

ANNUAL REPORT 2008 - 2009

STATE OF FLORIDA
CORRECTIONAL MEDICAL AUTHORITY



DECEMBER 2009

State of Florida Correctional Medical Authority

Section 945.602, Florida Statutes creates the Correctional Medical Authority. The governing board of the Authority is composed of nine persons appointed by the Governor and subject to Senate confirmation.

John T. Bailey, D. O.,
Representative, Florida Osteopathic Medical Association
Chair

David L. Hample, M.B.A.
Representative, Florida Hospital Association, Not-for-Profit
Chair July 2008 - December 2008

David Abercrombie, F.A.C.H.E.
Representative, Florida Hospital Association,
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Deborah A. Tedder , R.N., M.B.A.
Representative, Florida Hospital Association
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Ward Boston III, F.A.C.H.E.
Representative, Health Care Administration

Theresa Watson, R.N., L.H.R.M.
Representative, Practice of Nursing

Alma B. Littles, M.D.
Representative, Florida Medical Association

Edward Zapert, D.M.D.
Representative, Practice of Dentistry

Victor J. Maya
Representative, Florida Hospital Association,
Investor-owned Hospital

Representative, Mental Health Professional
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John T. Bailey, D.O., Chair
Ward Boston, III, FACHE
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**STATE OF FLORIDA
CORRECTIONAL MEDICAL AUTHORITY**

December 31, 2009

The Honorable Charlie Crist
Governor of Florida

The Honorable Jeff Atwater, President
The Florida Senate

The Honorable Larry Cretul, Speaker
Florida House of Representatives

Dear Governor Crist, Mr. President, and Mr. Speaker:

It is my pleasure to provide you with a copy of the Correctional Medical Authority's 2008-2009 Annual Report on the status of the health care delivery system in the Florida Department of Corrections including the required annual report on the status and treatment of elderly offenders. The report summarizes our activities during Fiscal Year 2008-2009 which included on-site physical and mental health surveys of 13 major correctional institutions and ongoing monitoring of the corrective actions taken by the Department based on findings from this and previous years' surveys. The report describes the work of the Authority's governing board, staff, quality management committee, and budget workgroup to fulfill our statutory responsibility to assure that adequate standards of physical and mental health care are maintained in correctional institutions.

During the last year, the Department has made significant efforts to contain the cost of providing health services to inmates without compromising clinical quality of care. Regional staff and the OHS continue to pursue opportunities to streamline and reorganize the OHS management structure to improve accountability of DC employees and contracted personnel and to assure that resources are used efficiently in the delivery of care to inmates. From the perspective of the CMA, these changes have been generally positive in that they have been implemented in concert with a focus on also ensuring quality and appropriateness of care consistent with constitutional standards and instituting evidence based practices in medicine and nursing. During the coming year, through the survey process, review of department utilization and cost data, and tracking trends in inmate correspondence, the CMA will continue to monitor how these management strategies affect the quality of care and the health care service delivery system.

We appreciate your recognition of the important public health mission that is at the core of correctional health care and hope that you will contact us if you have questions or need more information about our work.

Sincerely,

A handwritten signature in black ink, appearing to read "Murdina Campbell", with a long, sweeping flourish extending to the right.

Murdina Campbell
Executive Director

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Introduction

The Correctional Medical Authority (CMA) was created in July 1986, while the state's prison health care system was under the jurisdiction of the Federal Court as a result of litigation that began in 1972. *Costello v. Wainwright* (72-109 M.D. Fla.) was a class action suit brought by inmates alleging that their constitutional rights had been violated by inadequate medical care, insufficient staffing, overcrowding, and poor sanitation. The CMA was created as part of the settlement of that case and continues to serve as an independent monitoring body providing oversight of the systems in place to provide health care to inmates in the Department of Corrections (Department/DC). The CMA's statutory mission is to assure adequate standards of physical and mental health care for inmates are maintained at correctional institutions and to advise the Governor and Legislature on the status of the Department's health care delivery system. The nine-member governing board of the CMA consists of volunteers appointed by the Governor and confirmed by the Senate. The composition of the board is defined in statute and includes representatives from both clinical fields and administrative health care organizations. By ensuring that the quality of inmate health care does not fall below constitutionally mandated standards, the CMA performs a risk management function for the State of Florida's correctional health care system.

It is relatively well documented that inmates are disproportionately more likely to suffer from a variety of chronic communicable diseases, mental health problems, and substance abuse issues than persons in the community. More than 18 percent of hepatitis C virus (HCV) carriers in the country pass through the jail or prison system annually, as well as eight percent of those with HIV, and one-third of those with active tuberculosis (TB).¹

¹ *The Health Status of Soon-To-Be-Released Inmates: A Report to Congress*, National Commission on Correctional Health Care, September 2004, Document Number 189735

Many inmates come into prison with poor health status due to lack of preventive medical and dental care, untreated chronic disease, and years of substance (alcohol, drugs, tobacco) abuse. The generally poorer health status of inmates combined with the increasing cost of health care has led to medical care being one of the major costs in steadily increasing correctional budgets. The logistics of providing care to inmates has also been complicated by forces at work in the community at large including a shortage of doctors and nurses, the cost of prescription medications, and evolving models of health care delivery.

State governments faced with decreasing sources of revenue and increasing prison populations are struggling with the consequences of losing control of health care in their correctional systems. Regardless of the cost, inmates are entitled to health care and “deliberate indifference to serious medical needs” by a prison system is a violation of the Eighth Amendment prohibition against cruel and unusual punishment (*Estelle v. Gamble* 429 U.S. 97, 1976). The consequences of inadequate health care in a state prison system are grave and have significant and long term fiscal impact. The California Department of Corrections and Rehabilitation (CDCR) is currently involved in several cases relating to serious constitutional violations involving conditions of confinement and inadequate health care (*Plata v. Schwarzenegger*), dental care (*Perez v. Tilton*), mental health care (*Coleman v. Schwarzenegger*), and disability accommodation (*Armstrong v. Schwarzenegger*). The Plata case (C01-1351TEH) resulted in medical care in CDCR being turned over to a federal court-appointed receiver in 2006. On August 4, 2009 the federal district court directed California to reduce its prison population by 43,000 inmates within two years. “The court found that the cap is necessary to cure the constitutional violations that have long existed with respect to the provision of medical and mental health care.”² Although immediate release of prisoners was not ordered,

² Civil Rights Litigation Clearinghouse, Washington University School of Law, <http://clearinghouse.wustl.edu> accessed October 10, 2009.

the court did order the state to submit a plan to reduce the current prison population to 137 percent of capacity within two years. On September 11, 2009 Governor Schwarzenegger signed legislation to relieve prison overcrowding through changes to parole and early release programs. On the same day the U.S. Supreme Court rejected a request by California officials to delay an order by the three-judge panel to submit a plan to reduce the state's prison population.

The CMA was established in the wake of a similar class action suit over conditions of confinement. After many years of settlement agreements, stipulations, and the appointment of a special master and court monitor, the creation of the CMA made it possible for the federal court to relinquish the monitoring and oversight functions it had performed for twenty years. More recently, in December 2001, DC entered into a settlement agreement in a lawsuit (*Osterback v. Crosby*) involving mentally ill inmates housed in close management (CM). The purpose of close management is to confine inmates separate from the general inmate population for reasons of security and for the order and effective management of the prison system. The Osterback agreement included a stipulation that the CMA monitor provisions of the agreement including clinical, administrative, and security components of the program designed to ensure effective treatment of mental illness in the CM population. The CMA completed its special monitoring responsibilities pending the outcome of the federal court's hearing of the case. The Department completed and complied with each component of the CM corrective action plan assessment process. The court entered a final judgment ruling in favor of the Department and the case was closed on March 28, 2008. Facilities with CM are now monitored as part of the regular CMA survey process.

The CMA's specific responsibilities and the authority to carry out these mandates are described in detail in sections 945.601 – 945.6035, Florida Statutes, and include:

- Objectively assessing the Department's physical and mental health care delivery system.
- Monitoring the Department's Quality Management (QM) Program.
- Determining whether the Department incorporates all policies and procedures into a consistent and comprehensive system of health care delivery.
- Holding regularly scheduled CMA Board and QM Committee (QMC) meetings.
- Advising the Governor and Legislature on the status of the Department's health care delivery system, including providing recommendations regarding its annual operating budget.

Strategies employed by the CMA to meet its objectives include:

- Conducting on-site and data collection surveys of the physical and mental health care delivery system of each correctional institution.
- Determining if the Office of Health Services (OHS) QM activities positively influence the health care program.
- Reviewing and analyzing OHS legislative budget requests.
- Reviewing OHS policies pertinent to health care and providing qualified professional advice regarding that care.
- Assessing and summarizing the status of the Department's health care delivery system in the CMA's annual report.

This annual report describes the activities of the CMA during FY 2008-09. It includes the findings of on-site institutional surveys, recommendations of the CMA's QMC, Budget and Personnel Workgroup activities, policy review activities by staff, and significant accomplishments in Health Services.

CMA Activities – FY 2008-09

CMA Strategic Plan Accomplishments

During FY 2008-09 the CMA continued to implement the objectives of the three-year strategic plan adopted in May 2006 to monitor and promote the delivery of cost-effective health care that meets accepted standards of care for inmates. On-site surveys were conducted at 13 correctional facilities. The results of the surveys are presented later in this report.

Survey Activities

In an effort to ensure resource constraints did not affect the CMA's ability to meet its legislative mandates to conduct triennial surveys of each major institution, staff engaged contracted surveyors more efficiently, including having licensed CMA staff act as a surveyor. The CMA staff developed the FY 2008-09 survey schedule in early 2008, determined to increase the number of institutions to be surveyed in FY 2008-09 by 50 percent. Due to unforeseen circumstances, surveys of two institutions were cancelled, Hardee Correctional Institution (CI) due to a hurricane forecast and Glades CI because the inmate population was in transition due to implementation of a faith and character-based mission. The survey for Jackson CI was cancelled because of norovirus and chicken pox outbreaks; however, this survey was rescheduled within the fiscal year (May 2009). The goal of the CMA within current resources is to complete a minimum of 15 on-site surveys each fiscal year.

Health Systems Review

In FY 2007-08 CMA piloted a Health System Review (HSR) of all institutions. The pilot was designed as an off-site survey of institutions that would be productive to both CMA and OHS, while also ensuring that all major institutions are reviewed triennially. The CMA and OHS are collaborating on the development of a revised HSR that more

closely resembles the issues examined during on-site surveys.

CMA Collaboration with the Department

The Department regularly provides CMA staff with opportunities for input on the OHS policy and procedure development process. The CMA is required to provide this advice prior to the Department implementing policy changes. CMA surveyors and board members who are physicians, dentists, and nurses also collaborated with the Deputy Secretary of Health Services by providing input on proposed policy changes in clinical practice protocols. This year, CMA staff revised all chronic illness survey documents to ensure the tools are compatible with current Department policies and procedures. Staff continues to update nursing, mental health and administrative survey tools so that when policies and procedures are appropriately altered for the benefit of inmate health care, survey tools are amended to include those revisions.

