivery of health care services. However, variability among institutions existed in the adequacy of care provided. At some institutions, certain aspects of care were below minimum standards when the institution was surveyed (see the table in Appendix A). This year's report reiterates concerns surfaced in the four most recent annual reports. In the provision of physical health care, the quality of nursing and physician assessment skills remains a concern. In the provision of mental health care, appropriate treatment and follow-up remain concerns. The authority again notes the need for emphasis on staff education in the areas of operational procedures and clinical decision-making.

Of 20 institutions surveyed during fiscal year 1997-1998, six institutions had no physical health citations, while eight institutions had no mental health citations. Four institutions had no physical or mental health citations. Only two institutions demonstrated institution-wide deficiencies in the

provision of both physical and mental health care. The remaining 14 institutions demonstrated deficiencies in the provision of *either* physical or mental health care. Five institutions, where aspects of care were not adequate, demonstrated similar results in previous surveys. Seven institutions showed improvement over previous surveys. One institution, where previous physical health care survey results were acceptable, demonstrated problems in this monitoring cycle. In one institution, where mental health care survey results were previously acceptable, problems were identified in this review cycle. No life-threatening or otherwise serious deficiencies warranting immediate notification to the secretary of the department were found. However, one institution was formally reported to the department's Inspector General for investigation of excessive use-of-force allegations.

Reviews of institutional dental programs during fiscal year 1997-98 revealed improvement in the timeliness and appropriateness of services provided as compared to the last reporting period. These findings may be a function of the type of institutions surveyed during FY 1997-98, or may indicate an overall improvement in the system. Cumulative survey data over several years will prove out the validity of any findings. At 84% of the institutions surveyed, the dental component was rated as a "strength" in individual survey reports. Concerns regarding clinical management, documentation, and/or the administrative process were identified in three institutions.

Since few institutions house special populations (e.g., youthful offenders, females, etc.), it is difficult to identify whether there are any trends in the treatment of these groups based on one year's sample. Last year's report summarized the care provided female inmates at all female institutions surveyed during the preceding triennium. This year's report covers care provided at youthful offender institutions over the triennial survey cycle from FY 1995-96 through FY 1997-98.

The authority publishes its survey reports within 60 calendar days following a survey, as required by law. Florida Statutes require that institutions submit a written corrective action plan (CAP) to the authority within 30 calendar days after the receipt of a survey report. Thirteen institutions were required by statute to submit either a physical health and/or mental health CAP during FY 1997-98. None of the institutions submitted the CAP within the statutorily required 30-day time frame. On average, the CAPs were 45 days overdue.

For FY 1997-98 the authority monitored care provided at 20 institutions. Roughly half of the 20 institutions monitored for follow-up during the fiscal year had received Level I citations. Thirty-seven percent (37%) of all Level I physical health citations were corrected at the CAP visit and 63% of all Level I mental health citations had been corrected. Level I citations are based on conditions where the severity and risk of compromise to health care is high.

At the conclusion of each survey, evaluation forms are provided for input from institutional staff. During fiscal year 1997-98, 17 institutions returned a total of 114 evaluation forms. Ninety-six percent (96%) of respondents expressed satisfaction with the survey process. Ninety-three percent

(93%) of respondents felt survey team members were adequately prepared and oriented to the department's organization and mission.

Mental Health Committee Report

The mental health committee is responsible for monitoring and evaluating the performance of the department's mental health program. Six volunteer members represent a variety of mental health fields. Their backgrounds include community-based mental health delivery systems, corrections mental health, state government, private practice, and academic settings.

The committee continues to monitor a variety of policy issues and initiatives. Among these are substance abuse programs, emergency treatment orders and psychotropic medication issues, after-hours transfer of inmates, and behavioral management programs.

During fiscal year 1997-98, the authority became aware the department had modified mental health policies via memo or telex. Those policy changes had been implemented prior to any review by the authority, as required by law.

Quality Management Committee Report

The authority's quality management committee (QMC) provides oversight of the department's health care quality management (QM) program. The committee consists of three physicians, four nurses, and one licensed mental health counselor, whose backgrounds include family practice, correctional medicine, infection control, risk management, quality management, and counseling.

The OHS QM program is comprised of seven components: Credentials Review, Utilization Management, Mortality Review, Quality Assessment, Risk Management, Infection Control, and Program Evaluation. A continuous effort to strengthen the effectiveness of the OHS QM program has been undertaken. A pilot project focused on this effort concluded this fiscal year, generating a number of activities. The central office QM committee adopted performance measures (indicators) for physical, mental, and dental health services. In response to health care consolidation, each QM component is being evaluated to determine whether the flexibility necessary to meet the needs of institutions with varying medical/dental/mental health missions exists. Revision of the Health Services Bulletin governing the OHS QM program is underway.

The credentials review component has begun to place emphasis on practitioner profiling. The risk management component has standardized reporting of data, while attempting to address under-reporting of risk events that hampers the risk management program's effectiveness. The utilization management component demonstrated effective cost-control through pre-approvals, continued stay reviews, and transfers to lower cost beds where appropriate. Development of a clinical component is recommended to assess the impact of cost containment on quality of care. The mortality review component has demonstrated a reduction in time to reach case closure under the revised format. Implementation of the practitioner profiling portion of this component will

complete the mortality review component. The program evaluation component has begun to implement recommendations resulting from the OHS' first evaluation of its QM program. Quality of care data are vital to a functional QM program. The quality assessment program began to amass the baseline data for a limited number of clinical indicators. However, the data reported during fiscal year 1997-98 were not sufficient to evaluate the quality of health care provided.

In 1996, external reviewers of the authority and its processes suggested the authority rely on the OHS' QM data to target institutions and areas requiring survey by the authority. While the information generated by the OHS' QM program is improving, the data available do not present a sufficient foundation upon which to base the survey process.

Miscellaneous

Florida State University School of Public Administration/Florida Public Affairs Center has assisted the authority in revising its survey instruments and improving data collection and analysis capabilities. A main component of this project has been the review of each question in the survey instrument to capture better data for performance measurement.

By invitation, the Office of Health Services participated in the survey instrument review. Many constructive changes to improve the clarity and objectivity of various parts of the instrument were incorporated into the final document. The strengthening of the survey methodology has been inherent in the survey revision project. By maximizing the sensitivity and reliability of the survey data, the objectivity of the survey process is strengthened. This has further enhanced the caliber and usefulness of the authority's reports to the Governor and Legislature regarding correctional health care issues.

Recommendations

Budget and Personnel

- Develop a five-year financial management plan based on the Criminal Justice Estimating Conference's population projections that incorporates use of historical and morbidity data of the inmate population to estimate future health care costs.

Survey

- Place automatic external defibrillators in each institution and provide operational training to staff.

- Implement an effective training program for nurses and physicians for "hands on" physical assessment and treatment modalities, while increasing the frequency and intensity of any training presently offered, and adding a "return skills demonstration" component.

- Review the practice of having initial clinical assessments conducted by licensed practical nurses or registered nurses and/or implement appropriate intervention to assure that inmates have their medical needs adequately assessed.

- Develop an effective program to ensure sustained correction of survey citations.

- Revisit the necessity for an interim corrective action plan (CAP) and modify the process by which an institution begins to address the problems and concerns surfaced at the survey exit conference presented by the authority's staff.

- Submit CAPs to the authority within the statutorily required time frame and implement the corrective action immediately.

- Assure the provision of authority comments on final CAPs to regional and institutional staff.

- Review and revise institutional treatment protocols related to assessment and treatment of acute asthma attacks and monitoring for associated rebound conditions. Assurance that all institutional staff are trained in current assessment and treatment modalities is also indicated.

Mental Health

- Expand the capacity to involuntarily medicate inmates on a pilot basis only.
    a. Develop a formal mechanism that clarifies and documents the justification for involuntary medication while assuring a safe balance of inmate autonomy in health care decision making,
    b. Assess the training needs of clinicians, and provide necessary training before implementing a statewide program,
    c. Develop oversight and monitoring mechanisms, and
    d. Collaborate with judicial circuits to facilitate the court order process.

- Continue to provide staff training in the appropriate use of emergency treatment orders and physical restraints, and monitor subsequent application to determine if health care staff are making the least restrictive and best therapeutic treatment choices.

- Provide the authority's mental health committee with a written analysis of the results and changes which actually occur in clinical management relative to reduction in frequency of psychiatric management of eligible S3 inmates, including service effectiveness and cost savings.

- Evaluate the clinical and administrative aspects of the after-hours transfer policy at the institutional level, and report findings to the authority

- Ensure that the inmate record documents the housing location of suicidal/self-injurious inmates managed in settings other than certified isolation management rooms.

- Develop a pilot behavior management program that will address inmate eligibility, resource allocation issues, health care and security roles, and report on the appropriate management of suicidal and self-injurious behaviors in that context.

- In collaboration with the authority's mental health committee, assess the impact of an increasing close management population on suicidal and self-injurious behaviors and the rate of completed suicides. An analysis of the impact of the after-hours transfer policy should be considered in this assessment.

- The mental health needs of inmates in confinement/close management often escalate while in those settings. Identify and address the needs of confinement/close management inmates who require more frequent mental health intervention. Report those findings to the authority's mental health committee.

- Conduct a workload and staffing study of all institutional mental health programs to determine equitable staffing allocations. This study should address all factors that impact workload, including inmate S-grade levels, close management inmates, youthful offenders, and female

inmates. Concomitantly review security staffing at those institutions with the highest mental health workload. Reallocate existing positions as necessary.

- Conduct a review of all mental health forms and paperwork to eliminate duplication, increase efficiency, and promote effectiveness.

- Establish close communication between the substance abuse and mental health programs to assure continuity of care. During CMA surveys, documentation of that communication has been noticeably lacking in the medical record. Formally document the substance abuse referral process and the result of the referral in the medical record to ensure continuity of care.

- Implement a tracking mechanism (e.g., log) at the institutional level to track:
  1) inmate-declared psychological emergencies (including inmate name, DC number, date and time, problem description, and outcome);
  2) inmates returned to security after a mental health assessment determines they are not suicidal;
  3) inmates assessed as suicidal but housed in a cell other than a certified isolation management room (IMR) (alternative suicide observation housing); and
  4) the use of emergency treatment orders (ETOs).

- Implement specialized training for institutional security staff for mental health issues including personal assertiveness, anger management, and conflict resolution strategies.

Quality Management

- Fully implement a practitioner profiling system that monitors and evaluates practice patterns. Use in biennial recredentialing process.

- Implement a clinical component which evaluates whether unnecessary or invalid restriction of use of resources occurs in association with the utilization management program.

- Identify patterns of health care practice. Acknowledge good health care practices or recommend staff education and training programs or other appropriate interventions.

- Continue to develop quality management performance measures (indicators) that will generate data from which conclusions about the quality and adequacy of the health care delivery system can be drawn.

- Develop health care studies and performance measures (indicators) based upon findings generated by the OHS quarterlies and the authority's survey findings.

- Use health care risk management data to identify training opportunities and other interventions to reduce injuries and liability. Link grievance data with the risk management program.

Other

- Inform the authority of all proposed physical health and mental health policy initiatives and modifications, and ensure the authority is copied on all telexes and memoranda outlining procedural changes in health services as required by statute.

- Concurrently advise the authority of all changes in institutional mission and inmate mix.

- Develop additional relationships with willing medical schools in Florida to serve as a resource for ongoing medical education for OHS staff and provide better, more cost-effective care to inmates.

- Seek opportunities to expand the HIV Inmate Peer Education Program.

Budget and Personnel Committee Report

Introduction

Oversight of the financial and management activities of the Office of Health Services (OHS) is assigned to the authority's budget and personnel committee. The committee consists of seven citizen volunteers whose backgrounds include health care financing and consulting, hospital administration, and governmental accounting, budgeting, and personnel. This responsibility includes development of funding level recommendations for issues included in the OHS legislative budget request. In addition, the committee examines requests for proposals, invitations to bid, and contracts for major ancillary services such as radiology, laboratory, electrocardiology, and renal dialysis. The committee also reviews the OHS' expenditures in relation to legislative appropriations.

Budget

The OHS has successfully controlled growth of health care expenditures over the past several years. Over the past five fiscal years, the inmate population has increased nearly 20% from 53.2 thousand to 63.8 thousand. Actual health care expenditures per inmate have increased from $8.69 per day to $9.87 per day over the same five-year period, an increase of 13.5%. Four percent of that increase was directly attributable to expenditures related to HIV/AIDS. When compared to the 20% increase reflected in the medical care component of the Consumer Price Index (CPI) for that same five-year period, the OHS' success in controlling health care expenditures is evident. The Office of Program Policy and Government Accountability (OPPAGA) noted in its November 1996 report entitled *Review of Inmate Health Services within the Department of Corrections* that the OHS' cost of providing health care services had increased over the past five years. However, it is noted those costs increased at a slower rate than Florida's medical care inflation rate.

The OHS has controlled health care expenditures.

OHS GROWTH FACTORS

	93/94	94/95	95/96	96/97	97/98
Population (in thousands)*	53.2	58.1	61.7	61.4	63.8
Percent increase over prior year	10.4%	9.2%	6.2%	0%	3%
Actual Per Diem*	$8.69	$8.32	$8.60	$9.11	$9.87
Percent increase over prior year	0%	(4.3%)	3.4%	5.9%	8.3%
Percent increase in population from 93/94 to 97/98					19.9%
Percent increase in OHS per diem from 93/94 to 97/98*					13.5%
Percent increase in medical care component of CPI from 93/94 to 97/98**					20.7%

*Data source: Office of Health Services **Data source: Bureau of Labor Statistics

Expenditures for AIDS have increased from a per diem of $0.38 in FY 1993-94 to $0.77 during FY 1997-98. This increase is directly attributable to triple drug treatment regimens, which are the minimum standard of care, and more specifically to the cost of drugs, especially protease inhibitors. Despite the efforts of the OHS to contain costs, the treatment of HIV/AIDS is a significant drain on resources.

HIV/AIDS GROWTH FACTORS

	93/94	94/95	95/96	96/97	97/98
AIDS Population	453	618	747	705	693
Percent increase over prior year	72.2%	36.4%	20.8%	(5.6%)	(1.7%)
Known HIV Population	1,707	1,937	1,918	1,923	1,794
Percent increase over prior year	19.6%	13.4%	(.9%)	.2%	(6.7%)
AIDS Per Diem	$.38	$.39	$.34	$0.48	$0.77
Percent increase over prior year	(2.5%)	2.6%	(12.8%)	41.1%	60.4%

*Data source: Office of Health Services

Cost Containment Initiatives

The OHS has implemented numerous cost containment strategies recommended by the authority.