In December 2008 OHS updated the Outpatient Mental Health Services Bulletin to direct significant changes in ongoing service delivery for inmates with a psychological grade of S2 or S3.³ The intervals for providing case management services were increased from every 60 days to 90 days for inmates with a psychological grade of S2. For inmates with a psychological grade of S3, the intervals were increased from every 30 days to 90 days. All inmates on the mental health caseload must be offered individual and/or group counseling as clinically indicated, however they must be offered counseling no less than once every 90 days. All inmates with an active diagnosis with a psychotic component must have monthly contacts with mental health. These changes were made with the intention of providing clinical staff the flexibility to individualize care provided to each inmate on the mental health caseload.

³ Inmates with a psychological grade of S2 require ongoing outpatient psychological services. Inmates with a psychological grade of S3 need ongoing outpatient psychiatric and psychological services; most require psychiatric medication.

Like many people who receive mental health services in the community, a number of inmates function well with very little support from mental health. Some inmates will require more frequent contacts to ensure their mental health needs are addressed and the requirement for less frequent contacts will allow clinicians the opportunity to focus resources on inmates who need them most.

Inmate Correspondence

As a part of its mission to ensure adequate standards of physical and mental health care are maintained at all institutions, CMA staff regularly responds to inmate correspondence. During FY 2008-09, 291 inmate letters from 129 inmates were reviewed and responses were provided to inmates. This is a 72 percent increase in inmate letters and a 27 percent increase in the number of inmates writing compared to the number of received in FY 2007-08 (169 from 101 inmates). The increase in inmate correspondence may be related to the increased visibility of CMA survey teams in institutions over the last two years after establishing a more rigorous survey schedule.

Because the CMA is not authorized to direct staff in DC institutions or to require that specific actions be taken, inmate letters relating to health care issues were sent to OHS for response. In cases relating to security or other issues, the letters were referred to the Department's Inspector General or General Counsel. Copies of responses to inmates from DC are also provided to the CMA upon request. Health care issues identified in inmate letters are subsequently reviewed during on-site surveys. Monitoring inmate correspondence is a valuable risk management function in which the CMA and OHS collaborate to prevent systemic deficiencies in health care from occurring.

Corrections Infection Workgroup

The Corrections Infection Workgroup (CIW) is a collaborative arrangement among the Department of Health (DOH), the Department of Children and Families (DCF), the Department of Juvenile Justice (DJJ), county jails, the Department, and the CMA. The CIW meets quarterly to discuss current issues affecting health care in the correctional system. An offshoot of the CIW, the Infectious Diseases in Correctional Facilities Summit (IDCFS) Committee presented its first annual summit in December 2008. Event planning was coordinated by members from DOH, CMA, DJJ, the Department, the Florida Sheriff's Association, and the AIDS Institute. The summit highlighted best practices for inmate health care and infectious disease control from around the state. Collaboration among correctional staff, health departments, and community partners was promoted throughout this summit. Over 300 representatives of various organizations participated in the event. Participant evaluations indicated that the summit was an outstanding forum for collaboration.

Quality Management Committee

Introduction

Through its Quality Management Committee (QMC) the CMA operates as an oversight body of the Department's quality management program, reviewing the self-evaluation of quality of care (including the mortality review process), utilization management, and credentialing/re-credentialing. The makeup of the CMA QMC is one physician, three registered nurses (one of whom is a CMA Board member) and one Ph.D. level mental health professional. Ex-officio members from OHS include the Department's Deputy Secretary of Health Services, Assistant Secretaries of Health Services Clinical and Administration, and the Quality Management Supervisor. Legal and other Department staff, such as representatives from mental health, infection control, etc., participates in the CMA QMC as needed.

The mission of the CMA QMC is to provide feedback to the Department regarding its quality management process and to assure that corrective actions and policy changes identified through the process are effective. The Department's quality management process is designed to detect statewide trends in health care treatment and track any problems that require corrective action. The Department intends to complete a major revision of its entire quality management process and all proposed revisions will be provided to the CMA prior to implementation. The CMA will continue to work with the Department on improving these processes and encourages DC to complete the revisions to the quality management program by the end of FY 2009-10.

Mortality Review Process

The primary focus of the CMA QMC during FY 2008-09 was a quality review of the Department's mortality review process. The CMA QMC carefully reviews the mortality review documentation produced by the Department, focusing on the effectiveness of the process for identifying and correcting both clinical care and health care management deficiency issues.

The CMA QMC conducted four meetings in FY 2008-09, including a special review of a sample of suicides occurring statewide in the last year, as well as three scheduled meetings which focused on physical causes of death. The format for each meeting includes an overview of Department quality management activities as well as a discussion of cases presented, including the inmate's name, age, gender, psychological grade, housing location at time of death, a brief physical/mental health history, the mortality review process followed by the Department following the death (who conducted reviews, whether there was any difference of opinion among reviewers, etc.), and any corrective actions taken based on the review outcome.

Part of the Department's mortality review process includes a review by a contracted community-based physician. This review is then compared to reviews conducted by Department staff. The Department re-bid this contract, effective July 1, 2008, to improve the quality of the outside review process. New contract language ensures the reviewing physician has sufficient qualifications and experience related to the decedent's primary diagnosis to provide an adequate review of the quality and appropriateness of health care provided. The OHS mortality review coordinator manages this contract to ensure compliance.

Suicide Mortalities

According to the Bureau of Justice Statistics, the suicide rate between 2001 and 2006 in state prisons averaged 16 per 100,000.⁴ The following table displays the Department's rates for the past four years compared to national averages for the years for which data is available.

Calendar Year	# of Suicides in DC prisons	DC average daily population	DC suicide rate per 100,00	National Rate per 100,000 for
2005	8	86,496	9.24	16
2006	7	90,299	7.75	16
2007	8	95,252	8.39	Not Available
2008	6	99,937	6.0	Not Available

⁴ U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, Deaths in Custody Statistical Tables, State prison deaths, 2001-2006, Table 13. Average annual mortality rate, per 100,000 state prisoners, by cause of death and state, 2001-2006 @ <http://www.ojp.usdoj.gov/bjs/dcrp/tables/dcst06spt13.htm>

Budget and Personnel Work Group

In order to carry out the CMA's responsibilities to advise the Secretary on cost containment measures and make recommendations on the OHS budget, the CMA convenes a budget and personnel workgroup. The workgroup is comprised of a group of three citizen volunteers and a CMA Board member with expertise in hospital administration and government budgeting and accounting. The workgroup's primary activities are reviewing the OHS legislative budget request (LBR), providing recommendations regarding funding the request to the Governor and Legislature, and reviewing the Department's health care expenditures and cost management processes.

DC Health Care Budget Fiscal Year 2008-09

Legislative Budget Request (LBR)

In its FY 2008-09 LBR, the Department requested \$459.5 million for health services. Many of the issues in the FY 2008-09 LBR (price level increases, pay additives, shift differentials) had also been requested in the previous fiscal year but were not funded. The request included a \$16,307,953 price level increase for health services, excluding drugs. The request was distributed among Other Personal Services (OPS) (\$3,468,223), Expenses (\$1,559,864), and Inmate Health Services (\$11,279,866). A price level increase of \$37,896,775 was also requested for general drugs, psychotropic drugs, and infectious disease drugs.

A workload increase in the amount of \$11,425,102 was requested based on the Criminal Justice Estimating Conference (CJEC) population estimate of an average daily population in FY 2008-09 of 100,781 inmates. Funding was also requested for support staff for Suwannee Work Camp (\$113,261) and for health services support staffing (\$969,946) for eight new dorms being brought on line during FY 2008-09.

Funding was requested for replacement of broken equipment and to add new equipment necessary to upgrade institutional infirmaries to reduce the number of referrals to the Reception and Medical Center (RMC) at Lake Butler and local hospitals (\$819,084). The request included \$33,120 for a prescription barcode scanner for 24 facilities in Regions I, II, and III to more efficiently fill prescriptions.

A total of \$2.3 million was requested to enhance the recruitment and retention of health care staff by providing pay additives of \$200 bi-weekly for physicians, physician assistants, and emergency medical technicians, \$160 bi-weekly for nursing staff working at S3 facilities, and \$124.80 bi-weekly for senior psychologists and psychological specialists permanently assigned to S3 facilities.

Retention of health care staff was also addressed by the request for \$750,000 for an increase in shift differential rates. Registered nurses (RNs) would receive an additional \$2.00 and \$3.00 per hour and licensed practical nurses (LPNs) \$1.50 and \$2.00 per hour for evening shift and night shift, respectively. The Department has paid RNs and LPNs a shift differential of \$1.00 per hour for many years. In addition to the shift differential, DC also requested a \$10 million market adjustment for salaries of clinical professionals in an attempt to reverse the high turnover rates in health care staff.

After reviewing the DC budget request and considering the agency reductions taking place during the current fiscal year, the workgroup recommended the CMA support the Department's budget as proposed. Based on this recommendation and at the direction of the CMA Board Chair, a letter was sent to the Governor, Speaker of the House, and President of the Senate expressing the CMA's strong support for the Department's request as proposed and stressing the importance of the issues included in the request to the continued functioning of the health care system in DC.

Legislative Appropriation FY 2008-09

The total appropriation to the Department was \$2.6 billion and a total of 29,224.5 positions. The majority of new funding to DC was for new prison beds for the projected increase in the inmate population: \$308.6 million in fixed capital outlay funds for the construction of 10,224 new prison beds and \$83.7 million and 1,395 positions for operations. The final appropriations bill continued into the 2008-09 fiscal year the nearly \$78 million in General Revenue reductions from the previous fiscal year. Additional cuts were made in the areas of inmate education and programs (\$8.8 million and 216 positions), community corrections (\$14.9 million and 199 positions), and administration (\$8.3 million and 132 positions). The OHS issues requesting a shift differential, a market adjustment for salaries, and a pay additive for workload for health care staff were not funded.

The total health services appropriation was \$425,639,309 (which included \$52.7 million to partially fund the FY 2007-08 deficit). Although OHS received \$30 million to fund price level increases in FY 2008-09, a \$57 million shortfall existed at the end of the fiscal year. A deficit of approximately \$5 million was carried over into FY 2008-09 and the budget was reduced by that amount during special session early in the fiscal year.

DC Health Care Expenditures Fiscal Year 2008-09

With the exception of FY 2004-05, in every year since the 2000-01 fiscal year funds appropriated for health services were insufficient to cover the actual expenditures in health services, requiring budget amendments and transfers from other DC budget entities to cover the deficit. The significant budget cuts the agency had absorbed over time and escalating health care costs generally made it increasingly difficult to cover the cost of inmate health services. Fiscal Year 2008-09 saw a reversal of this trend. At the end of FY 2008-09, the OHS did not end the year with a budget deficit. Health services

year-end expenditures were \$400.5 million, a significant reduction from the previous year expenditures of \$421.3 million. From the original \$425.6 million appropriation to Health Services, \$21.5 million was transferred out of OHS to cover deficits elsewhere in DC and \$2 million was used to cover expenses not previously paid out of the OHS budget. These transfers were in addition to the \$5 million deficit carried over from the previous year.

The following table displays the OHS LBR and appropriation compared to actual expenditures since FY 2000-01.

**Department of Corrections
Office of Health Services
Agency Final Request, Final Appropriation, Actual Expenditures
FY 2000-01 through FY 2008-09**

Year	Average Daily Pop	Agency Final Request* A12	Final Appropriation*	Actual Expenditures*	Surplus / (Deficit)
2000-01	67,706	\$236,787,458	\$230,477,893	\$247,211,595	(\$16,733,702)
2001-02	68,495	\$265,867,798	\$248,625,196	\$257,908,310	(\$9,283,114)
2002-03	70,812	\$271,601,052	\$267,780,873	\$279,853,413	(\$12,072,540)
2003-04	75,089	\$294,212,158	\$297,096,464	\$307,626,417	(\$10,529,953)
2004-05	8,640	\$328,630,135	\$321,252,150	\$315,487,038	\$5,765,112
2005-06	81,167	\$338,297,930	\$335,588,990	\$336,339,039	(\$750,049)
2006-07	84,930	\$349,542,591	\$355,360,684	\$379,086,727	(\$23,726,043)
2007-08	88,041	\$399,534,570	\$422,170,541	\$421,381,245	\$789,296 a.
2008-09	91,860	\$459,453,424	\$425,639,309	\$400,580,203	\$25,059,106 b.

a: Prior to transfers from other DC entities, the deficit was \$53.1 million.

b: \$21.5 of this was transferred through budget amendments to cover deficits in other DC entities.

*These figures are pulled directly from LAS/PBS.

Source: DC Budget Office

In addition, per diem inmate health care costs decreased 9.1 percent over the last two fiscal years after steadily increasing each year since 2004.

**Per Diem Inmate Health Care Costs
FY 02-03 through FY 2008-09**

Fiscal Year	Per Diem	Percent Increase/ (-Decrease)
2002-2003	\$10.91	-
2003-2004	\$11.18	2.5%
2004-2005	\$10.99	-1.6%
2005-2006	\$11.54	5.0%
2006-2007	\$12.23	5.9%
2007-2008	\$13.04	6.6%
2008-2009	\$11.85	-9.1%

OHS Legislative Budget Request for FY 2009-10

The workgroup convened in October 2008 to review the DC budget request for FY 2009-10 and to develop recommendations for the CMA to submit to the Legislature and Governor. Total funding requested by OHS for FY 2009-10 was \$527,647,127 and 954 new FTE's. Most of the major issues were similar to previous years' requests. A price level increase of \$40,760,452 was requested for Inmate Health Services excluding drugs. The request for \$21,910,601 for drugs was based on projections for FY 2009-10, which were anticipated to exceed FY 2008-09. Projections were based on FY 2007-08 expenditures and adjusted for each subsequent year by 7.4 percent, based on current literature on the rate of increase in pharmaceutical costs.

Ongoing health care support issues totaled \$11,618,314 and 207 FTEs to provide health care services for new beds coming on line in FY 2009-10. The OHS also requested new staff for institutions already in the process of being expanded with additional mental health and close management beds, Wakulla CI 23 FTEs (\$2,254,357) and Suwannee Transitional Care Unit 84 FTEs (\$7,535,074).

New and replacement medical and infirmary equipment (\$1,486,612) necessary to upgrade institutional infirmaries was requested again as it was not funded the previous year. The request supported OHS's cost containment efforts by limiting the use of costly outside contractors and reducing the number of referrals to RMC and local hospitals.

A fund shift to facilitate the transition of health services from a private contractor to a state-operated program in Region IV and other key positions in health care was requested. Positions and funds to be transferred included 432 FTEs (\$25 million) to transition Region IV and 196 FTEs (\$12 million) to reduce contract staffing in health services. The FTEs were requested at midpoint of the salary range and only the funds in the current contracts were converted to FTEs. The goal of this effort was to establish a more cohesive and stable leadership team at the institutions and the regions and reduce the use of agency staff. Secondary benefits to having DC staff providing care are better control of use of outside providers and specialists and better administrative control of the system.

Consistent with Secretary McNeil's focus on re-entry efforts and on keeping inmates out of prison once they are released, additional positions were requested for mental health aftercare specialists to help inmates obtain community mental health services and to apply for disability payments upon release from DC. Funds were shifted (\$716,460 from OPS) to establish 12 FTEs. The original FTEs had been lost in budget cuts over time and these positions had been filled by OPS workers in recent years. The turnover rate for the OPS positions was very high; after the shift from full-time DC employees to OPS, the rate of approvals for first time SSI applications went down from a 31 percent approval rate to 18 percent.

The request for \$12 million for salary adjustments reflected OHS's continued efforts to reverse the high staff turnover rates in health care staff. (This recommendation was

included in OPPAGA Report No. 09-07.) The funds requested would allow all clinical health services staff to be compensated at or above the median of the pay range and DC would begin to offer midpoint salaries to all new hires.

The request included pay additives for certain professionals in key hard to recruit and retain positions at higher acuity institutions and mental health units (\$3 million). This is also related to improving recruitment and retention of health care staff as there is an increased workload associated with higher medical and mental health acuity.

The workgroup recommended the CMA support the Department's request. The workgroup noted that providing adequate resources is critical to the Department's ability to maintain a functional health care delivery system capable of addressing inmates' medical and mental health needs competently and on a timely basis. The recommendation noted the continued progress OHS made in addressing clinical and management issues in Region IV through the conversion of contracted positions to Department employees and recommended that the requested FTEs be provided.

The workgroup also met in March 2009 to review the budgets proposed by the House and Senate. At that time, no additional recommendations were submitted.

Legislation Relating to Health Services

The Department proposed two substantive legislative issues relating to health services, all of which related to reducing or controlling health care costs. The proposals included creating statutory language which limited reimbursement for providers not under contract to DC to 110 percent of the Medicare rate and expanding this limitation to air ambulance services and medical transport. Similar language had been enacted in proviso language in the Appropriations Act during the previous two years.

The proposed legislation also placed specific requirements on timelines for vendors to submit medical payment claims for services, giving OHS rights and responsibilities with respect to recovering overpaid claims and standardizing the delivery of claims, payments, and disputes between the Department and its health care vendors. The legislation was needed because there were no time limits for a provider to submit a bill for payment; claims could be submitted to DC as long as five years after the service was delivered.

Senate Bill 1722 (Chapter 2009-63, Laws of Florida) was enacted by the Legislature and included the OHS legislative issues relating to medical claims payment and the cap on rates for non contracted health care providers.

FY 2009-10 Appropriations Act

The total appropriation to the Department for FY 2009-10 was \$2.4 billion and a total of 30,522 positions. The appropriation to OHS was \$439,163,920 and 2,792.5 FTEs. Through a fund shift of \$26,897,095 the Legislature provided 432 FTEs to continue transition of health services from a private contractor to a state-operated program in Region IV and 196 FTEs (\$12,930,010) to reduce the use of contract staffing. The OHS issues requesting a shift differential, a market adjustment for salaries, and a workload pay additive for health care staff were not funded.

In addition, \$14.9 million and 274 FTEs were funded to provide workload increases for health care staff for new beds coming on line. There was also a reduction in OHS of 15 positions from central office and regional administration. The co-payment for inmate requested health care visits was increased from \$4 to \$5 which was expected to bring in an additional \$116,000.

Management of DC Health Care Costs

Like many other states, Florida is experiencing steady growth in the prison population in the face of decreasing revenues; 521 of every 100,000 Floridians were incarcerated on June 30, 2008 compared to 468 in 2004. The number of inmates in prison rose approximately 20 percent over the last five years from 81,974 in June 2004 to 98,192 in June 2008.⁵

The Department is continually challenged to provide health and mental health services to the approximately 100,000 inmates in its custody. Meeting the health care needs of this population is complicated by the increasing numbers of older inmates (15.1 percent of the population in June 2009 up from 11.6 percent in June 2005), the number of inmates with a serious mental illness, and the escalating cost of health care.⁶ The Bureau of Labor Statistics reports that from July 1, 2008 through June 30, 2009, medical care costs increased overall by 3.2 percent and hospital and related services increased by 6.5 percent.⁷

In spite of steadily increasing costs in the health care market, during the last two years the Department has made significant progress in managing medical costs. Beginning in FY 2007-08, the OHS began a focused effort to control health care costs by strengthening the management of health services at central office, in regional offices, and at the institutional level. The language in various vendor contracts was strengthened by the Department to ensure vendors complied with all applicable Health Service Bulletins, procedures, rules, and statutes. The contract monitor supervisor continues to

5. Florida Department of Corrections, 2007-2008 Annual Report accessed September 9, 2009 @: http://www.dc.state.fl.us/pub/annual/0708/stats/im_pop.html

6. Florida Department of Corrections, Office of Research and Data Analysis, Population projection -ad hoc report via personal communication, August 12, 2009.

7. US Dept. of Labor, Bureau of Labor Statistics, Consumer Price Index, July 2009, at: <http://www.bls.gov/news.release/pdf/cpi.pdf>

review all vendor contracts during the contract negotiation process to ensure quality assurance/quality management oversight. These initiatives continued into FY 2008-09 and were directed toward reducing costs through strengthening the utilization management (UM) process, improving contract negotiation and monitoring, continuing the restructuring of health services in Region IV (South Florida), and more careful oversight of statewide, regional, and institutional care operations and systems. The Department reports costs avoided by reducing hospital and external physician expenses in FY 2008-09 were approximately \$7 million. The total savings reported for all UM activities was \$9.4 million.

By the end of the fiscal year, OHS's efforts began to have a significant impact on inmate health care costs. Hospital and provider costs decreased during FY 2008-09 due to the continued effect of proviso language in the 2009 Appropriations Act (now in statute) which directed that if no contract existed between the Department and a licensed hospital or a health care provider providing services at a hospital, payments could not exceed 110 percent of the Medicare allowable rate. If a contract had already been executed between the Department and a licensed hospital or a health care provider, payments continued at the established rate through the remaining term of the contract. From July 2008 through June 2009, OHS reported savings of \$20.1 million due to the implementation of this provision. Prior to the implementation of this limitation (services provided before July 1, 2008), OHS was paying claims at 100 percent of billed charges, a substantially higher rate than the industry standard.

The statutory language now provides that new contracts with hospitals, health care providers, emergency transport services, diagnostic services, and ambulatory surgical centers may not exceed 110 percent of the Medicare allowable rate. The only exception allows the Department to pay up to 125 percent of the Medicare rate to hospitals with

a negative operating margin (based on audited financial statements reported to the Agency for Health Care Administration). During the year before the statutory changes were enacted (the rate limits were in proviso language), OHS renegotiated contract rates. These savings will continue to be realized during FY 2009-10. In October 2008, the major ambulatory surgery center contract at the hospital at RMC was also renegotiated resulting in savings of \$900,000. In April 2009, the statewide laboratory services contract was renegotiated and OHS is projecting it will result in savings of \$5 million annually (approximately 50 percent savings over pre-renegotiation costs).