Implementation of the authority's recommendations resulted in cost avoidance of over $77 million in costs over the past five fiscal years.

For a detailed summary of these strategies, refer to the authority's November 1996 annual report. In addition, OHS staff received 18 Davis Productivity Awards for cost containment recommendations implemented by the department. The chart and narrative below updates information relative to

implementation of cost containment initiatives and resulting cost avoidance for the preceding five fiscal years.

OHS COST CONTAINMENT/AVOIDANCE INITIATIVES

	FY 93/94	FY 94/95	FY 95/96	FY 96/97	FY 97/98	Total
Utilization Management*			$3,817,450	$7,137,450	$9,317,800	$20,272,700
Contract Negotiations*	$8,499,236	$8,841,077	$11,546,036	$11,855,650	$12,412,657	$53,154,656
Pharmacy*			$913,000	$1,043,000	$1,600,000	$3,556,000
Alternative Health Care Service Delivery			$1,076,426	$3,213,309	$4,490,790	$8,780,525
Dental Services		$1,057,168	$1,577,661	$2,466,655	$2,900,000	$8,001,484
Claims Review*	$95,702	$39,926	$34,108	$61,129	$91,179	$322,044
TOTAL	$8,594,938	$9,938,171	$18,964,681	$25,777,193	$30,812,426	$94,087,409
TOTAL COST SAVINGS RESULTING FROM IMPLEMENTATION OF AUTHORITY RECOMMENDATIONS						**$77,305,400**

Data source: Office of Health Services *Denotes cost savings as a consequence of implementing authority recommendations

Utilization Management

Utilization management (UM) is a strategy to minimize expenditures by controlling use of costly health care services. The authority's first annual report, published in December 1987, recommended development of a formal UM system. The OHS began to develop a regional UM program in 1989, and over the next several years expanded its UM efforts. The UM program is now centralized at North Florida Reception Center (NFRC) and aggressively ensures appropriate utilization of health care resources by closely managing the movement of inmate patients to contract hospitals, the NFRC hospital (NFRCH), and institutional infirmaries. The OHS estimates approximately $9.3 million in costs were avoided during fiscal year 1997-98 as a result of utilization management.

Implementation of the authority's recommended UM program has resulted in over $20 million in cost avoidance over the past three fiscal years.

Contract Negotiations

Implementation of the authority's recommendation to negotiate contracts resulted in cost avoidance of $53 million over the past five fiscal years.

In the 1987 report, the authority also recommended the department enter into contract negotiations with community hospitals on a per diem basis. At that time the department paid "usual and customary charges." As early as 1989, the department began contract negotiations with community hospitals for services. Early efforts focused on negotiating charges by diagnostic related groups and reductions in charges. Currently, per diem contracts are used with most hospitals with which the department does a large volume of business, while contracts for emergency services are based on reductions in charges. By 1994, the department had so successfully implemented the authority's recommendation of negotiating contracts for services, the OHS received a Davis Productivity award. The OHS estimates avoidance of approximately $52 million in community hospital costs over the last five years. In fiscal year 1997-98, the OHS estimates it avoided slightly over $11 million in costs due to contract negotiations.

In addition to negotiation of discounted contracts with community hospitals, the department has negotiated discounted contracts with numerous other medical providers. Discounted contracts are in place for such services as radiation therapy, physical therapy, speech therapy, outpatient laboratory work, and computerized tomography (CT) scans. The department reports the recent contract for radiation therapy has resulted in cost avoidance of $1.3 million since its inception.

Consolidation of Services

In 1991 the authority recommended that the department consider consolidated housing for inmates with chronic and severe medical conditions. The authority believed this approach would result in better use of limited medical resources and would provide more economical and effective care for all inmates. The authority also felt concentrating inmates by medical grade in regional facilities could reduce staff recruitment and retention problems experienced by the OHS. For several years, the OHS worked internally to implement consolidation of services. Early efforts involved consolidating mental health services and transferring inmates with chronic conditions and those requiring non-emergency hospitalization to institutions in Region II. Although the concept of consolidation was presented to the executive leadership committee of the department in January 1995, the resulting impact on inmate classification and the restrictions on inmate movement hindered full implementation of such an effort. OPPAGA also recognized the cost containment benefits of health services consolidation in its November 1996 report and recommended creation of a formal consolidation plan. At that time, consolidation gained momentum. The 1997 Legislature adopted that recommendation requiring the OHS to submit a consolidation plan to the Governor and Legislature in January 1998. The plan calls for three processes originally recommended by the authority in earlier reports: consolidating inmates by medical grade, consolidating inmates by disease entity, and sharing of health care staff by closely located institutions. Increasing the utilization of NFRC, as well as designating it as a

The OHS submitted a consolidation plan to the Governor and Florida Legislature in January 1998.

central medical holding facility, has been an integral part of the consolidation plan. Consolidation should allow the OHS to better use limited resources to provide for increasing health care needs.

Implementation of the medical consolidation plan is currently underway. During the 1997-98 fiscal year, all medical grade 3 and 4 inmates were moved to approximately 30 of the department's institutions. Twenty of those institutions are designated to house inmates with AIDS and HIV disease. Additionally, a special care facility for terminally ill AIDS patients and AIDS patients with complications was opened at Central Florida Reception Center. This unit is expected to favorably impact the growing costs of treating AIDS, while providing a more consistent quality of care for these inmates. Cost avoidance is anticipated through on-site specialty care and reduced hospitalization and security costs.

Implementation of the dental services consolidation plan was completed during fiscal year 1997-98. The resulting reduction in dental staffing by 28 positions has generated cost avoidance of approximately $2.9 million annually. Dental per diem has remained stable. This program was awarded a Davis Productivity Award and was invited to participate in the Governor's Sterling Award competition.

The authority has not consistently been informed in a timely manner of institutional changes associated with consolidation. These changes impact the staffing of authority surveys. In order to function effectively and efficiently, the authority must be notified of changes in institutional mission and inmate mix as they occur.

Pharmacy

The department continues to participate with the Department of Health in use of a statewide formulary and on a statewide contract for drug purchases. This results in considerable savings to offset the rising cost of pharmaceuticals.

Reductions in salaries resulting from the cluster concept have been more than offset by unanticipated increases in the cost of pharmaceuticals.

The cluster pharmacy concept originally resulted from an authority recommendation that the OHS review its pharmacy system. In response to legislative direction in 1993, the cluster plan was initiated. The ongoing cluster pharmacy process has shown a salary cost avoidance of approximately $1.6 million annually. However, the department reports drug expenditures increased from $14 million during fiscal year 1995-96 to $24 million during fiscal year 1997-98. These increased pharmaceutical costs are the direct result of medications for treatment of mental illness and HIV/AIDS. Even the best pharmacy consolidation efforts cannot generate sufficient cost avoidance to offset increases of that volume.

Alternative Health Care Services Delivery

The department has implemented other alternatives for providing health care services in a number of settings. Rather than replicate laboratories and radiology suites at each institution, private

vendors provide laboratory and radiological services. In addition, private vendors provide primary health care services at several institutions.

An oncology program was initiated at NFRCH in April 1996. Under the direction of contract physician-oncologists, department staff provide chemotherapy services on-site. These services were previously performed at community hospitals. Cost avoidance for those procedures are estimated at over $750,000 for fiscal year 1997-98. In addition, inmates undergoing chemotherapy are no longer required to travel several hours to and from their treatments during time when the effects of the treatment cause the greatest discomfort. The authority reviewed this program during the NFRC survey. Data collected suggested the program met community standards.

The OHS is using contract medical specialists to provide specialty care on-site at NFRCH.

Also at NFRCH, a mobile surgery unit is used for routine surgeries such as those performed in freestanding ambulatory surgical centers. This unit eliminates the transfer of inmates to a contract hospital in Jacksonville. This saves on security costs and avoids transport of inmates experiencing the after-effects of anesthesia and surgery. Use of the mobile surgery unit during fiscal year 1997-98 generated cost avoidance of over $1.8 million. The authority also reviewed the policies and procedures developed in conjunction with this program, as well as medical records documenting surgical procedures performed at the mobile surgical unit. Those reviews suggested the program met community standards. The OHS was awarded a Davis Productivity Award in conjunction with this project.

The department also increased the use of its operating rooms at NFRCH, avoiding the cost of some procedures at community hospitals or doctors' offices. Both department and contract personnel are involved in this endeavor which generated a cost avoidance of approximately $1 million during fiscal year 1997-98.

Claims Review

The OHS participates in a contract for claims review in which hospital bills are reviewed for accuracy and appropriateness of treatment provided. During fiscal year 1996-97, the OHS reported its claims review contract, originally recommended by the authority, returned over $91,000. This equated to $4.27 per dollar of cost. An estimated $322,000 have been recovered by this process since its inception.

Survey Findings

Introduction

During fiscal year 1997-98, the authority's staff visited 40 of the department's 60 major institutions. Twenty institutions were visited as part of the triennial survey process. Thirty-two individual physical and mental health corrective action assessments were conducted for 20 institutions as a part of follow-up monitoring.

Of the 20 institutions surveyed during fiscal year 1997-98, four experienced their first authority survey—Gainesville, Okeechobee, Quincy, and Santa Rosa. At one department facility, health care services were provided by the private sector—EMSA Correctional Care at Okeechobee Correctional Institution. Additionally, three institutions providing care to special populations were among those surveyed—Corrections Mental Health Institution, an inpatient psychiatric hospital for male and female inmates; Gainesville, a residential drug treatment facility, and Brevard, which houses male youthful offenders. The remaining institutions surveyed house adult males.

First-time Surveys in FY 1997-98		
Department of Corrections facilities	**Correctional Privatization Commission facilities**	**Department facilities with privatized health care**
• Gainesville • Santa Rosa • Quincy	• None	• Okeechobee (EMSA)

As noted in previous years, the authority found the department demonstrated an adequate structure for the delivery of health care services. However, variability among institutions existed in the adequacy of care provided. At some institutions, certain aspects of care were below minimum standards when the institution was surveyed (see the table in Appendix A). This year's report reiterates concerns surfaced in the four most recent annual reports. In the provision of physical health care, the quality of nursing and physician assessment skills remains a concern. In the provision of mental health care, appropriate treatment and follow-up remain concerns. The authority again notes the need for emphasis on staff education in the areas of operational procedures and clinical decision-making.

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provision of both physical and mental health care. The remaining 14 institutions demonstrated deficiencies in the provision of *either* physical or mental health care. Five institutions where aspects of care were not adequate demonstrated similar results in previous surveys. Seven institutions showed improvement over previous surveys. One institution where previous physical health care survey results were acceptable, demonstrated problems in this monitoring cycle. One institution where mental health care survey results were previously acceptable, demonstrated problems in this review cycle. No life-threatening or otherwise serious deficiencies warranting immediate notification to the secretary of the department were found. However, one institution was formally reported to the department's Inspector General for investigation of excessive use-of-force allegations.

Four of 20 institutions surveyed had no physical health or mental health citations.

The table in Appendix A presents a summary of institutions surveyed by region and specifies whether health care service delivery met minimum standards of care at the time of the survey. More specific information on each institution can be found in Appendix D.

Physical Health Services

The medical grade 1 designation describes an inmate with little or no medical involvement in functional capability. A level 4 medical grade indicates an inmate has one or more severe medical conditions or physical impairments that require restrictions in work or other activity assignments. A medical grade 5 designation describes an inmate who is impaired and is unable to engage in any work, recreation or training due to physical or mental impairment. Of the 20 institutions surveyed last year, nine institutions provided health care services for the full range of medical grades, including impaired inmates. Nine institutions served medical grades up to levels 3 or 4. The remaining two institutions served only medical grades 1 and 2.

The CMA survey process is designed to evaluate institutions regarding the adequacy of provision of episodic and chronic disease care, medical administrative procedures, and the ability of inmates to access care. Six of 20 institutions surveyed had no physical health citations. Seven of 20 surveys revealed Level I and II citations, while five surveys resulted in Level II citations only.

Problems with clinical management of inmates accounted for 61% of physical health survey citations.

Clinical management, as it pertains to the provision of episodic and chronic disease care, represented 61% of the 62 physical health survey citations identified during the 1997-98 survey year. Administrative and access citations accounted for the remaining 39%. Administrative citations totaled 21 and access issues were cited three times.

Inadequate care rendered in chronic illness clinics (CICs) was cited in surveys of seven institutions compared to 13 institutions that were cited for deficiencies in episodic care. That pattern is consistent with previous annual reports.

Access

Access to health care is a critical and multi-faceted issue in a correctional setting. In order to assure adequate access to health care, inmates must know of the care available to them and processes must be in place to ensure their ability to request and obtain care. A delicate balance is required between maintaining security and assuring adequate access to health care. Health care services are provided in a setting that has varying degrees of inmate freedom of movement. Health care services often must be provided in confinement settings or coordinated with security personnel to escort inmates for medical care. These factors can complicate adequate access to health care.

Three access citations pertaining to physical health care were noted during the 1997-98 survey year.

Denied access to care may be defined as an act, or failure to act, that results in the inability to obtain adequate care. Two institutions during the past survey year received a total of three access citations for physical health care. One institution was issued one Level I (having a high probability of seriously affecting the inmate's health) and one Level II (having a lower probability of serious long-term effects) citation. The Level I citation concerned actions by security staff that included threats to inmates and harassment of health care staff. That institution's Level II citation pertained to restricted access to confinement sick call services. The second institution received a Level II access citation because of a restricted pharmacy formulary. The cluster pharmacy that served the institution eliminated some medications that were listed on the OHS approved formulary. Those inmates coming to the institution successfully treated with an approved medication were faced with receiving a change in a previously successful drug regimen. Otherwise, medical staff was required to submit a drug exception request to the regional office for approval, which still resulted in at least short-term changes in medication treatment. For labile medical conditions such as difficult to control hypertension, such pharmacy limitations and changes in medication can have drastic results. Medications recommended by consultants also fell under the same restrictions.

Clinical Management

◊ *Episodic Care*

Episodic care includes sick call, emergency care, and infirmary stays in excess of 24 hours. The vast majority of episodic care events present in sick call or emergency care. Initial clinical interaction is generally with a registered or licensed practical nurse. Critical decision-making is demanded at this point. The decision is made at that time to treat, refer for additional care or assessment, or return the inmate to the compound. Unfortunately, in some cases inadequate assessment and decision-making have contributed to worsened conditions and death.