In addition to renegotiation of contracts, in January 2009 OHS obtained a third party vendor to identify medical claims overpayments. Annually the Department has paid approximately \$110 million in claims for external hospital and physician services. The vendor has identified more than \$4 million in overpayments. These overpayments are being pursued and about \$200,000 has been collected to date.

In May 2008, OHS terminated the contract with a private company that provided dental services to 40 institutions. The 115 dental services contract positions were converted to Department employees. The elimination of substantial overhead and administrative profit is expected to save OHS approximately \$200,000 per month, or \$2.4 million annually.

Contracted agency (temporary) staffing was reduced 26 percent (\$4 million) from FY 2007-08. Agency staff costs between \$8 and \$10 more per hour than regular full-time state employees in comparable positions. Agency staffing hours were either reduced overall or replaced with more cost efficient full-time or OPS staff.

The Department has made significant efforts to contain the cost of providing health services to inmates without compromising clinical quality of care. Regional staff and the OHS continue to pursue opportunities to streamline and reorganize the OHS management structure to improve accountability of DC employees and contracted personnel and to assure that resources are used efficiently in the delivery of care to inmates. From the perspective of the CMA, these changes have been generally positive in that they have been implemented in concert with a focus on also ensuring quality and appropriateness of care consistent with constitutional standards and instituting evidence based practices in medicine and nursing. During the coming year, through the survey process, review of department utilization and cost data, and tracking trends in inmate correspondence, the CMA will continue to monitor how these management strategies affect the quality of care and the health care service delivery system.

Department of Corrections Office of Health Services Accomplishments Fiscal Year 2008-09

During FY 2008-09, the Department continued to make progress implementing programmatic changes and cost containment measures to ensure appropriate quality and cost efficiency of inmate health services.

Region IV

During FY 2007-08, the Department assumed management control of health services in Region IV after more than six years of contracting these services to a private provider. This transition began in November 2006, when a hybrid model of health care was adopted consisting of retaining some contracted health and mental health staff but converting key management staff from contracted positions to Department employees. During the 2009 Legislative session, 432 FTE positions were created in OHS to complete this transition of health services from a private contractor to a state-operated program. Because funds were shifted from the expense category to salaries and benefits, no new funding was required. Taylor CI health services and mental health staff became DC employees on August 21, 2009. Health services staff at Homestead, South Florida Reception Center, Everglades, Broward, and Dade CIs became Department employees on August 28, 2009. Mental health services in Region IV continue to be provided by a private contractor. The contract for these services was re-bid and in July 2009, the new provider took over the mental health program in the region. On September 25, 2009 the conversion of all other contracted health services staff in Region IV was completed when staff at the remaining eight institutions in the region became DC employees.

Dental Services

Prior to June 1, 2008 approximately 65 percent of DC's routine dental services were outsourced. During FY 2007-08 OHS began working on a plan to convert dental

services provided through contract to a state operated system. This transition began on May 31, 2008 and conversion was completed during FY 2008-09.

The Department reached a verbal agreement with the Oral Surgery Department at Nova Southeastern College of Dental Medicine to provide specialized oral surgery care for reimbursement at 100 percent of the Medicare rate. The procedures included in the agreement are those that could not be done at RMC. Since Nova surgeries are done at Broward General Hospital, DC also has a verbal agreement with Broward General Hospital for the same 100 percent of Medicare rate for hospital stays. In addition, the oral surgeon under contract to assist RMC dental staff agreed to reimbursement rates lower than provided for in previous contracts.

The Department also has verbal agreements with several other dental disciplines at Nova to provide specialized care at reduced rates and is in the process of finalizing an agreement for senior dental students to rotate through several institutions in South Florida. Dentists employed by DC will become adjunct faculty at Nova Southeastern College of Dental Medicine to provide required supervision of the students.

Public Health Collaboration

STD/HIV Pilot Project

In December 2008, the Department entered into an interagency agreement with DOH to provide treatment for DC inmates with sexually transmitted diseases (STDs), including HIV/AIDS. This arrangement allows DC to realize substantial savings by being able to purchase HIV drugs through the DOH via the Federal 340b drug pricing program. DOH is eligible for the 340b Public Health Service drug acquisition program, a federal program which allows procurement of STD/HIV and other drugs at discounted prices (usually 25 percent of the wholesale acquisition cost). The Department is otherwise not

eligible for 340b drug savings. The DOH has obtained the concurrence of the Health Resources and Services Administration (HRSA) and Centers for Disease Control (CDC) to conduct this program as a pilot with the Department.

The services to inmates are rendered through local DOH county health departments, which have teams of staff to provide care at several institutions. Each DOH team is made up of a physician, a nurse, and a support staff. During FY 2008-09 teams at the Alachua and Jackson County Health Departments provided services to inmates at nine DC institutions. Eligible inmates were identified by DC clinical staff and enrolled in the pilot program. In order to schedule appointments and laboratory tests, which are administered by DC staff, DOH staff has been given access to the Department's Offender Based Information System (OBIS).

The benefits from this partnership between the Department and local county health departments accrue to both the community as a whole and inmates who participate. Approximately one third of the inmate population is released back to the community each year. Inmates who are HIV positive or who have a communicable disease return to their families and neighborhoods in need of follow up, medication, and other supports. Risk of untreated illness spreading to the community at large can be mitigated by timely intervention by public health professionals. This type of community-based medical care has been developed successfully at jails in Massachusetts in the early 1990's and at the Marion and Duval County jails in Florida more recently. The model ensures that sick inmates will have access to care in their communities after release.

Since the health departments have an expanded formulary for HIV medications, inmates may be able to access other medications that could enhance control of their disease and reduce the likelihood of transmission. The statewide DOH electronic medical record

system will benefit enrolled inmates who are being released, as they will be able to access care at any health department and their current medical record will be available. Services were to be expanded through Miami Dade Health Department to include five more institutions in fall 2009. As of the end of FY 2008-09, the Department reports the pilot program has resulted in net savings of \$1 million. For FY 2009-10, the Department anticipates as much as \$5 million in additional savings. The Department plans to expand this program to other prisons on an incremental basis.

Preparations for H1N1

Department representatives meet regularly with DOH staff and will continue to identify the number of inmates who meet current CDC recommendations for novel flu vaccination. Both novel and seasonal flu vaccinations will proceed as usual with guidance from CDC and DOH. Department staff are referred to local county health departments for vaccination in accordance with priority groups recommended by CDC and DOH,

Pharmacy Services

Health care providers in DC write approximately two million prescriptions in a given year for the nearly 100,000 inmates in custody. Most of the drugs dispensed are distributed as unit doses using “bingo cards” to ensure inventory control, and maintain the integrity of medication purchased in large quantities. For many years the Department has contracted with a private company that repackages bulk drugs into bingo cards. The charge for this service is \$1.85 per card.

During FY 2008-09, OHS worked with DOH on an inter-agency agreement to transition repackaging to the DOH Statewide Pharmacy program. The DOH charge is \$.60 per card and initially DOH will repackage one-third of the cards needed. For the first 6

months of FY 2009-10, the private contractor will continue to manufacture two thirds of the bingo cards. The contractor has agreed to reduce their per card price from \$1.85 to \$.89. At the end of the six month period, all repackaging is expected to transition to the DOH Statewide Pharmacy. The Department reports the projected savings for the first fiscal year the program is operational is \$1.5 million.

Mental Health

Training was provided to departmental staff on suicide and self-injury prevention, crisis intervention, re-entry planning, and social security eligibility to improve interdisciplinary collaboration, improve delivery of services to the mentally ill inmate population, and to prevent suicides and self-injuries.

A system was developed during the past year to monitor incidents of self-injurious behavior (SIB) that result in outside hospital expense. By identifying patterns of SIB and specifically targeting those who engage in this behavior, efforts are under way to increase patient safety, improve treatment, and reduce hospital expenditures.

In a joint effort with the DCF and Florida's community mental health providers, Department staff continued to build upon an innovative web-based system for arranging community-based mental health care for inmates following release. A new policy (Health Service Bulletin 15.05.21) was developed to guide these efforts. The Department worked with DCF staff to develop standardized practices for accessing intensive community and/or state hospital services (voluntary or involuntary) for offenders requiring services under the Baker Act upon release. In order to effectively transition severely mentally ill offenders back into the community, Department staff also collaborated with the Social Security Administration to initiate disability benefits when clinically indicated. The DC mental health re-entry program has focused on facilitating the transition of mentally ill inmates from prison to community care consistent with

Secretary McNeil's focus on strengthening re-entry initiatives.

The OHS staff is partnering with the Department's Office of Re-Entry to negotiate an agreement with the Veterans Administration (VA) to link released veterans to VA services. The goals of the agreement are to provide these veterans with the health, mental health, and community support services they will need through the VA upon release to allow them to function as citizens in the community, reduce recidivism, increase public safety, and preclude shifting the cost of inmate care to the community.

Recognizing the increasing demand for services for mentally ill inmates, the Department opened Wakulla Annex as a facility for inmates requiring psychiatric services and is preparing for the opening of Suwannee CI in 2010. Suwannee CI will house inmates requiring outpatient psychiatric services and will also have an inpatient mental health unit. The Department also initiated the planning process for additional mental health inpatient care units to meet the future needs of mentally ill inmates. During the past year, the Department also negotiated a new contract for mental health services in Region IV and prepared for an effective transition of vendors that occurred on July 1, 2009.

The Department's psychology doctoral internship program successfully graduated its second year of interns in FY 2008-09. Following a rigorous self-study and application process, the program was accepted by the American Psychological Association and is scheduled for review for accreditation in December 2009.

Utilization Management

The hospital unit at the RMC at Lake Butler provides care for inmates who require specialty care or surgery that can be provided on-site by contracted physicians. However, inmates often require a level of care that must be provided in community

hospitals and ambulatory surgical centers. The increasing costs in the health care marketplace combined with the increase in the inmate population have resulted in significant deficits in the Department's health care budget over the past several years. As mentioned earlier in this report, in an effort to assure that inmates were receiving appropriate and timely care in the most cost effective manner, OHS revised and strengthened its health services utilization management (UM) program beginning in February 2008. The program added several critical components including an updated database and new procedures for the management of care. In addition, six new Registered Nurse Consultant (RNC) positions and two clerical support positions were added to implement the revised program. The program components include increased oversight through improved case management of inmates who require specialty services and medical procedures. A utilization management RNC was placed in each region to provide on-site community hospital case management and institutional consultations for medical transfer reasons and full-time case management was provided at the primary contracted hospital facility (Memorial Hospital Jacksonville). The UM database was upgraded to include electronic submission of consults and prior approvals, new data tracking reports, and statewide real-time hospital census reporting. Increased efforts were directed to screening and resource management for services that require pre-authorization including outpatient surgery, diagnostic procedures, medical devices, and specialty consultations. The system of billing notification and service authorization for privately contracted institutions that use medical services provided by DC facilities was strengthened.

For FY 2008-09, OHS reported cost avoidance savings of approximately \$7 million in reduced hospital and external physician expenses. The total savings reported for all UM activities was \$9.4 million. The utilization management program staff also received a Davis Productivity Award for their efforts.