The 1997-98 survey year illustrates continuing deficiencies in the clinical management of episodic care events. Clinical management, as a whole, totaled 61% of the 62 physical health citations issued. Of that number, two-thirds were issued for episodic care deficiencies. Thirteen of the twenty surveyed institutions were issued citations regarding episodic care. Seven institutions were issued Level I citations and six were issued Level II citations. These figures closely reflect the authority's findings during the 1994-95, 1995-96, and 1996-97 survey years.

Thirteen institutions were cited for issues related to episodic care.

Another aspect of episodic care service is the preventative opportunities provided by adequate first-line assessments. Managed care organizations acknowledge the importance of dedicating resources for early intervention. They note that the sooner medical conditions are addressed, the less likely the need for more costly interventions that develop as a disease or illness worsens. The authority is hopeful that the OHS' decision to cluster medical care at designated institutions will partially address the problems associated with first line assessment in episodic care. Clustering services may also help promote availability of health care staff better trained to handle episodic care events for a more medically homogenous inmate population.

One recommendation to address this issue pertaining to first line assessments is to encourage the expanded use of comprehensive, condition-specific guidelines for nursing staff to apply in episodic care situations. Another potential approach would be the expanded use of Advanced Registered Nurse Practitioners (ARNPs) or Physician Assistants (PAs) in the triage process. While salary concerns are a consideration with higher level staff, cost-offsets may be realized by enhancing first-line assessments. Offsets might be found in preventing complications, hospitalizations, and second-line medical interventions. Of course, an enhancement of initial assessments should help in lessening the incidence of mortality within the correctional system.

The department has protocols for unlicensed staff and guidelines for licensed staff for several presenting conditions in the area of episodic care. Problems sometimes occur when staff do not use these protocols or guidelines in their initial assessments or when they encounter an illness that they do not know how to handle. This is where the authority sees the importance of training. Over the past several years the OHS has improved and expanded its training opportunities for all health care staff. However, frequent turnover in nursing staff is a complicating factor, when trained nurses leave for other employment. As in past annual reports, the authority recommends providing ongoing dedicated training to first-line clinicians.

◊ *Chronic Illness Clinics*

Health care staff conduct chronic illness clinics (CICs) to treat six general categories of chronic illnesses. These categories are diabetes, seizure disorders, chronic obstructive pulmonary disease/asthma, cardiovascular disorders/hypertension, immunodeficiency disorders, and tuberculosis/prophylaxis treatment. Inmate CIC appointments are scheduled on a routine basis, with increased frequency of visits due to medical necessity. The longest time permitted by the department between clinic visits is 90 days.

Thirteen institutions, or 65% of those surveyed, had no clinical management deficiencies identified in their CICs. Three institutions received Level I citations and all three citations represented deficiencies that were identified in more than one clinic. Two institutions with Level II citations had deficiencies in only one of the six clinics. Primarily, deficiencies included the following: failing to schedule required clinic visits, failing to perform appropriate

Thirteen institutions had no clinical management deficiencies in their chronic illness clinics.

or ordered laboratory studies, inadequate follow-up of abnormal lab test results, failing to administer medications, failing to perform diagnostic tests, and failing to provide indicated inoculations.

As noted earlier, the department's move to cluster special needs medical populations may improve compliance with established standards for the care of inmates in CICs. In addition, the authority recommends that the OHS provide additional training for health care staff to target these areas of recurring clinical management deficiencies.

Administrative

Administrative functions represent the managerial aspects of operating a health care delivery system. They include orientation, inservice and emergency preparedness training, staff vacancies and retention efforts, documentation of logs, manuals, and policy and procedure documents, physical plant responsibilities, and security within the unit. Administrative citations represented slightly over one-third of the deficiencies identified during the past survey year. This pattern also has been reported in previous annual reports and closely approximates the findings from the 1996-97 survey year. Four Level I administrative citations were identified at two institutions. Level II citations totaled 17 at seven institutions. The two institutions identified in the first group also had Level II administrative citations.

Sixty-four percent (64%) of institutions surveyed received no administrative citations.

Deficiencies in staff training were identified as problematic at five institutions surveyed. Deficiencies included failure to provide training in cardiopulmonary resuscitation (CPR), failure to use and monitor emergency equipment, failure to conduct disaster drills, and failure to comply with minimum health care staff basic training requirements.

A second category of administrative deficiencies was documentation deficiencies in logs, manuals, and policy and procedure documents. Citations were also issued for those deficiencies at five institutions.

Staffing deficiencies were significantly lower during this survey year than in the previous year.

Staffing deficiencies, a third category, was an identified concern at two institutions. However, of the 20 institutions surveyed, staffing deficiency citations were significantly lower during this survey year in comparison to the previous year.

The final category of administrative deficiencies dealt with documentation contained in mortality records. This was noted at two institutions. The information found in death certificates, autopsy reports, and the physician's final summary is important in reviewing a cause of death. Mortality reviews often illustrate the strengths and weaknesses of an institution's medical services. Reviews of mortality records can be learning tools for improving care. In the two institutions cited, mortality record documentation typically lacked death certificates, autopsy reports, and final physician summaries, significantly lowering the potential good generated by comprehensive mortality reviews.

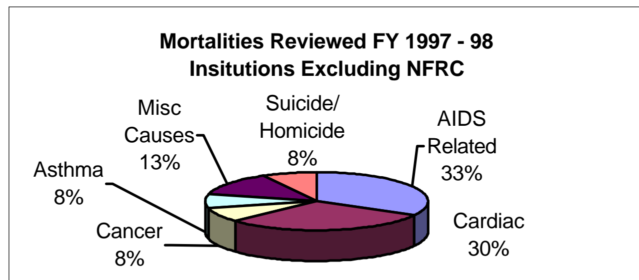
Two areas of deficiencies previously noted in the 1996-97 annual report were identified much less frequently among institutions surveyed during 1997-98. Comparably, fewer citations were issued pertaining to the failure to conduct required administrative meetings and maintain logs. Two institutions failed to properly maintain monitoring logs and one institution failed to conduct the required quarterly meetings between the chief health officer and superintendent.

Mortalities

All deaths are reviewed by the OHS. Authority surveys review mortality records to determine if all reasonable and available medical interventions were employed by institutional staff to prevent or delay an inmate's death, or to minimize pain and suffering if death was inevitable. All mortalities that have occurred since a previous survey are subject to review. At the 20 institutions surveyed during fiscal year 1997-98, a total of 476 deaths occurred over the previous two and one-half to three years. Eighty-eight mortality records were reviewed. The table in Appendix B presents the regional distribution of mortalities for the institutions surveyed in fiscal year 1997-98 and identifies occurrence of problematic cases.

Institutions

Excluding NFRC, 76 deaths had occurred at 12 of the institutions surveyed. None occurred at the remaining seven institutions. The survey teams reviewed 63 records, or 82% of deaths occurring at the twelve institutions. One third (33%) of the deaths reviewed were due to AIDS or related illnesses. Of the remaining deaths, 30% were cardiac related, 8% were due to cancer, 8% were asthma related, and 13% were due to miscellaneous causes. Three (5%) of the deaths were due to suicide and two deaths (3%) were a result of homicides.



Five survey reports noted concerns regarding eight deaths. Citations reflected continuing inadequacies related to appropriate assessments and accurate and timely diagnosis/treatments. Additionally, three of the eight records indicated a need for more aggressive interventions by institutional staff during emergent cardiac events.

Authority surveyors determined eight of 63 deaths reviewed at institutions surveyed (excluding NFRC) were problematic.

Five of the problematic deaths were cardiac related, two were related to acute asthma attacks, and one death was AIDS related. A brief summary of the eight identified problematic deaths follows:

1. An inmate died as a result of bacterial pneumonia secondary to AIDS. An assumption had been made that the inmate had pneumocystis carinii pneumonia (PCP), a viral pneumonia. The physician failed to accurately diagnose and treat the inmate for bacterial pneumonia.

2. An inmate died as a result of an acute asthma attack. There was a lack of appropriate treatment and a delay in needed treatment.

3. An inmate with a known history of heart disease died as a result of cardiac problems. There was lack of appropriate treatment, failure by nursing staff to notify a physician of the inmate's severe chest pains, and failure to obtain needed laboratory and electrocardiogram studies.

4. A young adult male who had a history of severe asthma died as a result of cardiac arrest, secondary to an acute asthma attack. There was lack of appropriate assessment and treatment needed for the severity of the inmate's condition.

5. An inmate, who had a history of cardiac problems, died as a result of an acute myocardial infarction. There was lack of appropriate assessment and treatment for abnormal electrocardiogram results.

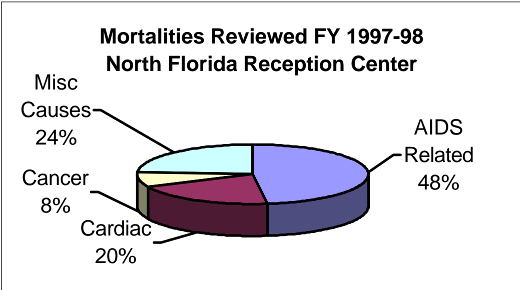
6. There were concerns regarding the clinical management of an inmate who died of arteriosclerotic heart disease. There was failure to provide follow-up for an abnormal electrocardiogram. The cause of death was reported as ventricular fibrillation and the need for more aggressive interventions by institutional staff were indicated for the emergency situation.

7. An inmate died of an unanticipated cardiac arrest. More aggressive interventions by institutional staff were indicated for the emergency situation.

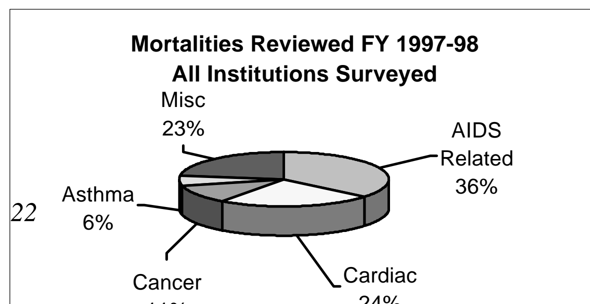
8. An inmate died as a result of an unanticipated cardiac arrythmia. The inmate's cardiac disorders were not noted on the master problem list, and the need for more aggressive interventions by institutional staff was indicated for the emergency event.

North Florida Reception Center

Four hundred (400) deaths had occurred since the previous survey at the NFRC, the location of the state prison hospital. Due to the large number of deaths that had occurred, only 25 records were reviewed. Forty-eight (48%) of the reviewed deaths were due to AIDS or related illnesses, 20% were cardiac related, 8% were due to cancer, and 24% were due to miscellaneous causes. None of the mortalities reviewed at NFRC were identified as problematic.



None of the mortalities reviewed during the NFRC survey were problematic to surveyors.



Summary

As stated previously, a total of 476 mortality records were subject to review during fiscal year 1997-98. These mortalities had occurred since the

most recent survey of the institutions over a period of two and one-half to three years. Eighty-eight mortalities were reviewed in total. Categorizing the total number of deaths reviewed, 36% were due to AIDS or related illnesses, 24% were cardiac related, 11% were due to cancer, 6% were asthma related, and 23% were due to miscellaneous causes. Of the total, 3% were due to suicide and 2% to homicides. Eight mortalities were found problematic by the authority. As evidenced by physical health care findings outlined earlier, mortality citations reflected inadequacies related to appropriate assessments, diagnosis, and treatment. Three cardiac deaths indicated the need for more aggressive staff intervention during the emergent episode. The authority recommends the placement of automatic external defibrillators (AEDs) in institutions statewide, with operational training provided to staff.

The two deaths related to asthma required more immediate intervention and follow-up. Previous authority reports have identified similar concerns. The authority recommends review and revision of institutional treatment protocols related to assessment and treatment of acute asthma attacks, and monitoring for associated rebound conditions. Assurance that all institutional staff are trained in current assessment and treatment modalities is also indicated.

Dental Services

Reviews of institutional dental programs during fiscal year 1997-98 revealed improvement in the timeliness and appropriateness of services provided as compared to the last reporting period. These findings may be a function of the type of institutions surveyed during FY 1997-98, or may indicate an overall improvement in the system. Cumulative survey data over several years will prove out the validity of any findings. At 84% of the institutions surveyed, the dental component was rated as a "strength" in individual survey reports. Concerns regarding clinical management, documentation, and/or the administrative process were isolated to three institutions.

Dental survey results revealed few problems associated with timeliness and appropriateness of services.

Access

In last year's annual report, the CMA expressed concern that the department's dental consolidation efforts and dental staff reductions might have the potential to negatively impact the timeliness and quality of inmate dental care. This year's data do not support this supposition. Further analysis of survey findings is indicated and cautious optimism is recommended. In next year's annual report, after another year of data is compiled and analyzed, this issue will be revisited.

Clinical Management

At 89% of the institutions surveyed this year, no citations were issued for dental clinical management issues. Two institutions received clinical management citations. In the judgment of surveyors, based upon records reviewed, overall dental care provided to inmates met department standards. No significant negative trends in care were noted.

Mental Health Services

The typical profile of institutions surveyed was that of an S2 institution located in Region I or II. S1 and S2 institutions are typically less complex as they offer only outpatient services. Inmates at these institutions who require mental health services generally need only periodic case management and/or outpatient counseling. Of the twenty institutions surveyed in FY 1997-98, 13 (65%) housed inmates with a maximum psychological grade (S-Grade) of S2. Seventy percent (70%) of all institutions surveyed were in Region I or II. Only four institutions surveyed housed close management inmates, while in the prior survey year, eight institutions housed close management inmates. Other institutions included two S1, three S3, and two S4/5 institutions. Similar to the prior survey year, inmates receiving mental health services constituted approximately 12% of the surveyed institutions' total populations.

Sixty percent (60%) of all institutions surveyed had mental health citations.

Of the institutions surveyed, eight institutions (40%) had no Level I or II mental health citations. Seventeen institutions (85%) had no Level I citations. However, Level II citations occurred in 12 (60%) of the institutions surveyed.

Access

Sixty-five percent (65%) of institutions surveyed had no mental health access citations.