2008-09 Survey Activities

Introduction

During FY 2008-09 CMA staff conducted 13 on-site institutional surveys to evaluate the provision of both physical and mental health services. The table below displays the institutions surveyed by region:

<p><u>Region I</u></p> <p>Santa Rosa CI and Annex</p> <p>Jackson CI</p> <p>NW Florida Reception Center</p> <p>Wakulla CI and Annex</p>	<p><u>Region II</u></p> <p>Florida State Prison</p> <p>Taylor CI and Annex</p> <p>Union CI</p>
<p><u>Region III</u></p> <p>Tomoka CI</p> <p>Sumter CI</p> <p>Marion CI</p>	<p><u>Region IV</u></p> <p>Desoto CI Annex</p> <p>Moorehaven CF</p> <p>Everglades CI</p>

All institutions were selected for surveys based on the date of the most recent last survey. Every effort is made by CMA staff during the scheduling process to ensure a fair representation is selected from each region of the state. Individual survey reports may be viewed on the CMA's website. <http://www.doh.state.fl.us/cma/reports/index.html>

As in years past, to conduct these surveys the CMA contracted with a variety of licensed community and public health care practitioners, such as physicians, psychiatrists, dentists, nurses, psychologists and other mental health professionals. The survey process included

a clinical review of the physical, dental, and mental health care provided at each institution. Cases selected for review were representative of inmates who were receiving mental and/or physical health services (or who were eligible to receive such services). Administrative issues such as the existence and application of written policies and procedures, staff credentials, staff training, and confinement practices were also reviewed.

Conclusions drawn by members of the survey team were based on the following methods of evidence collection:

- Physical evidence – direct observation (tours and observation of evaluation/treatment encounters).
- Testimonial evidence – obtained through staff and inmate interviews (and substantiated through investigation).
- Documentary evidence – obtained through the review of specific materials including assessments, service/treatment plans, schedules, logs, administrative reports, records, physician's orders, training records, etc.
- Analytical evidence – developed by comparative and deductive analysis from several pieces of gathered evidence.

Survey Findings

For the purposes of this report, both the physical and mental health areas reviewed during surveys fell into two general categories:

1. Clinical -- directly related to diagnosis and/or treatment. In physical health care for example, these may be reflected as concerns with the management of chronic illnesses, procedures when inmates transfer in or out of institutions, or routine care such as immunizations, physical examinations, and ongoing comprehensive dental care. In mental health care, these concerns may surface following evaluations of psychiatric

medication usage, treatment, or referral following abnormal laboratory testing, or outpatient mental health care.

2. Non-clinical -- related to administrative processes. For example, this may be reflected as inconsistently or poorly documented baseline histories or mental health program descriptions not posted in housing areas.

As reflected in the following tables, in no cases were all institutions found to have deficiencies in all the areas identified. In fact, the findings identified below represent only those that were noted at two or more institutions. All findings for mental health inpatient services were included since only two institutions providing these services were surveyed. In addition only one reception center was surveyed, so all these findings were included.

Physical Health Clinical and Administrative Findings	
Administrative Systems	Problem lists were not consistently current or complete. (TOMCI, EVGCI, DESCI, WAKCI, SUMCI, TAYCI)
Medication Administration	<p>Medication administration records (MARs) did not consistently match the physician's order, including drug name, route of administration, dose, frequency, and/or start times. (NWFRC, FSP)</p> <p>Code boxes on the MAR were not consistently completed when the nurse administered medications. (NWFRC, TOMCI, TAYCI)</p> <p>Medication orders were not always legible or complete. (TOMCI, TAYCI)</p>

Medication Administration cont'd	<p>Medication orders were not consistently signed, dated, and/or timed. (TOMCI, TAYCI, FSP)</p> <p>Medication orders did not consistently have a corresponding note in the medical record. (TOMCI, TAYCI)</p> <p>Oral cavity checks were not consistently conducted at pill lines. (TOMCI, TAYCI)</p> <p>MARs did not consistently note allergies. (TOMCI, TAYCI)</p>
Overall Chronic Illness Clinics	<p>Physical examinations upon clinic enrollment or during clinic visits were not consistently documented as required. (NWFRC, WAKCI, EVGCI)</p> <p>Medical histories and/or baseline information upon clinic enrollment or during subsequent clinic visits were not consistently documented as required. (NWFRC, TAYCI, WAKCI, UNICI, FSP, SARCI)</p> <p>Laboratory studies prior to clinic appointments and/or follow up for abnormal laboratory results were not consistently documented. (TAYCI, SARCI)</p> <p>A statement as to control of the disease (good, fair, poor) was inconsistently documented. (WAKCI, UNICI)</p> <p>Evidence of annual testing for the presence of microalbuminuria (albumin protein in urine) was inconsistently documented. (TOMCI, FSP, TAYCI)</p>
Neurology Clinic	<p>Neurological evaluations during clinic visits were inconsistently documented. (NWFRC, TAYCI, UNICI)</p> <p>The type and/or frequency of seizure and/or cause of any acute complications were not consistently documented. (UNICI, SARCI, TAYCI)</p>

Mental Health Clinical and Administrative Findings	
Administrative Issues	The mental health program description was not posted in all housing areas. (NWFRC, JACCI)
Outpatient Mental Health Services	<p>Individualized Service Plans (ISP) were not consistently completed and/or reviewed within the required time frame. (NWFRC, TAYCI, SARCI, FSP)</p> <p>Case managers were not consistently assigned to eligible inmates within the required time frame. (NWFRC, TOMCI, TAYCI)</p> <p>Mental health staff did not consistently conduct orientation to mental health services, service planning interviews, or medical record reviews within the required time frames for newly arriving inmates. (TOMCI, TAYCI)</p> <p>An accurate S grade was not consistently documented on the profile sheet. (TOMCI, WAKCI, JACCI)</p> <p>Mental health problems were not consistently documented on the problem list. (TOMCI, WAKCI)</p>
Outpatient Psychiatric Medication Practices	<p>Physician orders were not consistently dated, timed, and/or stamped. (TOMCI, FSP)</p> <p>Initial laboratory reports and/or follow up for abnormal laboratory results were not consistently completed as required. (NWFRC, TOMCI, SARCI, FSP)</p> <p>A rationale for medication/diagnosis changes was not consistently documented. (FSP, TOMCI)</p> <p>Assessment of Involuntary Movement Scale (AIMS) testing at appropriate intervals (required to ensure no adverse reaction to medications) was not consistently documented. (NWFRC, TOMCI, SARCI)</p>

<p>Outpatient Psychiatric Medication Practices (cont'd)</p>	<p>Inmate signatures were not consistently documented on medication consent forms. (NWFRC, TOMCI)</p> <p>Psychiatric evaluations were either not consistently present in the record or completed within the required timeframe. (WAKCI, SARCI)</p>
<p>Self-Harm Observation Status (SHOS)</p>	<p>Physician's orders did not consistently specify required 15 minute checks for inmates in SHOS. (TOMCI, EVGCI, SUMCI)</p> <p>Inmates were not consistently observed every 15 minutes as ordered by the physician. (DESCI, UNICI, WAKCI)</p> <p>Notes and/or orders were not consistently signed and/or dated. (TAYCI, EVGCI, SUMCI)</p> <p>SHOS post-discharge follow-up was not consistently present in the record or completed within the required timeframe. (EVGCI, TAYCI, WAKCI)</p>
<p>Special Housing</p>	<p>Initial mental status exams were not consistently completed within the required time frame. (TAYCI, TOMCI)</p> <p>"Mental Status of Confinement Inmates" (Form DC4-528) was not consistently completed after each mental status exam. (TOMCI, JACCI)</p>
<p>Sex Offender Services</p>	<p>Group notes were not consistently individualized. (TOMCI, EVGCI)</p>
<p>Inpatient Mental Health Services</p>	<p>Laboratory testing was not consistently ordered prior to the initial dose of medication or some laboratory results were incomplete. (UNICI, SARCI)</p> <p>Psychiatric evaluations or admission notes were not consistently completed within the required time frame. (UNICI)</p>

Inpatient Mental Health Services (cont'd)	<p>Supporting evidence for the current diagnosis or medication (symptoms and responses to medication, rationales for medication changes, evaluation of medication side effects, and/or abnormal laboratory findings) was not consistently documented. (UNICI)</p> <p>Informed consents for each class of medication prescribed were not consistently present in the record. (UNICI)</p> <p>AIMS testing at appropriate intervals (required to ensure no adverse reaction to medications) was not consistently documented. (SARCI)</p> <p>Daily nursing notes for the first seven days of an inmate's admission to the Transitional Care Unit were not consistently completed. (UNICI)</p>
Reception	<p>Case management notes did not consistently address medication compliance for inmates remaining at the reception center for longer than 30 days. (SARCI)</p>

Discussion

Problem lists provide an ongoing guide for reviewing the health status of a patient and planning appropriate care. During the FY 2008-09 survey process, several trends were noted regarding problem lists. These included missing or incomplete required documentation (diagnoses inconsistently numbered, titled, dated, and signed). Constant inmate movement among institutions and numerous clinicians being involved in the diagnosis and treatment process contributes to this problem. Clinicians may fail to enter a new diagnosis or incorrectly enter new diagnoses on the problem list. In order to comprehensively address this issue, each volume of the inmate's record should be reviewed each time he/she is transferred to a new institution to ensure all previously identified problems are included on the current problem list. The Department agrees

that the accuracy of the problem list is crucial to providing adequate inmate care.

During multiple medical record reviews, adequate documentation of appropriate physical examinations and/or medical histories upon enrollment in a clinic or during subsequent clinic visits was not consistently documented at several institutions. Baseline information such as physical examinations and medical histories are important in determining how to treat inmates who seek medical care. In some cases it was noted by surveyors that the problem may have had to do with over-thinning records.

The CMA recommends that the Department determine how current problem lists can be tracked and that clinic staff ensures that when new volumes of medical records are assembled for inmates, the baseline information be brought forward as a part of the new record. In addition, all new problems should be entered into OBIS appropriately and in a timely fashion.

Corrective Action Plan (CAP) Process

Each time an institution is surveyed by the CMA, a written report is published which outlines the findings noted and suggests corrective actions to be taken at the institutional level. Within 30 days after the survey the report is provided to the Department and after approval by OHS, institutional staff and regional representatives submit the CAP to the CMA. The CAP must be submitted within 30 days of the publication of the report. The CAP addresses the concerns noted in the survey report by describing the corrective actions the institution is proposing to remedy the deficiencies.

Usually four to five months after the CAP is implemented (but no less than three months) CMA staff evaluates the CAP to measure the effectiveness of the corrective actions. These actions most often take the form of in-service training to applicable staff

and an internal records monitoring effort to ensure staff are complying with the recommended changes. Based on the yearly statistics on the effectiveness of individual CAPs, Department staff is generally successful in implementing positive changes. The CMA urges increased emphasis by regional management and institutional health care staff to successfully close CAPs during the CMA's first review. Overall, OHS, regional, and institutional staff are to be commended for fostering an atmosphere where the process of quality improvement is positive, not punitive.