In a correctional environment unimpeded access to care is critical. Assuring unimpeded access to care is an ongoing challenge in most correctional settings; it is not an issue peculiar to this state's correctional system. Factors influencing access include institutional operations and security issues as well as inmate knowledge of how to seek care. While 13 institutions surveyed (65%) received no access citations, two institutions received Level I and II mental health access citations. One institution received a Level I mental health citation only and four received Level II mental health citations only.

Security Issues

Security related impediments to access comprised a significant portion of the mental health access problems noted in this year's surveys. Over half of the seven institutions cited received citations due to security impediments to access, two of which were Level I citations. These impediments included the following:

- delaying/denying confinement inmate requests for services (two institutions);
- issuing disciplinary reports to inmates as punishment for having a mental health crisis (e.g., a suicide attempt) (one institution); and
- numbers of security staff were inadequate for mental health services to be safely provided in an inpatient setting (one institution).

As identified in last year's survey cycle, in some institutions security officers reportedly discourage access to mental health services by use of disciplinary reports or other punitive/abusive measures. This was again reported during three institutional surveys. One of those institutions was formally reported to the department's Inspector General for investigation of excessive use of force allegations.

Security staff at all institutions continue to require specialized mental health training beyond the basic suicide prevention course to enable them to more effectively and safely manage the inmate population. Such training would also help them better differentiate between manipulative behaviors and a true mental health emergency.

◊ *Other Access Issues*

The remainder of the mental health access citations related more directly to mental health staff and included the following:

- confinement evaluations were not conducted within required time frames (one institution);
- while group therapy was indicated, none was offered (two institutions);
- inmate orientation to mental health services was not conducted (two institutions) and mental health services were not addressed in the inmate handbook;
- reception center testing conditions compromised confidentiality (one institution);
- a lack of discharge planning for inmates approaching end-of-sentence (one institution); and
- responses to requests for services were not specific and appropriate (one institution).

As mentioned above, 65% of the institutions surveyed had no access citations; however, this is a slightly poorer performance than last year in which 70% had no access citations. Mental health staffing levels and position vacancies contributed to concerns noted in three institutions. One institution evidenced difficulty recruiting and retaining adequate numbers of psychiatrists. At another institution, an influx of close management inmates with no correlating increases in mental health staff positions may have contributed to the high number of citations received by the institution. At a reception center, workload was noted to be too high for the number of mental

health staff providing the reception services. As security staffing shortages and psychiatric recruitment/retention difficulties continue, access problems may increase, as there is an implicit link between staffing and adequate access to health care. The authority will continue to monitor this important aspect of inmate health care.

Clinical Management

Fifty-five percent (55%) of the institutions surveyed received no mental health clinical management citations. As a result of authority surveys, two Level I clinical management citations were issued relating to inadequate evaluations and nursing assessments and lack of appropriate medication management. The 21 citations issued for clinical management problems generally can be categorized into five areas: treatment intervention issues (29%), inmate care while in suicide observation status (24%), issues related to Individualized Service Plan (ISP) preparation (23%), assessment/evaluation issues (14%), and documentation issues (10%).

Fifty-five percent (55%) of surveyed institutions received no clinical management citations.

◊ *Treatment Interventions*

Five institutions were cited for issues related to inappropriate and/or inadequate treatment interventions. These citations included the following:

- failure to conduct necessary laboratory tests and failure to follow-up on abnormal results (one institution);
- treatments were not implemented (one institution);
- inadequate medication management including a lack of physical examinations, absence of drug histories, insufficient laboratory testing, and absence of justification for dosage changes (one institution);
- failure to address and treat identified problems (one institution);
- nursing progress notes in an inpatient setting were too infrequent given the patients' acuity levels (one institution); and
- treatment interventions were not documented at the frequency specified in the service plans and the service plans were not revised to reflect actual activities (one institution).

◊ *Suicide and Self-injury Prevention*

Five institutions received citations for issues relating to the care of inmates on suicide observation status (SOS). The citations were as follows:

- failure to justify the denial of privacy wraps (specifically designed for suicidal patients) to inmates housed in the SOS infirmary cells (one institution), i.e., leaving inmates naked in suicide holding cells with no clinically valid reason;
- inappropriate follow-up treatment for inmates discharged from SOS (two institutions);
- ISPs were not modified to address the suicidal behavior (one institution);
- physician's orders for suicide observation were absent (one institution); and
- inadequate observation of suicidal inmates (one institution).

◊ *Assessment/Evaluation*

Three institutions were cited for inadequate assessments of inmates. The specific citations were for a failure to utilize the *Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition)* criteria to assess depressive symptoms; a lack of thoroughness of nursing and psychiatric assessments; and a lack of timeliness in development of biopsychosocial assessments.

◊ *Individualized Service Plans*

Three institutions were cited for issues related to ISP (treatment plan) preparation. The citations included the following: a lack of inmate signatures on ISPs (two institutions); a lack of timeliness in ISP preparation; a failure to identify treatment interventions in the ISP; and omission of critical details in the ISP.

◊ *Documentation*

Two institutions were cited for issues related to medical records and documentation. The specific citations were for misfiled and disorderly records and for inadequate detail and thoroughness in the documentation of mental health services.

Administrative

Administrative issues relate to factors such as staffing levels, physical facility characteristics, and operational policies and procedures that provide a framework for the delivery of services. Those issues can enhance or impede access to care and the clinical management of that care. Seventy percent (70%) of institutions surveyed received no citations related to administrative issues. There was, however, one Level I citation issued. At one institution an infirmary isolation cell used to house suicidal inmates did not meet certification requirements, thus posing a safety risk. Of the 13 administrative citations, one related to the non-certified SOS cell, one related to a lack of mental health staff in-service training, and the remainder (85%) related to incomplete mental health logs and/or inadequate internal operating procedures.

Special Populations

Since few institutions house special populations (e.g., youthful offenders, females, etc.), it is difficult to identify whether there are any trends in the treatment of these groups based on one year's sample. Last year's report summarized the care provided female inmates at all female institutions surveyed during the preceding triennium. This year's report covers care provided at youthful offender institutions over the triennial survey cycle from FY 1995-96 through FY 1997-98.

Youthful Offenders

The department's 1996-97 Annual Report describes a youthful offender as an inmate who:

- commits a crime prior to his or her 21st birthday;
- is 24 years old or under, with a sentence of 10 years or less; or
- is assigned youthful offender status for protective purposes (vulnerable inmates who are 19 years old or younger with a sentence of more than 10 years may be classified as a youthful offender if their safety would be jeopardized in an adult institution).

Capital or life felons may not be classified or sentenced as youthful offenders, regardless of whether they meet the above criteria. Youthful offenders ages 14-18 must be housed separately from those 19-24 years old.

As of June 30, 1997, the total statewide youthful offender population was 3,812. Approximately 2,700 were housed at the department's four main youthful offender male facilities: Brevard, Hillsborough, Indian River, and Lancaster Correctional Institutions. Sixty-nine female youthful offenders were housed at Florida Correctional Institution. The remaining inmates were housed in work camps, boot camps, community correction centers, drug treatment facilities, and reception centers.

Youthful offenders generally have difficulty adjusting to structured living.

Discussions with staff at each of the institutions surveyed revealed care and custody of youthful offenders offers challenges often times not experienced at adult institutions. Most often cited as the reason this population is particularly challenging is because inmates of this age adapt more slowly to structured living conditions. Because many youthful offenders lack appropriate coping skills to interact with others in a non-threatening manner, they often have little respect for others or their possessions. Because they are often unable to adjust to the regimentation required in a correctional setting, discipline problems are common.

Delineating between simple discipline/adjustment problems and problems which may have a psychological/mental disordered base offers special challenges to the mental health staff of youthful offender facilities. Conversely, because of their age, youthful offenders are generally considered a physically healthier population than older inmates and therefore place fewer demands on staff and facility resources for serious, long-term medical care.

◊ *Profiles of Youthful Offender Institutions*

Correctional Institution	Region	Maximum Capacity	Medical Grades	Psychological Grades
Brevard	3	966	I-III	1-3
Hillsborough	5	335	I-IV	1-3
Indian River	4	286	I-III	1-2
Lancaster	2	634	I-III	1-3

Data Source: Pre-survey questionnaires

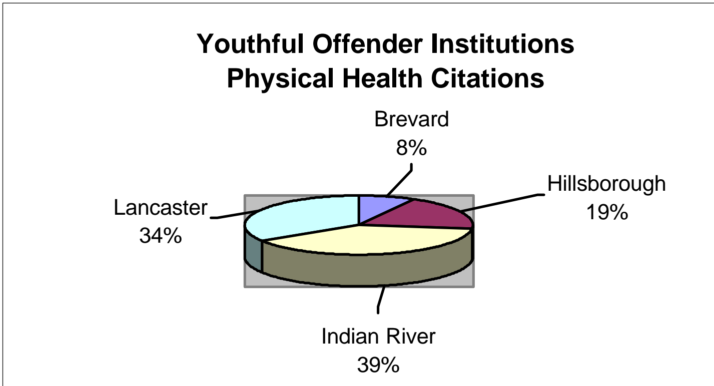
◊ *Survey Findings*

The information provided below was compiled over three years. Two institutions, Brevard and Indian River, were surveyed during fiscal year 1997-98; Lancaster was surveyed in fiscal year 1996-97; and Hillsborough in fiscal year 1995-96.

Physical Health

A total of 26 physical health citations were issued at the four institutions surveyed. Citations spanned access to care concerns, clinical management deficiencies, and administrative issues. Two of the four institutions were cited for concerns regarding access to health care; e.g., slow or no referrals to a physician following evaluation by the nursing staff. One institution was also cited for inadequate staffing which hampered the offender's ability to request care. Clinical management citations were noted at three of the four institutions surveyed; e.g., inadequate documentation of care in sick call and emergency care records. Administrative concerns were also noted at three of the four institutions surveyed. At one institution, most of the administrative concerns were of the environmental/safety nature; e.g., lack of cleanliness and dormitories in need of repair. Another institution, which was cited for access concerns due to staff shortages, was also identified with administrative shortcoming for the same reason. Although not specifically cited at the time of the survey, one institution was formally reported to the department's Inspector General for investigation of allegations of abusive treatment and harsh disciplinary measures. These allegations surfaced during medical/mental health and security staff interviews as well as during inmate interviews.

One-half of the youthful offender institutions were cited for physical health access issues.

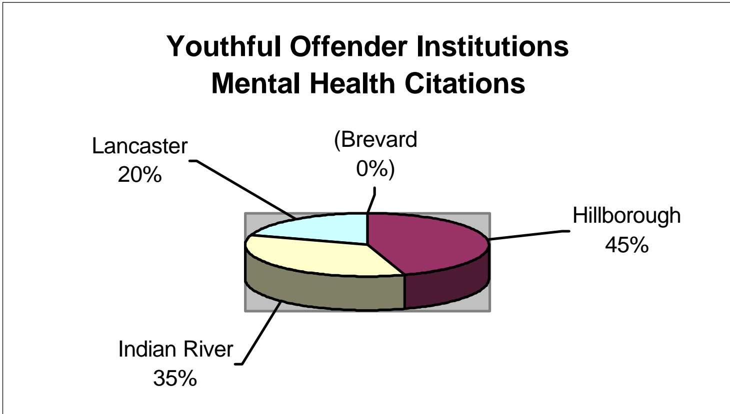


Mental Health

In the mental health area, a total of 20 citations were issued at three facilities. At one institution, no mental health concerns were identified. As noted in the physical health reviews, deficiencies spanned access, clinical management and administrative areas.

One-half of the youthful offender institutions were cited for mental health access issues.

Two of the three institutions that were issued citations received them for access to care concerns; e.g., disciplinary action taken against inmates for feigning illness, request for services not answered in an appropriate manner, and inadequate mental health staffing. Clinical management deficiencies were identified at all three institutions that received citations. These deficiencies



included mental health service plans with content errors and instances when prescribed suicide observation procedures were not followed. At one institution psychotropic medications were administered at a time other than prescribed, i.e., twice-a-day medications, traditionally administered at 12-hour intervals, were given at 9 a.m. and 4 p.m. This practice can result in undesired medication effects. This medication schedule was attributed to staffing patterns (nurses work 8 a.m.-4 p.m.). It was additionally noted that "at bed" medications were also given at 4 p.m. This schedule resulted in inmate drowsiness and non-productivity during the evening hours and difficulty sleeping throughout the night.

Administrative concerns were also identified at each of the three institutions that received citations. Included in this category were concerns regarding inadequate record screening and inadequate planning for staff. Inadequate suicide observation (SOS) room availability was also an issue at two institutions surveyed. At one institution, because of high usage of SOS rooms, offenders were frequently housed in infirmary beds, which presented safety concerns. At a second institution, SOS rooms were not used because an inadequate number of staff was assigned to conduct required monitoring and observation. At this institution, all offenders requiring SOS were automatically transferred to another facility.

Follow-up Monitoring

Corrective Action Plans

The authority publishes its survey reports within 60 calendar days following a survey. Florida statutes require institutions to submit a written corrective action plan (CAP) to the authority within 30 calendar days after the receipt of a survey report. Thirteen institutions were required by statute to submit either a physical health and/or mental health CAP during FY 1997-98. None of the institutions submitted the CAP within the statutorily required 30-day time frame. On average, the CAPs were 45 days overdue.

No corrective action plans were submitted by the department within the required thirty (30) days.

The purpose of the CAP is to address issues (both physical and mental health) that have been cited in the survey report. The CAP should document a plan of action for correction of identified issues. Following the OHS' submission of the final CAP, authority staff review all proposed institutional action for responsiveness to the cited issue. Written comment and clarification is then provided to the OHS. However, frequently at the follow-up assessment visit, the authority has determined institutional and regional staff were not aware of this commentary. Thus, the corrective action taken by the institution was determined not corrected or only partially corrected because the proposed action did not adequately address the concerns raised by the authority in the citation.

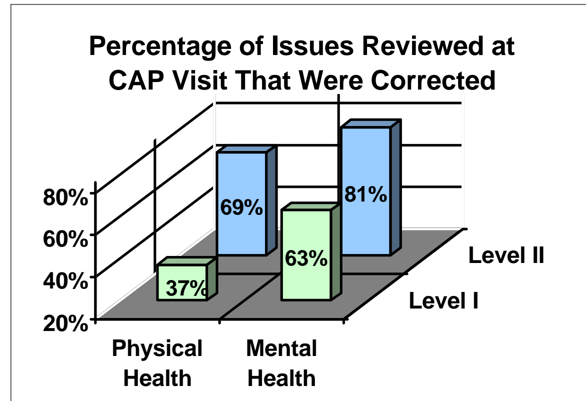
Corrective Action Assessment Visits

Approximately three months after submission of the CAP, the authority conducts an assessment visit to monitor the corrective actions outlined in the CAP. During these visits, authority staff may review all issues or conduct a focused review on selected issues. All Level I citations are reviewed, however, to determine the extent to which corrective action is implemented. Within 30

days of each assessment visit a report of findings is released to the department, the OHS, and Executive Office of the Governor. Following the issuance of the CAP report, any remaining uncorrected or partially corrected citations are monitored by the OHS until they are corrected. At that time the CAP is certified closed by the OHS.

Roughly half of institutions monitored for follow-up during the fiscal year had received Level I citations.

For FY 1997-98, the authority monitored care provided at 20 institutions. Review of the CAPs indicated that over half the institutions (52%) had received Level I physical health citations, and nearly half (48%) had received Level I mental health citations.



At the time of the CAP visit, 37% of the Level I physical health citations were determined corrected, while 69% of the Level II physical health citations were determined corrected.

Only thirty seven percent (37%) of all Level I physical health citations were corrected at the CAP visit.

Sixty-three percent (63%) of the Level I mental health citations were determined corrected, and eighty one percent (81%) of the Level II mental health citations were determined corrected. For more specific information on individual institutions please see Appendix C.

FOLLOW-UP MONITORING
Corrective Action Assessments
1997-98

Region I	Region II	Region III	Region IV	Region V
Apalachee	Baker	Marion	Dade	Hardee
Bay	Madison	Sumter	Everglades	Polk
Calhoun	Mayo		Glades	
Century	Taylor		Indian River	
Holmes			Okeechobee	
Liberty				
Washington				

Shaded institutions were surveyed during FY 1997-98. The remaining institutions were surveyed during FY 1996-97.

Institutional Evaluations of Survey Process

At the conclusion of each authority survey, evaluation forms are provided to the superintendent for distribution to key institutional staff. The purpose of the survey evaluation is to improve the survey process and identify any problem areas. Signatures are optional, so that institutional staff

may feel free to respond candidly. Institutional staff return the evaluation forms directly to the authority, where they are carefully reviewed.

During fiscal year 1997-98, 17 institutions returned a total of 114 evaluation forms. Ninety-six percent (96%) of respondents expressed satisfaction with the survey process. Ninety-three percent (93%) of respondents felt survey team members were adequately prepared and oriented to the department's organization and mission. The survey process was considered a positive learning experience by ninety five percent (95%) of respondents, and eighty four percent (84%) offered no suggestions to improve the survey process.

Mental Health Committee Report

Introduction

The mental health committee is responsible for monitoring and evaluating the performance of the department's mental health program. Six volunteer members represent a variety of mental health fields. Their backgrounds include community-based mental health delivery systems, corrections mental health, state government, private practice, and academic settings.

Policy Issues and Initiatives

Substance Abuse Programs

The authority's mental health committee has an ongoing interest in supporting cooperative initiatives between the department's Office of Health Services (OHS) and the Bureau of Substance Abuse Programs. In this regard, substance abuse program staff accepted the authority's invitation to regularly attend mental health committee meetings with their colleagues from the OHS. Substance abuse staff provided committee members with a comprehensive, historical overview of the department's substance abuse program and funding issues. Highlights included data on the significant numbers of inmates with substance abuse problems; the assessment process; treatment models; and decisions regarding when to provide treatment. Allocation of program development resources; after-care planning and relapse prevention; the role of departmental classification staff in program administration and delivery; and program monitoring were also discussed. Inmates most in need of services were targeted as the department continued to seek additional resources to expand substance abuse programming. However, not all inmates in need of substance abuse programming are receiving that assistance.

For dually diagnosed inmates (those with both substance abuse and mental health problems), substance abuse and mental health staff continued to cooperate on the implementation of a federally funded pilot program. This program, which consists of a modified therapeutic community model, was established at two sites in November 1997. A 40-bed program for adult females was located at Jefferson Correctional Institution in Region I. An 80-bed program for adult males was instituted at Zephyrhills Correctional Institution in Region V. On February 26, 1998, the authority's mental health committee was provided with a status report on the pilot program and a tour of the Zephyrhills site. Due to the infancy of the program, evaluation data are not available for the 1997-1998 fiscal year. Florida State University has secured the grant from the National Institute on Justice (NIJ) for providing on-going program evaluation. Quarterly evaluation data are available reflecting ongoing activities pertaining to start-up of the programs. A report on the status of the program is anticipated during the Spring of 1999.

Involuntary Medication Practices

The OHS continues to consider the development of a pilot program to extend involuntary medication practices beyond the Corrections Mental Health Institution (CMHI). The authority agrees with the OHS that the development of such a program must be carefully considered with appropriate safeguards built in, including a review of the training needs of individual practitioners. Although a site for the program has not been selected, North Florida Reception Center (NFRC) has been named by the OHS as a possible site.

Emergency Treatment Orders

The mental health committee continued to discuss the appropriate use of emergency treatment orders (ETOs), i.e., medication without the inmate's informed consent, administered primarily for inmate mental health emergencies. The OHS has developed guidelines for consideration by clinicians regarding the use of ETOs and/or physical restraints based on the clinical needs of the inmates. The authority's survey and committee processes continue to monitor this issue.

Health Care Classification System--S2P Proposal

During fiscal year 1995-96, the designation S2P was proposed as a sub-category of the S2 designation. This designation was intended to identify inmates on psychotropic medications who were stable and needed less intensive monitoring than S3 inmates. This proposal had the potential to expand work assignment opportunities for inmates on psychotropic medications. It also had cost reduction potential, and if implemented within certain parameters, was not expected to negatively impact patient care. However, as stated in last year's annual report, the OHS tabled further action on the proposal due to less than four percent (4%) of the S3 population being identified by mental health field staff as appropriate for reclassification. Although the proposal will not be implemented, practitioners continue to be encouraged to reduce the frequency of psychiatric contact, as appropriate, for S3 inmates, monitoring these cases for sufficient clinical management. It remains important that the OHS study the reduction in psychiatric management and report its findings to the authority. It is recommended that the OHS complete a longitudinal study to evaluate clinical outcomes for inmates whose psychiatric contacts are reduced. Cost and service effectiveness data would be useful components of this study.

Psychotropic Medication Administration Issues

As stated in last year's annual report, the authority recognizes the characteristics of the institutional environment that constrain medication practices, particularly the timing of medication administration. As also noted in last year's report, the OHS established a psychiatric subcommittee of the OHS pharmacy and therapeutics committee to consider institutional factors that impact medication administration practices. This subcommittee has continued to review the department's drug formulary, physician prescribing practices, the implementation of liquid dose medication, and alternatives to drug interventions for inmates experiencing sleeping problems. Administrative issues as well as physician prescribing practices which impact medication administration are currently being addressed in revisions to the relevant health services bulletins (HSBs). Survey information regarding the clinical impact of these factors remains useful to the OHS, particularly as institutions vary widely in administrative practices affecting medication administration.

After-hours Transfer Policy

This policy was introduced in September 1996. It encourages on-site management of suicidal and self-injurious behaviors until such time as an appropriate mental health assessment can be secured. If a certified infirmary isolation management room (IMR) is not available, the inmate may be housed in an alternative setting until one becomes available. Alternative settings include infirmary beds, confinement cells, and close management cells. Previously, if an inmate declared an emergency after 5:00 p.m. (typically when mental health staff were not on duty), and a certified IMR was not available, he or she would be transferred to another institution. The OHS reports that the number of after-hours emergencies has decreased significantly since the policy was introduced, and that this may have contributed to the lowering of the crisis stabilization unit (CSU) census statewide.

As noted in last year's annual report, the OHS has not published an evaluation of the after-hours transfer policy. While the OHS has provided data indicating a reduction in the number of after-hours emergencies, it is not clear what impact the policy has had on the quality of care provided inmates who declare psychological emergencies, or engage in self-injurious behaviors when mental health staff are not on duty. The authority's concerns, as noted in last year's annual report, include: the appropriate clinical management of suicidal and self-injurious behaviors; staff assessment skills and training needs; safety issues for inmates housed in alternative settings; and access to treatment for confinement and close management inmates. An additional concern is that administrative and clinical documentation is insufficient for the authority to track and evaluate the management of inmates handled under the after-hours transfer policy. Thus, the authority has reviewed only isolated cases managed under the policy. To assure the authority can address these concerns, the authority again recommends the OHS develop institutional logs that track the housing placement of inmates who declare after-hours emergencies, and assure that clinical documentation in the individual medical record also clarifies the housing placement.

The OHS has not yet evaluated the impact of the after-hours transfer policy regarding clinical management issues.

Behavior Management Program

The authority has encouraged the development of a treatment program designed to address the needs of inmates who are not mentally ill, but exhibit behavior management problems. At the February 1998 mental health committee meeting, the OHS reported that Martin Correctional Institution in Region IV was intended as the site of a behavior management pilot program. This has not been implemented as yet.

As noted in last year's annual report, the authority concurs with OHS in several key areas regarding the development of such a program:

(1) a need exists to increase the number of certified IMRs, which the authority believes are the appropriate site for managing suicidal and self-injurious behaviors;
(2) a need exists to increase staff training in the prevention and management of suicidal and self-injurious behaviors; and
(3) a need exists to focus on safely managing, through behavioral interventions where appropriate, an increasing confinement/close management population.

Additional staff may be required to ensure that mentally ill individuals in the behavioral management setting continue to receive required levels of care. The roles of security and health care staff should be explored, particularly regarding whether mental health staff can effectively provide both therapeutic and behavioral interventions. The use of "harm avoidance" cells in close management and confinement areas implies a less stringent standard than entailed in the use of certified isolation management rooms and thus raises significant clinical management issues. Finally, meeting the needs of inmates who simultaneously display mental health and behavior management problems will remain a challenge.

Suicide Status Report

The OHS asked to present the mental health committee with a suicide status report at its August 1997 meeting. At that time, OHS reported that the department's suicide rate was low compared to other states. Comparisons were based on statistics obtained by the department. Notably, the OHS quarterly report for April–June 1998 indicated that an "unusually high" number of suicides occurred during fiscal year 1997-1998. The OHS quarterly report for July-September 1998 stated that the department's suicide rate had increased to nine per 100,000 in 1997-1998. The rate had previously declined from 15 per 100,000 in 1993-1994 to six per 100,000 in 1996-1997. The OHS noted that analyses of the nine suicides occurring in 1997-1998 yielded "no particular patterns regarding age, sentence, housing circumstances, other demographics, or the level of mental health care being provided at the time." The OHS contends that an average rate for the past four years of 8.5 suicides per 100,000 remains lower than community rates of 14-18 per 100,000. The department obtained the community statistics. The authority will place a high priority on reviewing the department's data through its mental health and quality management committees.

OHS Mental Health Policy Directives

Florida law requires the OHS to submit all changes in inmate health care standards to the authority for its review prior to adoption by the department. Health care standards, as specified by law, include, but are not limited to, rules relating to the management structure of the health care system and the provision of health care services to inmates, health care policies, health care plans, quality management systems and procedures, health service bulletins, and treatment protocols. During fiscal year 1997-98, the authority became aware the department had modified four mental health policies via memo or telex. These changes were implemented prior to any review by the authority. The authority also was not informed of these policy changes at the time they were distributed to the field. A summary of the changes follows.

(1) Restraint Policy – A July 1997 memorandum from the assistant secretary for health services to the directors of regional health care required immediate policy and procedural modifications to HSB 15.05.10 (effective 7/3/96*), Use of Time-out, Psychiatric Seclusion, and Psychiatric Restraint*. The policy was modified to more closely resemble the Joint Commission on Accreditation of Healthcare Organization (JCAHO) standards. The July memorandum allows OHS psychiatrists to order restraints, verbally or in writing, in four-hour blocks for up to 16 hours before personally examining the inmate. HSB 15.05.10 formerly required a personal examination by the psychiatrist after four hours prior to extending the order for restraints.

(2) HSB 15.05.11 (effective 11/9/95), *Planning and Implementation of Individualized Mental Health Services* – An October 1997 memo from the assistant secretary for health services to the regional mental health consultants and senior psychologists required immediate policy change to HSB 15.05.11. The time required between individualized service plan (ISP) team meetings has been expanded in an effort to reduce paperwork requirements for mental health staff. The expanded timeframes represent minimum guidelines and more frequent reviews are required if clinically indicated.

(3) Risk for Violence Assessment – In December 1997, two telexes were sent to the field establishing policy in this area. The new policy requires a specific risk for violence assessment for close management, protective management, and disciplinary confinement inmates being admitted to inpatient settings. The assessment is to be performed by a team of clinical, security, and classification staff. The outcome of the assessment may restrict inmate movement and/or participation in group treatment and other activities while the inmate remains an inpatient. The emphasis of the policy remains on ensuring the inmates' clinical needs are met in the least restrictive environment and requires a documented rationale for restricting movement and/or access to treatment. Staff training was conducted in March 1998. The mental health rule is currently under revision to incorporate the risk for violence assessment.

(4) HSB 15.05.09 (effective 7/21/97), *Suicide and Self-Injury Prevention* – A November 1997 memo from the assistant secretary for health services to the directors of regional health care and the regional mental health consultants required immediate changes to HSB 15.05.09. A greater degree of clinical discretion is now allowed in assigning psychiatric (S) grade changes for inmates discharged from SOS. The policy change requires a mandatory follow-up visit at seven days post-SOS discharge regardless of the inmate's S grade. Formerly, release of an S1 inmate from SOS required an upgrade to S2; the recommended time frame for initial follow-up was discretionary.

While the authority does not have significant concerns regarding the substantive components of the policy changes outlined above, it is most concerned that these policy changes were implemented prior to the authority having an opportunity to review them, as required by law. Thus, the authority is concerned about other policy changes that may have been implemented by the department of which the authority is unaware.

Mental Health Strategic Planning

A departmental strategic planning group was established to review the department's current mental health services delivery system. The OHS quarterly report for April-June 1998 stated that preliminary suggestions for more efficient and cost effective provision of mental health services were due by August 1, 1998. A group conference to review and revise planning recommendations was to be scheduled in September 1998. The authority will review recommendations resulting from this planning process.