2006-2007 CMA Monitoring Schedule

Institution	Survey Date	1 st CAP Date	2 nd CAP Date	3 rd CAP Date	4 th CAP Date	Open/ Closed
Broward	May 29- June 1, 2007	November 27-30, 2007 (re- survey)	July 15, 2008	November 20, 2008	March 26, 2009	Closed
Lowell	June 27- 29, 2007	April 1, 2008	September 26, 2008	January 21, 2009	N/A	Closed

2007-2008 CMA Monitoring Schedule

Institution	Survey Date	1 st CAP Date	2 nd CAP Date	3 rd CAP Date	4 th CAP Date	Open/ Closed
Zephyrhills	October 9- 12, 2007	May 20, 2008	September 25, 2008	January 22, 2009	May 15, 2009	Closed
Broward (re-survey)	November 27-30, 2007	July 15, 2008	November 20, 3008	March 26, 2009	N/A	Closed
Jefferson	February 13-15, 2008	September 12, 2008	January 16, 2009	N/A	N/A	Closed
SFRC	June 24- 27, 2008	November 18, 2008	April 7, 2009	N/A	N/A	Closed

2008-09 CMA CAP Monitoring Schedule

Institution	Survey Date	1st CAP Date	2nd CAP Date	3rd CAP Date	Open/Closed
Everglades	July 16-18, 2008	November 19, 2008	N/A	N/A	Closed
Florida State Prison	August 4-7, 2008	January 26, 2009	N/A	N/A	Closed
Tomoka	October 15-17, 2008	March 30, 2009	July 17, 2009	August 20, 2009	Closed
Taylor	November 4-7, 2008	April 15, 2009	July 28, 2009	N/A	Closed
Santa Rosa	December 10-12, 2008	May 21, 2009	N/A	N/A	Closed
Sumter	January 13-16, 2009	June 9, 2009	September 14, 2009	N/A	Closed
Marion	February 3-5, 2009	June 25, 2009	October 16, 2009	N/A	Closed
NWFRC	March 4-6, 2009	October 2009	January 2010 pending	N/A	Open
Desoto	April 1-3, 2009	September 10, 2009	N/A	N/A	Closed
Wakulla	April 29-May 1, 2009	January 2010 (pending)	N/A	N/A	Open
Moore Haven	April 29-May 1, 2009	No Findings	N/A	N/A	Closed
Jackson	May 12-15, 2009	October 15, 2009	N/A	N/A	Closed
Union	June 10-12, 2009	December 10, 2009	N/A	N/A	Closed

Recommendations

Based on FY 2008-09 survey findings, corrective action plans, and oversight of the Department's QM program, the CMA makes the following recommendations:

Physical Health

- Ensure all required components of physical examinations are completed upon chronic clinic enrollment and during subsequent clinic visits as indicated.
- Ensure medical histories and baseline information are completed (and kept in the current volume of the medical record) upon chronic clinic enrollment and during subsequent clinic visits as indicated.
- Ensure indicated laboratory studies are ordered prior to chronic clinic appointments and steps are taken to address abnormal results in a timely manner.
- Ensure medication orders are documented as required and Medication Administration Records (MARS) are accurate.
- Ensure problem lists are current and accurate to provide an ongoing guide for reviewing the health status of patients and planning appropriate care.

Mental Health

- Ensure complete and timely documentation of Individualized Service Plans (ISPs), psychiatric evaluations, and assessment of involuntary movement scale (AIMS) testing.
- Ensure eligible inmates are provided timely case management.
- Ensure indicated laboratory studies are ordered for inmates prescribed psychiatric medication and steps are taken to address abnormal results in a timely manner.
- Ensure supporting documentation is complete for current diagnoses and psychiatric medication changes.
- Ensure documentation is complete for required medical and mental health

activities provided inmates in self-harm observation status (SHOS).

- Ensure mental status examinations and required follow-up activities are completed and timely for inmates in special housing status.

Administrative

- Ensure regional and institutional staff focuses on the goal of successfully closing corrective action plans (CAPs) on the first post-survey review by the CMA.
- Ensure revisions to the Department's quality management program are completed and implemented prior to the end of FY 2009-10.

Report on Aging and Older Inmates in the Florida Department of Corrections

The number of elderly and aging inmates in the prison population has become one of the most serious issues facing state correctional systems already struggling with growing populations and increasing health care costs. A report by the National Institute of Corrections in 2004 found the number of state and federal inmates aged 50 and older increased by 173 percent between 1992 and 2001.⁸ The average age of inmates in the U.S. has increased from 31 to 34.⁹ In Florida the average age of inmates has increased from 34.4 years on June 30, 2000 to 36 on June 30, 2009. Researchers predict by 2030, over one-third of individuals incarcerated in state prisons will be over the age of 50. Without changes in criminal justice policies that govern convictions, sentencing and release, this trend will continue. The growth in the prison population is due in part to mandatory sentencing for repeat offenders, a trend toward longer sentences, and the rising number of older people in the United States prison population.¹⁰ Elderly inmates are now the fastest growing cohort of the inmate population in most states. The U.S. Department of Justice (DOJ) reports that the number of inmates in federal and state prisons age 55 and older increased 33 percent from 2000 to 2005, over three times faster than the nine percent growth in the overall prison population during that same period.¹¹ The demands of caring for this aging population will continue to have a significant impact on expenditures for health services.

A report on aging inmates prepared for the California Medical Facility by Lumetra is still

⁸ Anno, BJ, Graham, C, Lawrence, J, Shansky, R. editors, *Correctional Health Care: Addressing the Needs of Elderly, Chronically Ill and Terminally Ill Inmates*, National Institute of Corrections, U.S. Department of Justice, 2004.

⁹ Gelb, Adam, *Public Safety, Public Spending: Forecasting America's Prison Population, 2007-2011*, Public Safety Performance Project, Pew Center on the States, Presentation to the National Conference on State Legislatures, September 6, 2007 @ <http://www.ncsl.org/Portals/1/documents/cj/sf-gelbppt.pdf>

¹⁰ Roberts, F., "Specialized Healthcare in Correctional Facilities," *Correctional News*, Jan/Feb 2001.

¹¹ *Addressing the Needs of Elderly, Chronically Ill and Terminally Ill Inmates*, p. 29

the most comprehensive evaluation of the elderly population conducted to date by any state prison system. The report focused on gaps in providing medical care to California's elderly population and provided an in-depth description of a study of a random selection of 431 inmates age 55 and older, including 24 who were assigned to a medical bed. The report also covered 196 randomly selected inmates of all ages assigned to medical beds across 33 institutions. Additionally, data on 57 inmates referred by custody staff during on-site surveys were included, but reported separately. The study centered on the functional characteristics or abilities of the sample group.¹²

After analysis of the data, Lumetra recommended integrated care management using a continuum of settings and services; interdisciplinary teams and expertise; environmental and program modifications; and organizational change. The study also reported that its review of off site hospital costs from July 2003 to December 2005 revealed while the 55 or older population is 5 percent of California's incarcerated population, they accounted for 22.4 percent of expenditures. The average cost of a hospitalization was roughly \$7,000 higher per inmate than hospitalization for the younger group. The report recommended vigorous development of specialized units and support programs that can keep inmates at lower levels of care.

In late 2006, the Council of State Governments, Southern Legislative Conference (SLC) released a report on the aging inmate population in southern states. The report noted that across the 16 states included in the SLC, rate of growth in the elderly prison population escalated by an average 135 percent between 1997 and 2006. With the exception of Alabama and Virginia, southern states meet the needs of elderly inmates through designating special units in existing prisons, or meeting the needs of the inmate

¹² Hill, T., Williams, B., Cobe, g., Lindquist, K., *Aging Inmates: Challenges for Healthcare and Custody - A Report for the California Department of Corrections and Rehabilitation*, Lumetra, San Francisco, CA., May, 2006.

within the context of a regular population housing assignment. In most states, special units within existing prisons are equipped and modified to meet the needs of elderly inmates. Every state surveyed reported that rising medical costs are becoming a significant factor in attempting to meet the needs of elderly inmates. The SLC reported that issues surrounding the increasing numbers of inmates, including elderly inmates, are of particular concern in the southern states because they have higher incarceration rates than the rest of the country and a higher percentage of inmates serving sentences for violent or sexual offenses which tend to be longer terms.¹³

Because the proportion of older inmates in the prison population is increasing, geriatric inmates, many of whom are in poor health at the time of incarceration, will continue to generate significant increases in health care costs. It is estimated that the average yearly cost for an older inmate is approximately \$70,000 – around two or three times that of younger inmates.¹⁴ A significant portion of that difference in cost may be attributed to increased health care costs. In addition to the costs for basic health care, states face rising expenses for dental health and mental health services. Rikard and Rosenberg note three key concerns regarding aging inmates: inmate capacity (the quantity issue); prison environment (the quality issue), and probation and parole (the reintegration issue). In response to these concerns, they make five policy recommendations:

- Given that significant changes in policy regarding criminal justice and in practice such as age-targeted sentencing are unlikely, prisons must prepare to adapt to the increasing number of aging inmates. This should include physical plant adaptations, staff training, and programming for inmates.
- Future research should focus on new policies including medical parole and community placements for aging inmates being released,

¹³. Southern Legislative Conference, *The Aging Inmate Population: Southern States Outlook*, Dec., 2006.

¹⁴. Warren, J., et al, *One in 100: Behind Bars in America 2008*, Pew Center on the States, Public Safety Performance Project, The Pew Charitable Trusts, 2008.

- The new programs and policies that are a result of the research should serve as a guide for national policy.
- Age-specific reintegration programs should be encouraged.
- States should exempt older inmates from parole once they are released from prison.¹⁵

The CMA and the Department report annually on the status of elderly inmates in Florida. The requirement for an annual report is the result of a 1999 Florida Corrections Commission and House of Representatives Committee on Corrections study of elderly and aging inmates. The legislation that required the annual report also included language directing the Department to develop and implement preventive fitness/wellness programs and diet modifications that might lead to decreased long-term medical costs for elderly inmates. The Department was directed to reexamine and alter then existing policies and procedures to allow for adoption of a healthier lifestyle by the elder population. The legislation required staff training programs on effective supervision of elderly inmates and information on detecting physical or mental changes that affect behavior and warrant medical attention.¹⁶

This report describes the population of inmates over the age of 50 admitted to Florida's prisons during FY 2008-09 and those housed in the system at the close of the last fiscal year. It also provides an overview of the health care services used by older inmates, and the cost of purchasing care that could not be provided within the system. The DC Bureau of Research and Data Analysis provided the data on Florida inmates used in this report and OHS provided data on health costs and programs for older inmates.

¹⁵ Rikard, R.V. and Rosenberg, E., "*Aging Inmates: A Convergence of Trends in the American Criminal Justice System*," *Journal of Correctional Health Care*, Vol. 13, No. 3, July 2007, p.158.

¹⁶ Section 944.8041, Florida Statutes.