Quality Management Committee Report

Introduction

The authority's quality management committee (QMC) provides oversight of the department's health care quality management (QM) program. The committee consists of three physicians, four nurses, and one licensed mental health counselor whose backgrounds include family practice, correctional medicine, infection control, risk management, quality management, and counseling. The QMC meets quarterly, approximately six weeks after meetings of the Office of Health Services (OHS) central office QM committee. At QMC meetings the OHS provides status reports on QM program activities, as well as other information as requested. One member of the authority is appointed to the QMC; this member reports QMC activities to the authority.

Overall Quality Management Program

During fiscal year 1997-98, the OHS completed its QM pilot project. This project, initiated in the fall of 1996, developed, tested, and implemented institution-specific indicators. These indicators will monitor patient care systems and processes over time and identify opportunities for improvement. The pilot project incorporated findings from the authority's surveys, the OHS quarterly survey process, risk management reports, and concepts from the department's correctional quality managerial leadership (CQML) program. The central office QM committee approved six physical health statewide indicators. Those indicators were implemented through the quality assessment component of the QM program during the third quarter of the fiscal year.

Presently, the health services bulletin (HSB) governing the OHS QM program is under revision. The revised HSB should reflect the new direction of the program and formalize the relationship between the OHS' QM program and the department's CQML program. The revision should include the department's problem solving process and other continuous quality improvement concepts.

The OHS' health care consolidation efforts require evaluation of all QM program components. Such an evaluation is indicated to determine if the QM needs of institutions with a variety of health care missions and staffing levels are met. Current program components of the QM program are being compared to similar components in the private sector, such as HMOs, walk-in clinics, single-day surgery centers, and physician offices. The OHS reports its goal is to design QM programs that comply with applicable regulations and accreditation standards, while maintaining comparability in scope to similar community based operations.

Quality Management Program Components

The OHS QM program is comprised of seven components: Credentials Review, Utilization Management, Mortality Review, Quality Assessment, Risk Management, Infection Control, and Program Evaluation.

Credentials Review Component

The OHS QM Credentials Review function serves to verify practitioners' medical training and experience and grant clinical privileges based on that background. This component continues to operate smoothly within defined parameters. The process of credentialing practitioners upon initial appointment remains timely. A practitioner profiling task force was initiated; however, a system for monitoring and evaluating practice patterns is not yet in place. The feasibility of acquiring computer software to further automate the credentials review process is being explored by the OHS. A corrections action team (CAT) to review the effectiveness of the current process was established.

A corrections action team (CAT) was established to review the effectiveness of the current credentialing process.

Utilization Management Component

The centralized utilization management (UM) program at NFRC monitors utilization and cost effectiveness of services throughout the system. The program monitors average length-of-stay for hospitalizations, the number and type of emergency hospitalizations, and the number of specialty consultations. It also tracks the cost avoidance that results from transferring inmates to the least costly appropriate facility for care and follow-up. The OHS estimates that in fiscal year 1997-98, the expenditure of $11 million has been avoided as a result of the UM program. To review the cost avoidance associated with the OHS UM program and other authority recommended cost avoidance programs, see page 12.

An automated data base system for tracking statewide UM activities has been implemented. Additionally, Region I implemented a system to manage consultation requests that resulted in an improvement that reduced elapsed time from consult request to initiation of treatment. The UM staff also participated in development of admission criteria and health care standards for the special care unit at Central Florida Reception Center (CFRC). An ongoing standardized UM in-service program was developed and presented to institutional and regional staff.

The authority continues to urge the OHS to expand its UM program to include a clinical component. The clinical component should assess the impact of utilization management on the quality of care provided to help assure no unnecessary or invalid restriction on use of resources exists. A clinical component should address the appropriateness, adequacy, and/or effectiveness of care. The authority recommends the inclusion of three clinical benchmarks in the UM program: (1) documentation demonstrating the provision of clinical services; (2) comparison internally or with other managed care providers to evaluate over- or

The authority continues to urge the OHS to expand its utilization management (UM) program to include a clinical component.

under-utilization of services; and (3) reporting over- or under-utilization of services to the credentials review program.

Mortality Review Component

The OHS' mortality review process ensures review of all mortalities for appropriateness of care. Completion of mortality reviews remains timely. Revisions to the OHS' July 1997 mortality review HSB were published in October 1997. The revised process significantly improved the timely closure of mortality reviews. Institutions are required to conduct a self-review of the appropriateness of the care provided the inmate before death. That review, along with the medical record, is submitted to central office. The OHS central office sends the medical record, but not the institutional self-review, to non-department physicians for a second, independent review. By July 1998, the OHS central office had received 218 records for the 222 deaths that occurred during the fiscal year. Institutions noted deficiencies in only seven of those cases. Outside reviewers cited deficiencies in care in 30 additional cases. In cases where a difference of opinion exists, the case is referred to the region for further review, reconciliation of findings, and case closure. By July 1998, 187 of 222 mortalities occurring during fiscal year 1997-98 were closed.

The authority continues to recommend the evaluation of practice patterns in association with the mortality review and credentialing process. Evaluation of practice patterns can identify the need for individual or group education and training or other preventive interventions. As previously recommended by the authority, the OHS should develop a method to include practice patterns in a practitioner's credentialing file.

During fiscal year 1997-98, the authority's QMC developed a process for concurrent mortality review. Mortality reviews by the committee began at the December 1997 meeting. The QMC review does not replace the authority's survey review of the quality of care delivered to inmates preceding any death. Rather, it is a supplement. The QMC review focuses on whether, in the committee's opinion, the OHS mortality review program effectively identified any deficiencies in inmate health care that contributed to the inmate's death, and effectively addressed those deficiencies to prevent recurrence. Of the 15 deaths reviewed, the QMC referred four cases to the OHS with questions pertaining to the adequacy of the mortality review process. Response from the OHS remains pending at the writing of this report. The authority's QMC hopes that through dialogue with the OHS pertaining to the adequacy of the mortality review program, improvements in patient care will result.

Quality Assessment Component

During fiscal year 1996-97, the OHS initiated substantial revisions to the quality assessment (QA) process. The OHS recognized the need to transition an outmoded QA model to the modern quality improvement model. The pilot project anchoring this transition ended in January 1998. As a consequence of this pilot project, five major categories for indicator development, applicable to all disciplines, were established. They are (1) access to care, (2) continuity of care, (3) preventative

Clinical indicators have been developed for physical, mental, and dental health services.

care, (4) clinical outcomes of care, and (5) patient care interventions. At the conclusion of the pilot project, the central office QM committee approved six physical health indicators pertaining to the five categories of care. Statewide training was conducted regarding the implementation of the quality indicators and review of indicator processes. Statewide dental indicators and mental health indicators were subsequently developed. Data reported by institutions are summarized by central office staff and provided to all institutions and regions. Grouping institutions with similar medical or psychological grade or mission for evaluating indicator variation patterns has been completed. Comparisons between groups can be useful to identifying best practices to avoid inmate injury and contain costs.

The data collection process is in its early stages and has not yet yielded sufficient information to begin drawing useful conclusions. However, the authority remains encouraged by the foundation that has been laid in the QA process.

Risk Management Component

Data generated by patient injury reports (PIR) and administrative/quality monitor reports (AQM) are collected in the risk management (RM) program. PIRs provide data on those adverse or untoward events that result in injury. AQMs monitor potential risk related events. AQM reporting should help identify and correct risk-related events and deficiencies before injuries occur. Despite ongoing training of institutional health services staff, risk management data remain under-reported.

Risk management data remain under-reported.

The authority's past two annual reports contained recommendations that the OHS standardize the reporting of RM data. As recommended by the authority, standardized reporting of RM data began during the 1997-98 fiscal year.

The OHS has begun to report standardized risk management data.

Infection Control Component

The infection control (IC) program continues to collect surveillance data to identify trends in selected infectious diseases and areas for further study. During fiscal year 1997-98, the OHS updated guidelines for more effective prevention or control of the spread of infectious diseases. The IC program continues to coordinate reporting infectious diseases to the Department of Health. This reporting is in response to regulatory requirements and should help provide for continuity of care of HIV positive inmates and inmates with tuberculosis as they reach end-of-sentence.

Program Evaluation Component

As noted in last year's annual report, the first evaluation of the OHS QM program was completed in January 1997. Since then, the central office QM committee approved six major recommendations that resulted from the evaluation project. During fiscal year 1997-98, project directors for each of the recommendations were appointed to implement the recommendations. Two CAT teams were formed. One CAT is addressing QM training and the other will examine communication primarily related to QM in the OHS.

A pilot project to evaluate regional and institutional quality management programs was initiated.

Additionally, Region V served as a pilot project for evaluation of regional and institutional quality management programs. Evaluation of the OHS internal quarterly review process was also initiated. The goal is to link the quarterly review process with other quality management activities. The authority continues to recommend the development of QA studies and indicators resulting from findings generated by the quarterlies and the authority's survey findings.

PROGRAM COMPONENT	FUNCTION	AUTHORITY RECOMMENDATIONS
Credentials Review	Ensure practitioners have proper credentials to practice, and that privileges are commensurate with training and clinical competence.	Fully implement a practitioner profiling system that monitors and evaluates practice patterns. Use in biennial recredentialing process.
Utilization Management	Maintain quality health care services while managing the volume of services used.	Implement a clinical component to help assure no unnecessary or invalid restriction of use of resources exists.
Mortality Review	Retrospectively monitor and evaluate the quality and appropriateness of health care and the health care delivery process to improve the quality of services and provide an avenue for professional growth and development.	Identify practice patterns and acknowledge good health care practices or recommend staff education and training programs or other appropriate interventions. Document performance related data in a practitioner's credentials file.
Quality Assessment	Monitor and evaluate the quality of health care delivery processes and outcomes.	Continue to develop clinical indicators that will generate valid, reliable data from which conclusions about the quality and adequacy of the health care delivery system can be drawn.

Risk Management	Reduce the number of inmate injuries caused by acts of omission or commission by health care personnel. Protect the financial assets of the state by reducing events that lead to increased liability.	Use risk management data to identify training opportunities and other interventions to reduce injuries and liability. Link grievance data with the risk management program.
Infection Control	Monitor, prevent, and control infections and communicable diseases. Provide necessary reports to Florida Department of Health.	None
Program Evaluation	Evaluate the OHS QM program. Link QA and other health care delivery monitoring mechanisms.	Recommend QA indicators based on institutional quarterly reviews and the authority's survey report findings.

Additional Topics

In addition to the seven components of the OHS QM program, other topics related to QM are also reported at the central office QM committee meeting.

Inmate Grievances

Information pertaining to inmate health related grievances is routinely presented to the committee. The authority continues to recommend the use of grievance data to identify topics for QA indicators or studies. The authority also continues to recommend linking grievance data and the risk management program.

Correctional Medical Authority Surveys

In previous reports, the authority suggested the OHS consider linking the authority's survey findings and the QA program through the QM program's appraisal component. That recommendation stands. In addition, the authority's QMC reviewed the OHS' analysis of the survey data presented to the OHS central office QM committee. The authority's QMC made seven specific recommendations to improve the presentation and clarity of those data for committee members.

Conclusion

A continuous effort to update the OHS QM program has been undertaken. A pilot project focused on this effort concluded this fiscal year, generating a number of activities. The central office QM committee adopted clinical indicators for physical, mental, and dental health services. In response to health care consolidation, each QM component is being evaluated to determine whether the flexibility necessary to meet the needs of institutions with varying medical/dental/mental health missions exists. Revision of the HSB governing the OHS QM program is underway.

The credentials review component has begun to place emphasis on practitioner profiling. The risk management component has standardized reporting of data, while attempting to address under-reporting of risk events that hampers the RM program's effectiveness. The utilization management component demonstrated cost control through pre-approvals, continued stay reviews, and transfers to lower cost beds where appropriate. Development of a clinical component is recommended to assess the impact of cost containment on quality of care. The mortality review component has demonstrated a reduction in time to reach case closure under the revised format. Implementation of the practitioner profiling portion of this component will complete it. Quality of care data are vital to a functional QM program. The quality assessment program began to amass the baseline data for a limited number of clinical indicators. However, the data reported during fiscal year 1997-98 were not sufficient to evaluate the quality of health care provided. The program evaluation component has begun to implement recommendations resulting from the OHS' first evaluation of its QM program.

In 1996, external reviewers of the authority and its processes suggested the authority rely on the OHS' QM data to target institutions and areas requiring survey by the authority. While the information generated by the OHS' QM program is improving, the data available do not present a sufficient foundation upon which to base the survey process.

Miscellaneous

Survey Instrument Revision

In conjunction with the Florida State University School of Public Administration/Florida Public Affairs Center, the authority has revised its survey instruments and improved data collection and analysis capabilities. A main component of this project has been the review of each question in the survey instrument to capture better data for performance measurement. Another was to improve inter-surveyor reliability. The OHS was provided an opportunity to comment on the draft revisions to the physical and mental health survey instruments.

The authority has revised its survey instruments to improve data collection and analysis capabilities.

The authority also reviewed its data collection methodology to assure greater reliability of data collected. Authority survey results are operating well within accepted research standards of reliability and validity. During the survey instrument revisions, key instruments were sent to experts in the fields of HIV/AIDS, tuberculosis, psychiatry, and the administration of psychotropic medications. Those experts carefully scrutinized survey instruments dealing with treatment of complex medical and psychiatric conditions to assure they reflected standards of care accepted in the medical community at large.

The strengthening of the survey methodology has been inherent in the survey revision project. Those activities have strengthened the objectivity of the survey process. This has further enhanced the caliber and usefulness of the authority's reports to the Governor and Legislature regarding correctional health care issues.

Central Florida Reception Center HIV Facility

Originally intending to develop a facility which would meet the special needs of inmates dying of AIDS-related complications, the department began development of an AIDS treatment unit by renovating existing buildings in the Central Florida Reception Center (CFRC) compound in Orlando. Opened in December 1997, this facility now serves the limited needs of some inmates in the terminal stages of AIDS. With advancements in the management of AIDS, the facility additionally serves as a treatment center for inmates from all over the state who require adjustments of complex AIDS treatment regimens or management of complications which once lethal, can now be handled effectively. Concentration of these efforts is not only cost effective, but also assures that inmates' complex medical needs are more effectively addressed.