Population and Demographic Trends

Florida classifies inmates age 50 and older as “aging or elderly.”¹⁷ Although age 50 is not generally considered “elderly,” many experts in prison health care use this age because inmates’ life experiences prior to and while in prison contribute to a lower life expectancy. In a review of state departments of corrections’ policies on older inmates, 15 of the 27 (58 percent) of the responding states defined “older inmates” as persons older than age 50.¹⁸ According to the US Census Bureau, 41 percent of non-institutionalized persons over the age of 65 have at least one disability compared to 67 percent of over 65 inmates. Older inmates generally have poorer health status due to lack of health care prior to incarceration, personal habits such as smoking, alcohol and drug abuse, the impact of the stress of isolation, and possible victimization experienced in prison.

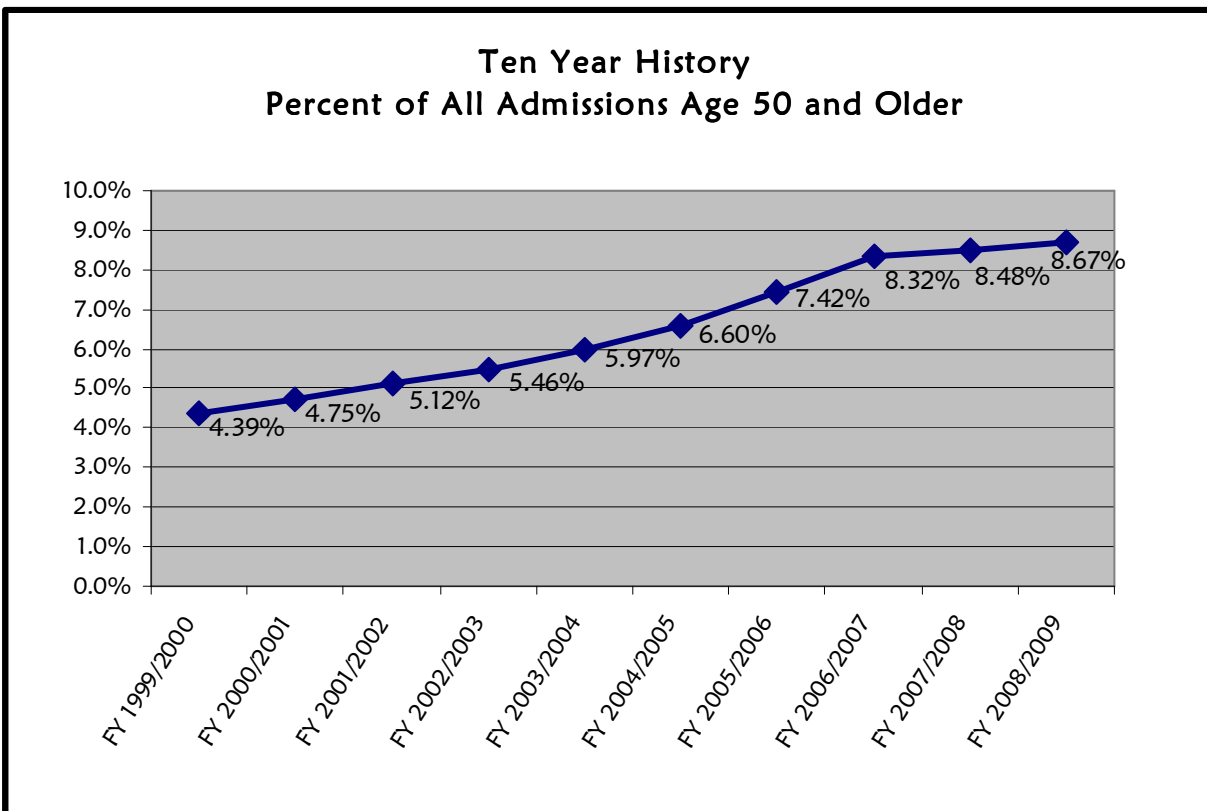
Admissions 2008-2009

During FY 2008-2009 admissions of inmates age ≥ 50 continued to increase as a percentage of total admissions. Although the total number of admissions to DC decreased by four percent from FY 2007-08, the percent of all admissions that were over age 50 increased by two percent. Compared to FY 2007-2008 when the age ≥ 50 admissions accounted for 8.48 percent of all admissions, this year they accounted for 8.67 percent (3,412) of the 39,354 admissions. The relative percentage of older inmates admitted to the Department has increased steadily since 1998; that increase is expected to continue over the next decade and is projected to reach ten percent of all admissions by mid-year 2010.

¹⁷ Chapter 33-601.217, Elderly Offender Housing, Florida Administrative Code

¹⁸ Sterns, Anthony A.; Lax, Greta; Sed, Chad; Keohane, Partrick; and Sterns, Ronni S., *A National Survey of Older Prisoners Health, Mental Health, And Programming*, Corrections Today, August 2008.

In FY 2008-09, 85 percent of age ≥ 50 admissions were between the ages of 50-59 years. Only 65 admissions, or 1.9 percent, were 70 or older. The average age of the oldest inmates (ten oldest males and ten oldest females) admitted during FY 2008-09 was 74; the oldest male inmate was 84 years old and the oldest female was 71 years old. The average age of the ten oldest male inmates admitted increased from 79.7 in FY 2007-08 to 81 and the average age of the ten oldest female admissions increased from 63.6 to 66. Sentence length ranged from 1.5 years to 50 years or more (two male inmates had 50 year or more sentences) with 11 of the 20 inmates having sentences of less than five years.



The average age at admission for inmates age 50 and older for male inmates was 55.4 and 54.4 for female inmates. Older admissions were more likely to be white (55.4 percent) than admissions as a whole (49.9 percent) and older admissions were over 90 percent male, slightly more than admissions as a whole (88.8 percent). Older admissions

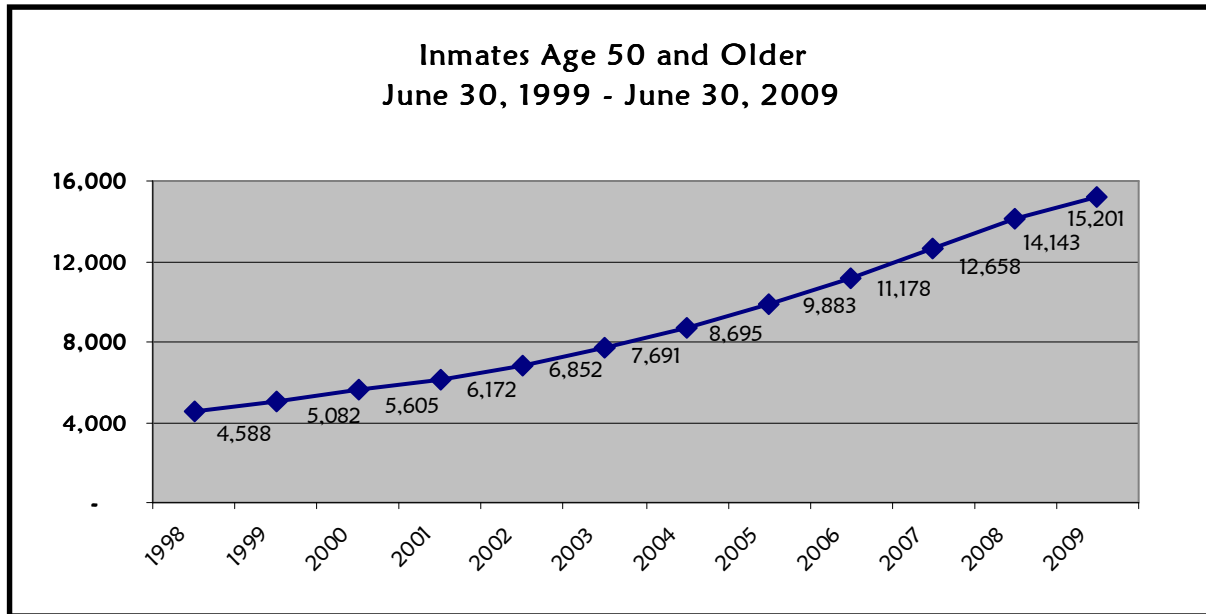
were more likely to have previous prison commitments than admissions as a whole; 76.5 percent of all admissions had only one or no previous commitments, while 57.5 percent of inmates age 50 or older had only one or no previous commitments.

Population Age 50 and Older

At the close of FY 2008-09 (June 30), the resident population of the prison system was 100,894 individuals. Inmates age 50 and older comprised 15.1 percent of that population, or 15,201 inmates. This represents a 7.5 percent increase in the older inmate cohort of the prison population over June 30, 2008 when there were 14,143 inmates age 50 and over, representing 14.4 percent of the total prison population. At any time during the course of FY 2008-09, DC housed a total of 138,395 inmates. Of those inmates 14.6 percent were age 50 or older.

As of June 30, 2009 the oldest male inmate was 90 and was admitted to DC at age 75 with a life sentence. The oldest female inmate was also 90 and was admitted at age 87 to serve a 31 year sentence. The ages of the ten oldest male inmates range from 86 to 90; the average age is 87 and six of the ten are serving a sentence of 50 years or more. The shortest sentence is an 86 year old with a ten year sentence. The ages of the ten oldest female inmates range from 75 to 90; the average age is 78.6 and four of the ten are serving a sentence of 50 years or more. The shortest sentence for the ten oldest female inmates is a 78 year old serving a seven year sentence. For the 20 oldest inmates, the average sentence length is 34.7 years and the youngest age of admission was a female inmate admitted at age 49.

Female inmates over age 50 accounted for 11.5 percent of all women in the prison population, 5.3 percent of inmates age 50 and older, but less than one percent (.8) of the entire prison population on June 30, 2009.



Profile of Florida Inmate ≥ 50	
Male	95%
White	54%
Mean Age at Admission	56
First Commitment	48%
Median Sentence Length	15 y
Served 15 y or Less	73%
Crime	
Murder /Manslaughter	21%
Sexual/Lewd Behavior	21%
Drugs	16%

Of the 100,894 inmates in prison on June 30, 2009, 12,118 (12 percent) are expected to die in prison. As could be expected, inmates age 50 and over are more likely than younger inmates to die in prison. Although older inmates were 15.1 percent of the June 30, 2009 population, they represent 37 percent of those inmates expected to die in

prison. Within the age cohort of all inmates over age 50 (15,201), almost one third (4,428) are expected to die in prison, and more than half (350) of all inmates over age 70 (642) will die in prison.

Housing Assignments

Older inmates are housed in most of the Department's major institutions consistent with their custody level and medical status. In the majority of DC facilities, the age 50 and older population is less than 25 percent of the total facility population. At the time of this report, seven facilities had no inmates age 50 and older. Seven facilities had older inmate populations that exceeded 25 percent of the total population; this is an increase from FY 2007-08 when only four correctional institutions had over 25 percent older inmates. The Department does not classify inmates for housing assignments solely based on age. Inmates who are elderly who have significant limitations in activities of daily living or serious physical conditions may be placed in an institution that has the capacity to meet those particular needs.