The CFRC HIV facility is also the center for a number of investigational drug studies. Those studies are conducted by the University of Miami under the direction of Dr. Margaret Fischl, a world recognized expert in the medical management of AIDS. A voluntary program, inmates who meet certain criteria are invited to engage in Phase III clinical trials of anti-retroviral drugs, which otherwise would not be available to them. Participation in these drug trials benefits the inmate

population by making available the latest medical advances in AIDS management. It also benefits the community because controlled studies such as these can improve the treatment opportunities and their effectiveness for all people with AIDS. Undoubtedly, the OHS health care professionals benefit through the collaboration with experts in the field of AIDS treatment.

The authority commends these efforts associated with the HIV facility. It also commends the partnership developed by the department and the University of Miami.

The authority recommends the OHS develop additional relationships with willing medical schools in Florida to serve as a resource for ongoing medical education for OHS staff and provide better, more cost-effective care to inmates.

Because of the advances in the treatment of AIDS, many inmates with AIDS are living longer; many complete their sentences and are released to the community. This transition requires close collaboration between the department, the Department of Health, and many social service organizations. The authority commends these efforts, and encourages the department to continue to collaborate with the Department of Health to assure continuity of AIDS treatment regimens once inmates end their sentences.

Expansion of a substance abuse treatment program to the CFRC compound, as well as other programs to enhance HIV positive inmates' re-assimilation into the community, should positively impact public health outcomes, and potentially improve recidivism rates. Assurance that all inmates who are on triple drug treatment protocols have available resources to continue those medications after their sentences are served, or upon entrance to a work release program, is in the best interest of Florida's public health system.

HIV Inmate Peer Education Program

Through a federal grant from the Center for Disease Control, the department established an Inmate Peer Educator Project in December 1997. Housed at Lawtey, Florida, and Dade Correctional Institutions, the department educates inmates to provide training to their peers through the HIV/AIDS Basic Awareness course, inmate orientation, and pre-release sessions. Recognizing that inmates may be distrustful of prison staff, the program uses peer educators to disseminate information to help prevent the spread of the disease, help HIV+ inmates recognize the need to maintain their health, and prevent transmission of the disease. Grant applications are underway by the Florida Department of Health to expand the program to another institution. The authority commends these efforts and recommends the department continue to seek opportunities to expand this program to other institutions.

APPENDIX A

AUTHORITY ASSESSMENT OF QUALITY OF CARE

Authority Assessment of Quality of Care 1997-1998				
Institution	**Physical Health** Minimum Standard of Care* Deficiencies		**Mental Health** Minimum Standard of Care* Deficiencies	
	NO	YES	NO	YES
REGION I				
Apalachee		X		X
Corrections Mental Health Institution		X		X
Liberty	X			X
Quincy	X		X	
River Junction	X		X	
Santa Rosa		X		X
Walton	X		X	
REGION II				
Baker		X		X
Gainesville	X			X
Hamilton		X	X	
Lawtey		X		X
New River		X		X
North Florida Reception Center		X		X
Putnam	X		X	
REGION III				
Brevard		X	X	
Lake		X		X
REGION IV				
Dade		X	X	
Okeechobee		X		X
REGION V				
Avon Park		X		X
Polk		X		X
Total	**6**	**14**	**7**	**13**

*Includes one or more Level I and/or Level II citations. Some or all of those deficiencies may be corrected at the time of the corrective action plan assessment visit.

CAP assessment visits for shaded institutions were conducted during FY 1996-97. CAP assessment visits for the remaining institutions will be conducted during FY 1998-99.

APPENDIX B

AUTHORITY ASSESSMENT OF MORTALITY CASES REVIEWED

Authority Assessment of Mortality Cases Reviewed 1997 – 1998				
Institution	Number of Mortalities	Number Reviewed	Problematic Physical Health Care	Problematic Mental Health Care
Region I				
Apalachee	4	4		
Quincy	0	0		
Liberty	2	2		
Santa Rosa	1	1		
Corrections Mental Health Institution	0	0		
River Junction	0	0		
Walton	4	4		
Region II				
Baker	6	6		
Putnam	0	0		
New River	19	10	1	
Gainesville	1	1		
Hamilton	2	2	2	
Lawtey	9	5	1	
Region III				
Lake	0	0		
Brevard	0	0		
Region IV				
Okeechobee	0	0		
Dade	13	13	1	
Region V				
Polk	8	8		
Avon Park	7	7	3	
Subtotal	**76**	**63**	**8**	**0**
North Florida Reception Center	400	25		
Total	**476**	**88**	**8**	**0**

APPENDIX C

PERCENT OF LEVEL I AND LEVEL II CITATIONS CORRECTED AT CAP ASSESSMENT

APPENDIX D

SUMMARY OF SURVEY FINDINGS BY CORRECTIONAL INSTITUTION

APALACHEE CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	Close	Male	1644	1424

The survey of Apalachee Correctional Institution was conducted in August 1997. APACI houses inmates on psychotropic medications and provides outpatient mental health services. This third physical health survey found no Level I citations, three Level II Clinical Management citations and two Administrative citations. While the survey suggested improvement in the delivery of health care from previous surveys, inadequacies in assessment or clincial management of presenting symptoms were revealed in episodic care (emergency care and sick call) records. The mental health survey resulted in one Level I Access citation, two Level II Access citations, and two Clinical Management citations. At this second mental health survey, data collected suggested improvements in individual service plan and treatment team documentation. Problem areas included inadequate care of inmates in suicide observation status, inappropriate responses to inmate requests, and inadequate laboratory testing/follow-up. Data reviewed at the CAP assessment visit suggested four of the physical health citations were corrected. Data collected supported that the Level I mental health citation was partially corrected, while the four Level II mental health citations were corrected.

AVON PARK CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	Close	Male	956	751

Avon Park Correctional Institution was surveyed in mid-May 1998. Deficiencies cited in previous surveys were again noted at AVPCI. This third physical health care survey resulted in two Clinical Management citations. Two Level II citations were noted--one Access and one Clinical Management. Clinical management deficiencies in the seizure, asthma, and tuberculosis/INH chronic illness clinics were noted, as were clinical management deficiencies in dental services. Clinical management deficiencies were also noted in four of seven mortalities reviewed. The AVPCI pharmacy formulary was more restrictive than the general statewide formulary. Thus, incoming inmates receiving medications prescribed at other institutions were faced with a change in treatment regimen. This second mental health survey found no Level I citations. One Level II Clinical Management citation was noted. This citation involved the care of suicidal inmates. The CAP assessment visit will take place in FY 1998-99.

BAKER CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	**Close**	**Male**	**1400**	**1173**

Baker Correctional Institution was surveyed in mid-October 1997. The recent survey identified three areas of concern reported during the previous survey. Data provided suggested these deficiencies had been corrected at the CAP assessment visit following the second survey, but correction had not been maintained. The third BAKCI physical health survey resulted in one Level I Clinical Management citation and six Level II citations. Three Level II citations involved Clinical Management; three were Administrative. Concerns included deficiencies in emergency care, infirmary care and three chronic disease clinics. The second mental health survey found no Level I citations. Eight Level II mental health citations were noted. One involved Access, while the remaining seven were related to Clinical Management. Problem areas included untimely completion of required documentation, lack of specific treatment interventions in individual service plans; inadequate follow-through on treatment implementation; and inconsistency in post-discharge follow-up of suicidal inmates. Data reviewed during the CAP assessment visit suggested all but one of the physical health citations were corrected; one was partially corrected. Six of the eight mental health citations appeared corrected; one was partially corrected; one was not corrected based on materials reviewed during the CAP visit.

BREVARD CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Youthful Offender	**Close**	**Male**	**966**	**963**

The third survey of Brevard Correctional Institution was conducted in late August 1998. The physical health survey resulted in one Level II Clinical Management citation. There were no physical health Level I citations. The physical health survey identified concerns relating to assessment and follow-up care in sick call and emergency care records. There were no citations noted in the mental health survey.

CORRECTIONS MENTAL HEALTH INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	**Maximum**	**Male/ Female**	**135**	**82**

The Corrections Mental Health Institution survey was conducted in late March 1998. CMHI serves as the inpatient psychiatric hospital facility for inmates. Generally, the third physical health survey showed improvements over the two previous surveys. There were no Level I physical health citations. Two Level II Clinical Management citations were noted. One involved the seizure disorder clinic; the other dental record documentation deficiencies. This third mental health survey also found no Level I citations. Two Level II Clinical Management citations were noted, and one Level II Administrative citation. The current survey noted a need for improvement in the area of implementing and modifying individual service plans to address suicidal behavior. Records reviewed suggested improvement in documentation of treatment activities. The CAP assessment visit will take place in FY 1998-99.

DADE CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	**Close**	**Male**	**713**	**700**

Dade Correctional Institution was surveyed in late October 1997. Generally, this second physical health survey identified concerns noted at the previous survey. Four Level I Clinical Management and three Level II Administrative citations were noted. Problems included inadequate or inappropriate assessments reflected in mortality, sick call, emergency care and chronic disease clinic records. The mental health survey was the second conducted at DADCI. No Level I or Level II citations were noted. Survey results suggested the mental health department provided an effective program with many strengths. At the CAP assessment visit none of the Level I physical health citations had been corrected, although three were partially corrected, based on documentation reviewed. Two of the Level II physical health citations were not corrected.

GAINESVILLE CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	**Medium**	**Male**	**378**	**370**

The first survey of Gainesville Correctional Institution was conducted in late January 1998. GNVCI provides Tier 3 substance abuse programs for inmates. The physical health survey found no Level I or Level II citations. No Level I citations were identified in the mental health survey. One Level II Administrative citation was noted. GNVCI does not have 24-hour nursing coverage. Nor does it have infirmary beds, certified suicide observation cells, confinement or holding cells. The institutional operating procedures pertaining to transfer of inmates with mental health

emergencies allowed time frames considered excessive. The CAP assessment visit will take place in FY 1998-99.

HAMILTON CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	**Close**	**Male**	**1823**	**1562**

The survey of Hamilton Correctional Institution was conducted in mid-April 1998. Although overall survey results for the third physical health survey of HAMCI suggested the services provided at the institution were adequate, two Level I Clinical Management citations were noted. Problems included documentation of nursing assessments during infirmary admissions and/or documentation of care components during infirmary stays. Two mortality records revealed evidence of inappropriate or delayed treatment. Records reviewed suggested mental health care met minimum standards. There were no Level I or II citations noted at the second mental health survey. The physical health CAP assessment will be conducted during FY 1998-99.

LAKE CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	**Close**	**Male**	**1015**	**872**

Lake Correctional Institution was surveyed in mid-February 1998. This was the third physical health survey. Generally, provision of physical health care had improved since the previous survey and only one Level II Clinical Management citation was noted. The second mental health survey resulted in four Level II citations; two Access and two Clinical Management. No Level I mental health citations were noted. The CAP assessment review will occur during FY 1998-99.

LAWTEY CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	**Medium**	**Male**	**788**	**686**

The survey of Lawtey Correctional Institution was conducted in early June 1998. This was the third physical health survey of the institution. One Level I Clinical Management citation was noted. The citation involved a mortality in which there was delay in notifying the physician of the inmate's condition. There were also concerns noted about the assessment and clinical management of the inmate's condition. Records reviewed suggested the mental health program met minimum standards. This second survey noted one Level II Administrative citation. There were no Level I citations identified. The CAP assessment review will occur during FY 1998-99.

LIBERTY CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	**Close**	**Male**	**1136**	**1025**

Liberty Correctional Institution was surveyed in late September 1997. Records reviewed during the third physical health survey suggested care met minimum standards. No Level I or II citations were noted. The second mental health survey identified two Level II citations--one Access and one Clinical Management. Records documenting therapy lacked detail and clinical conclusions. Additionally, correctional officers reportedly ignored requests made by confinement inmates for mental health services. The CAP assessment visit findings suggested all physical and mental health citations were corrected.

NEW RIVER CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	**Medium**	**Male**	**1821**	**1650**

New River Correctional Institution was surveyed in mid-December 1997. The third physical health survey resulted in one Level I Clinical Management citation and two Level II citations—one Clinical Management and one Administrative. Issues identified during the current survey included inadequate clinical management of one mortality, incomplete mortality records and

inconsistent administration of vaccines to HIV positive inmates. No Level I citations were identified at the second mental health survey. Three Level II citations were noted--one Access and two Clinical Management. No group therapy was available at the east unit. Follow-up of suicidal inmates was of concern. The CAP assessment review will occur during FY 1998-99.

NORTH FLORIDA RECEPTION CENTER

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	Maximum	Male	1426	1301

North Florida Reception Center was surveyed in mid-January 1998. The third physical health survey resulted in seven Level II Clinical Management citations. There were no Level I physical health citations. All seven Level II citations were related to clinical management concerns. Issues identified involved inadequate assessments, treatments and/or referrals, and incomplete and/or disorganized documentation in episodic care records. Also noted were inadequate assessments and follow-up in chronic illness clinics. The third mental health survey results identified issues involving inadequate access to care resulting in one Level I Access citation. Additionally, there were three Clinical Management citations—two Level I and one Level II. Nursing assessments, psychiatric evaluations, medication management, and individualized service plans were of concern. The CAP assessment review will occur in FY 1998-99.

OKEECHOBEE CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	Close	Male	1568	1168

The first survey of Okeechobee Correctional Institution was conducted in late July 1997. Health care at OKECI is provided by EMSA. The physical health survey resulted in seven Level I citations and six Level II citations. Level I citations consisted of one Access, four Clinical Management and two Administrative. Level II citations consisted of one Access, one Clinical Management and four Administrative. The most significant finding was that security impeded access to health care. These observations were referred to the Department of Corrections' Office of the Inspector General. Other concerns noted in the survey report included inadequate clinical management and/or documentation deficiencies in the asthma, immunodeficiency and TB clinics. Untimely referrals and incomplete documentation of episodic care was also of concern. Additionally, only one isolation management room was used. None were equipped with negative pressure ventilation nor had they been certified for suicide observation. The mental health survey resulted in two Level I and eleven Level II citations. The Level I citations consisted of one Access and one Administrative. Those issues involved correctional officers impeding access to care and the use of an uncertified isolation management. The Level II citations consisted of two Access, two Clinical Management, and seven Administrative. Concerns were related to the multiple systems deficiencies revealed during the survey. Problems were noted with incomplete or missing

internal operating procedures, institutional logs, and training records. Disorganization of inmate mental health records was also of concern. The CAP assessment visit suggested two of the physical health Level I citations were corrected, two were partially corrected and three were not corrected. All physical health Level II citations appeared corrected. The mental health assessment found one of two Level I citations not corrected. All but one of the reviewed Level II citations appeared corrected; one appeared partially corrected.

POLK CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	Maximum	Male	1011	985

Polk Correctional Institution was surveyed in late November 1997. The third physical health survey resulted in two Level I Administrative citations and five Level II citations. The Level I citations involved inadequate size and design of the medical building and insufficient pharmacy coverage resulting in delayed delivery of medications. Level II citations consisted of two Clinical Management and three Administrative. Generally, however, records reviewed suggested a number of areas identified at the previous survey had been improved. Access, assessments, treatments, and referrals of inmates accessing episodic care appeared improved. Based upon survey findings, the mental health program appeared to meet minimum standards of care. No Level I or II citations were noted. The physical health CAP assessment visit suggested all physical health citations had been corrected.

PUTNAM CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	Medium	Male	458	353

Putnam Correctional Institution was surveyed in early December 1997. Data collected during the third physical health survey suggested care met minimum standards. No Level I or II citations were noted. Records reviewed associated with the second mental health survey also suggested care met minimum standards. No Level I or II citations were noted.

QUINCY CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	Close	Male	404	280

Quincy Correctional Institution was surveyed for the first time in mid-September 1997. Survey findings suggested that both physical and mental health care appeared to meet minimum standards. No Level I or II citations were noted in either survey.

RIVER JUNCTION CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	**Medium**	**Male**	**761**	**389**

River Junction Correctional Institution was surveyed in early April 1998. It was the third physical and mental health survey of the institution. Data collected during the survey suggested that both physical and mental health care met minimum standards. No Level I or Level II citations were identified in either survey.

SANTA ROSA CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	**Close**	**Male**	**1093**	**821**

Santa Rosa Correctional Institution was surveyed in late February 1998. It was the first survey of the institution. One Level I Clinical Management and two Level II Administrative citations were identified. Emergency care and sick call records revealed deficiencies in documentation of nursing assessments and referrals for higher levels of care. The mental health survey resulted in one Level II Administrative citation relating to institutional operating procedures. There were no Level I mental health citations. The CAP assessment review will occur during FY 1998-99.

WALTON CORRECTIONAL INSTITUTION

Population	Custody	Type	Maximum Capacity	Occupied Beds
Adult	**Close**	**Male**	**1201**	**942**

The Walton Correctional Institution survey was conducted in mid-March 1998. Data collected during the third physical health care survey suggested the care met minimum standards. There were no Level I or Level II physical health citations identified. Records reviewed and data collected during the second mental health care survey also suggested the care met minimum standards. No Level I or Level II mental health citations were identified during the survey.

APPENDIX E

GLOSSARY

GLOSSARY

Adequate care/treatment - The process of carrying out an organized, individualized, planned intervention in response to assessed or emergency 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.

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 - Medical clinics established to monitor inmates who have chronic medical conditions in one or more of seven diagnoses—diabetes, pulmonary, hypertension, seizure disorder, IHN therapy, general medicine, and immunity. Inmates are seen as often as required by their medical condition(s), but not less than every 90 days.

Citations - Citations are deviations or departures from department policy or the standard of care generally accepted in the professional health community at large. Citations may arise from a single event or from a trend of similar events. Citations may involve past or present events or trends, which potentially result in the compromise of inmate health care. Citations are categorized by level based on severity and/or risk of compromise. Citations are also categorized by type--access, clinical management/documentation or administrative.

> **Level I citations** - Level I citations are based on conditions where the severity and risk of compromise to health care is high as a result of a deviation from a health care standard and/or established health care policy/procedure. Level I citations also include deficiencies in administrative support/management that have a high risk of directly or indirectly compromising care. The severity of compromising care has the potential to result in consequences that are (1) life threatening or potentially life threatening, (2) disabling or potentially disabling, (3) likely to affect a large portion of the population, (4) likely to worsen if not immediately corrected, and (5) impossible or potentially impossible to reverse. The risk of compromising care is immediate, or while not immediate has a high probability of seriously affecting health care over time.
>
> **Level II citations** - Level II citations are based on conditions where the severity and risk of compromise to health care is low-to-moderate as a result of a deviation from a health care standard and/or established health care policy/procedure. Level II citations also include deficiencies in administrative support/management that have a low-to-moderate risk of directly or indirectly compromising care. The severity of compromising care has the potential to result in consequences that are (1) not life threatening, (2) minor to moderate, (3) not likely to affect a large portion of the population, (4) not likely to worsen if not

immediately corrected, and (5) reversible. The risk of compromising care may or may not be immediate, but has a low probability of seriously affecting health care over time.

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.

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.

Disciplinary confinement - Confinement, which includes the loss of privileges normally, afforded other inmates. Housing is in a separate unit designated for confinement purposes.

Correctional Medical 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 14.

Crisis Stabilization Unit (CSU) - An inpatient facility which 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.

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.

Health Services Bulletins (HSBs) - Department of Corrections standards for the provision of care in the institutions.

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 that it meets certain standards. These rooms are also referred to as "approved suicide isolation rooms."

Medical grade - The medical functional grade assigned an inmate is based primarily on the function of body systems and their relation to life in the Florida correctional setting. 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.

Medical grade I - No demonstrable anatomical or physiological impairment; no work assignment limitation.

Medical grade II - Minimal organic systemic disease; work limitations of a minor nature.

Medical grade III - Moderate organic systemic disease requiring reasonable availability of care; work assignment must consider impact on limiting condition.

Medical grade IV - Severe organic systemic disease requiring continuous monitoring; requires strict limits on work assignment.

Medical grade V - Pregnant inmates.

Return skills demonstration - A procedure by which, following a training session during which a skill or procedure such as physical assessment, mental status evaluation, review of systems, etc., is demonstrated to a trainee, the trainee demonstrates to the instructor the ability to perform the skill or procedure.

"S" grade - The "S" grade refers to the mental functioning of the inmate. It 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.

S1 - No disorder or impairment in adaptive functioning.

S2 - 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.

S3 - Moderate mental retardation or an Axis I (clinical) 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.

S4 - Acute Axis I disorder or symptoms that severely impair adaptive functioning; mental condition cannot be safely managed and treated in an outpatient setting. The inmate requires inpatient care.

S5 - Transitional Care Unit housing assignment.

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.

APPENDIX F

CORRECTIONAL MEDICAL AUTHORITY CITIZEN VOLUNTEERS

CORRECTIONAL MEDICAL AUTHORITY

CITIZEN VOLUNTEERS

FISCAL YEAR 1997-98

Authority Members

Robert E. Windom, M.D., who serves as the current chair of the authority, is a medical doctor, licensed in the State of Florida. He is a past president of the Florida Medical Association, and serves as the FMA's delegate to the American Medical Association. He served as the Assistant Secretary for Health and the Director of the United States Public Health Services from 1986 until 1989. He is serving during 1997-1999 as consultant to the Secretary of the Department of Health and Human Services to plan the Health Objectives for the Nation for 2010. He has been appointed Senior Advisor to the Florida Department of Health. He is also a health care consultant in many other medical areas.

Jeannie B. Baker, was appointed to the Correctional Medical Authority in April 1996. She is the Chief Operating Officer for a rural health care facility in northeast Florida that also provides emergency medical care and other medical services to several neighboring State of Florida correctional facilities. Ms. Baker serves as liaison to the Budget and Personnel Committee.

Marsha Lewis Brown, M.S.W., is currently the executive director of a mental health center on the Gulf coast of Florida. She serves as the chair of the authority's mental health committee and as liaison of that committee to the authority. She has been a member of the authority since October 1993.

Nereyda P. Clark, D.M.D., is an associate professor in the dentistry program at a major Florida university. Dr. Clark is an active member of the International and American Associations for Dental Research, the Academy of Operative Dentistry, and the Association of Women Dental Faculty. Dr. Clark has developed several teaching videotapes on amalagam restorations, the mandibular molar and the maxillary molar. She has many publications on dental material groups as well as conducts presentations/lecturers in continuing education courses in the field of dentistry.

Max C. Dertke, Ph.D., is a professor and former dean of a mental health institute at a major Florida University. Dr. Dertke has served on the authority for the six years, and brings extensive expertise in mental health and criminal justice to the authority. Dr. Dertke also serves as a member of the mental health committee.

H. Jack Floyd, M.B.A., has several decades of experience in hospital administration. Now retired, he continues to actively serve as a consultant and interim administrator to hospitals in several states. Mr. Floyd serves as the Florida Hospital Association representative to the authority.

Thomas L. Hicks, M.D., is a medical doctor and a diplomate of the American Board of Family Practice in the State of Florida. He is a member of the Florida Medical Association, and chairman of the board and president of the Florida Academy of Family Physicians and the American

Academy of Family Physicians. A former chairman of the Florida Medical Association, in 1984 he was also appointed by the Governor to serve on the Florida State Radiation Advisory Council.

Winston Rushing, is a health care administrative consultant and the former chief executive officer (CEO) for a major Florida Hospital. He is a results-oriented senior level executive with an impressive record of significant achievements in diverse hospital and health care settings. He has extensive experience in health care financial management, governmental and community relations, physician relations, and other diverse areas of hospital/health care management. He is a member of the Board of Directors for the American Heart Association and American Cancer Society and is active in several state and local health care groups. Mr. Rushing serves as the representative of the Florida League of Hospitals to the authority.

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.

Budget and Personnel Committee

James J. Bracher, M.B.A., Chief of Life and Health Rates and Forms in the Division of Insurance, chairs the budget and personnel committee. He brings extensive experience in the financial area to the Committee. Mr. Bracher served as executive director of the Hospital Cost Containment Board and of the Florida Health Care Purchasing Cooperative. He has 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 the Palm Beach Health Care District and Vice President of Finance of a large voluntary hospital in southwest Florida.

Jeannie Baker, authority representative.

Michael R. Harris, C.P.A., M.B.A., is the Assistant Bureau Chief, Finance and Accounting, for the Florida Department of Agriculture and Consumer Services. He has over 30 years of financial management experience, with over twelve years in health care financial management. He previously served as Assistant Vice President of Finance at Tampa General Hospital, Finance and Accounting Director for the Florida Department of Commerce and Assistant Controller for Florida State University.

Melissa C. Jacoby, B.A., executive staff director of the Department of Children and Families, has served on the budget and personnel committee since its inception. She brings 24 years of personnel and management experience in state government to the committee.

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 college of osteopathic medicine. He brings over 20 years of health care finance experience to the authority. He has 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 has served as an editorial advisor to the *Journal of Accountancy.*

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

Marsh Lewis Brown, M.S.W., Chair and authority representative.

John Bailey, D. O., is a psychiatrist with an active adult private practice in the Florida panhandle. He has also provided psychiatric services to inmates in the Georgia and Florida prison systems.

John Bryant, is the assistant secretary of the mental health program office in the Department of Children and Families. He has worked in the fields of juvenile and adult mental health for more than two decades and also has extensive experience in dealing with delinquent juveniles in structured settings. Mr. Bryant has also published several articles and training manuals in the areas of mental health and drug abuse treatment.

Max C. Dertke, Ph.D., authority representative.

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 20 years experience in community mental health.

Morris L. Eaddy, Ph.D., is a licensed clinical psychologist, serving as president and CEO of a comprehensive behavioral health care program. He has over 30 years administrative experience in behavioral health care. Well published in mental health administration, he has held numerous state and national leadership positions in the field of mental health and substance abuse.

Cassandra F. Newkirk, M.D., is an adult and forensic psychiatrist. She is currently a psychiatric consultant to the Los Angeles County Sheriff's Department, and is the court-appointed Special Master for an inmate lawsuit pertaining to mental health services in the state of Arizona. She serves as vice-chair on the Council of Psychiatric Services, American Psychiatric Association. In

1990 she was psychiatrist of the year for the Georgia Psychiatric Physicians' Association. Dr. Newkirk brings to the authority's mental health Committee a vast working knowledge of forensic and adult psychiatry, as well as experience in the mental health needs of incarcerated women.

Donald R. Taylor, Jr. M.D., is a clinical assistant professor for the Department of Psychiatry & Behavioral Medicine at a large university in Florida. He is also currently in the private practice of adult and forensic psychiatry in a major Florida city. He is a diplomat, American Board of Psychiatry & Neurology and Forensic Psychiatry. Dr. Taylor is an approved psychiatric evaluator for the United States District Court, Middle District of Florida, as well as several central Florida counties. Dr. Taylor has published articles on forensic psychiatry as well as provided research materials to the department of psychiatry at a major Florida university.

Randy Wilcox, B.S., directs governmental regulations for the Florida Council for Community Health. He has been in the field of mental health and drug rehabilitation in a variety of settings for over 20 years.

Quality Management Committee

Carol N. Velasquez, R.N., B.S.N., M.B.A., C.P.H.Q., serves as the chair of the quality management committee. She is currently the nurse manager for an orthopedic unit at a major central Florida hospital. She formerly served as the rounding nurse for a physician in private practice who specializes in infectious diseases as well as the quality assessment manager at a major central Florida hospital.

Kathryn B. Clinefelter, M.S.N., M.B.A., C.P.H.Q., has over fifteen years experience in development and implementation of programs to monitor and improve the quality of clinical care and related health care service in hospitals and managed care settings. She is an independent health care consultant and lecturers on health care quality and resource management and the effects of organizational change. Ms. Clinefelter is currently treasurer for the National Association for Healthcare Quality and executive director of Florida's Association for Healthcare Quality.

Bernard Kimmel, M.D., F.A.F.P., 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 has also served as a surveyor at department institutions for the Federal court and for the authority.

Irving Koehler, M.B.A., B.S.N., R.N., served as the director of quality management at two private hospitals in central Florida. Mr. Koehler resigned from the committee in January 1998 due to his relocation to Tennessee. He had fourteen years of experience in health care organization management.

Donald L. McBath, D.O., is in private medical practice in the field of family medicine. He has extensive experience in the field of correctional medicine serving as the medical director for two Florida county jail systems.

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.

Nancy Suellau, R.N., B.S.N., a certified health care risk manager, serves as the quality improvement coordinator and risk manager in an outpatient surgical center in the Florida panhandle. She is a member of the American Society for Healthcare Risk Management, and the Florida Society of Ambulatory Surgical Centers.

Brenton A. Textor, D.O., is the medical director of a large federal prison complex in Florida. He is board certified in general practice, and has extensive experience in the field of correctional medicine.