The River Junction Work Camp (RJWC) was designated by the Legislature to house aging inmates. The facility has a capacity of 340, which is reduced from its previous capacity of 736. Only individuals who are in good health, able to work, are at a minimum/medium custody level, and have no major medical problems are appropriate for RJWC. The stated mission of RJWC is to provide work squads for Florida State Hospital, and provide programs for elderly inmates.

Excluding RJWC, there are six other correctional facilities with the highest concentration of inmates age 50 and older: Everglades, Polk, Zephyrhills, CFRC South, Union, and SFRC South. Most of these institutions have limited capacity for specialized programs for older inmates.

Correctional Facility	Under Age 50	Age 50 and	Total
Everglades C.I.	1,298 (75%)	427 (25%)	1,725
Polk C.I.	819 (69%)	373 (31%)	1,192
Zephyrhills C.I.	380 (59%)	263 (41%)	643
Central FL Reception Center	43 (42%)	59 (58%)	102
Union C.I.	671 (33%)	1,375 (67%)	2,046
South FL Reception Center	124 (22%)	439 (78%)	563
River Junction Work Camp	48 (14%)	292 (86%)	340

Generally any programs offered are limited to group activities geared toward older persons such as exercise, weight loss, or memory games. Union and SFRC have no specific medical programs or services for older inmates but provide these services on an as needed basis. Zephyrhills CI is the only facility that has assigned housing and special programming (a continuum of care) for elderly inmates. There is a special dorm designated for older inmates where there is an exercise program held inside if weather is severe. Older inmates are allowed to get extra blankets, sweat shirts, long johns or wear their coats. Zephyrhills and CFRC also offer palliative care. The Department has a palliative care program at the CFRC South unit which serves inmates of all ages with terminal conditions.

Previous reports by the CMA and the Florida Corrections Commission examined the possible housing options for older inmates, including specific facilities for older inmates and there continues to be significant debate regarding how best to meet the needs of aging inmates. The state of Ohio has been the most proactive in developing a special unit for older inmates. Like Florida, Ohio defines older inmates as those persons age 50 and older; as of January 2009, 6,495 of the 50,655 inmates in Ohio were age 50 or

older. Designated for older inmates, the Hocking Correctional Facility has a population of 483. The facility has an Associate Aide program developed to assist inmates with memory or cognitive deficits.¹⁹

The current DC policy regarding older inmates allows those who are aging but healthy to be integrated into the prison population with special accommodations as needed. This model of aging in place is consistent with best practices in the community regarding aging policy which provide for integrating appropriate supports into a community to allow seniors to remain in their homes as long as possible.

Health Status of Older Inmates

The Department provided health services to 138,395 inmates (June 30, population plus new admissions) during FY 2008-09. Every inmate is assigned a health classification at the time of his/her admission to the system. This classification includes a medical grade (M1 – M 5, M9), mental health grade (S1 – S5, S6), impairment grade (P, H, E, S), and a work classification (W1 – W5). The number assigned to an inmate is based on the severity or acuity of the medical or mental health condition with 1 being the lowest level of need and 5 the highest. Medical grade 9 is assigned to pregnant women and mental health grades 4 through 6 are assigned to inmates needing various levels of residential treatment. Impairment grades are assigned based on physical limitations, hearing impairment, visual impairment, or developmental disability. Of the 1,656 inmates with an assigned impairment grade at the end of FY 2008–09, nearly half (49%) were inmates age 50 or older.

¹⁹. State of Ohio Department of Rehabilitation and Correction, Hocking Correctional Facility website @ <http://www.drc.ohio.gov/Public/hcf.htm>

Impairment	All Inmates w/Impairment	Impaired Inmates Age 50 and Older
Visual	372	151 (41%)
Hearing	230	116 (50%)
Physical	972	527 (54%)
Developmental	82	20 (24%)
Total	1,656	814 (49%)

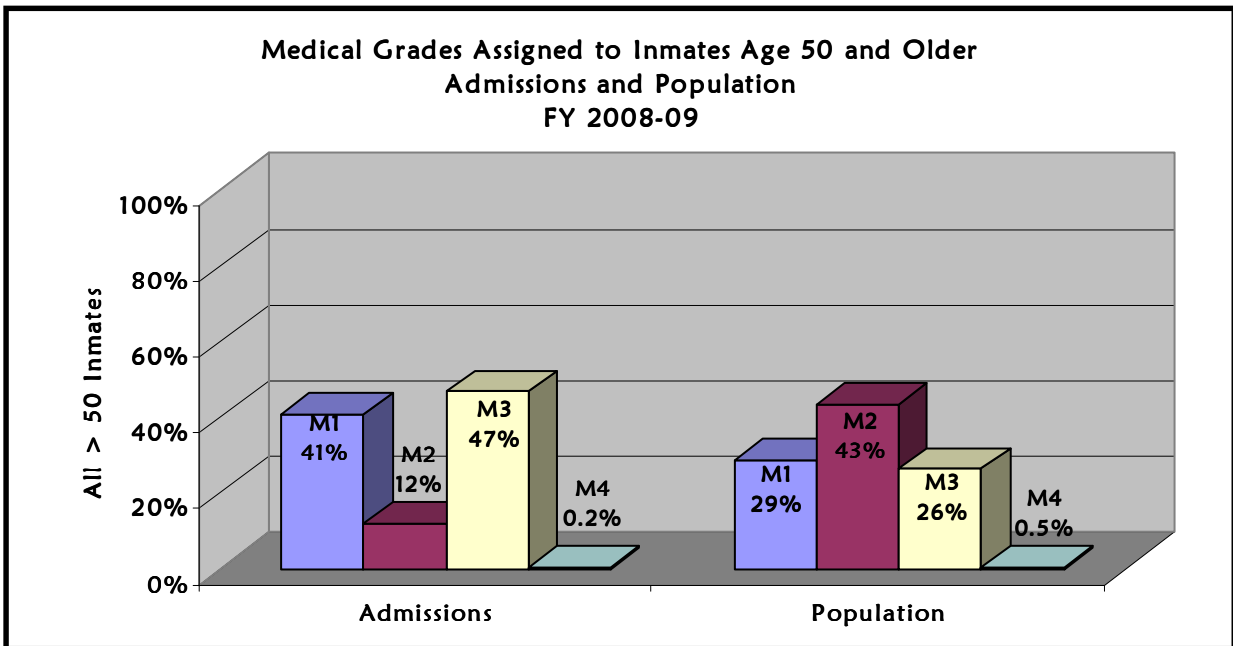
Inmates who need special assistance or require adaptive devices such as hearing aids, wheelchairs, low bunks, or inmate assistants are provided with these accommodations and issued a special pass. Slightly more than one in four of the inmates issued a special pass is over age 50. The largest numbers of passes issued are for lower bunks (27,868); one in four of these passes are issued to an inmate over age 50.

Health Services

In FY 2008–09, 73 percent of all admissions were classified as M 1. Older inmates were more likely to be assessed as being in poorer health at admission than were inmates under age 50; 76 percent of inmates under 50 were M 1 at admission compared to only 41 percent of inmates age 50 and older. Only 16 percent of younger inmates were M 3 at admission compared to 47 percent of older inmates. Although there are fewer older females admitted than younger females (317 versus 4,094), older women were significantly more likely to be M 3 (66 percent) at admission versus younger women (33 percent).

There was more similarity between inmate age cohorts in regard to psychiatric grade (S grade) upon admission; 85 percent of inmates under age 50 were admitted as S 1 compared to 80 percent of older inmates. The S 2 classification was virtually the same for both groups and S 3 admissions were only slightly more likely for older inmates (16

percent versus 11 percent). The total status population and the under age 50 population was more likely to be classified M 1 (63 percent and 69 percent respectively) than was the age 50 and over status population (29 percent). The older inmate population was also almost twice as likely to be M2 (43 percent) or 3 (26 percent) than the population as a whole (24 percent M 2, 13 percent M 3) or the under 50 population (20 percent M 2, 10 percent M 3).



The shift of older inmates to M 2 from both M 1 and M 3 after initial assessment may be due to the both the identification of conditions during intake that were unidentified or untreated prior to incarceration and the improvement in inmates' condition in response to care provided for chronic conditions in DC.

Inmates assigned mental health grades S 3 on admission were 11 percent of all admissions compared to 15 percent of inmates age 50 and older. This trend evened out slightly in the status population; 13 percent of both the total population and the age 50 and older inmates were S 3.

Inmates request health care services through sick call, which involves submitting a written request. Inmates are then placed on a call out list and report to the designated area at the appointed time. During FY 2008–09, there were 1,610,504 sick call encounters for the 138,395 inmates admitted and in the population during the year. As indicated in the following table, female inmates have nearly double the average number of clinic visits as male inmates and the average number of per inmate clinic visits increases significantly with increasing age.

Average Number of Sick Call Encounters by Age and Gender				
	All Inmates	Age < 50	Age >50	Age > 65
Males	10.9	9.6	18.8	24.9
Females	19.7	18.5	29.1	34.2
All Inmates	11.6	10.3	19.4	25.1

Inmates with chronic illnesses are enrolled in specialty clinics. These clinics provide ongoing monitoring and treatment of chronic diseases or conditions to ensure compliance with medication regimens and to detect any changes in an inmate’s health status that may have an impact on his/her condition. Inmates with several chronic conditions may be assigned to more than one clinic. There are 41,708 inmates assigned to at least one chronic clinic and approximately one third of those assigned are age 50 or older.

There were a total of 266,670 chronic clinic encounters in FY 2008-09. Of those, 91.7 percent were by male inmates and 8.3 percent were by female inmates. This is consistent with evidence that women utilize health services more frequently than men; less than one percent of the total prison population is female. Older inmates are overrepresented in the total clinic contacts; they represent 36 percent of all contacts but comprise only 15.1 percent of the total prison population.

Clinic Contacts for Inmates Age 50 and Older as Percent of All Contacts					
Clinic Type	Males	Females	Total >50	Total All	Percent > 50
<i>Cardiovascular</i>	40,975	2,368	43,343	100,996	43%
<i>Endocrine</i>	11,833	798	12,631	28,726	44%
<i>Gastrointestinal</i>	13,712	678	14,390	33,336	43%
<i>Immunity</i>	3,945	169	4,114	20,908	20%
<i>Renal</i>	392	9	401	1,007	40%
<i>Miscellaneous</i>	3,082	100	3,182	8,314	38%
<i>Neurology</i>	1,597	178	1,775	11,392	16%
<i>Oncology</i>	1,701	54	1,755	2,602	67%
<i>Respiratory</i>	7,566	534	8,100	30,241	27%
<i>Tuberculosis</i>	4,653	451	5,104	29,148	18%
TOTAL	89,456	5,339	94,795	266,670	36%

Community Purchased Health Services

The Department contracts with community providers and hospitals to provide medical care and specialty services to inmates in most areas of the state. Some of these services are provided on site at the institution when there is sufficient space, equipment, and personnel to support the provider. In other cases, inmates are transported to community facilities for emergency or highly complex procedures. In FY 2008–09, the Department paid \$56.8 million for community health care services to inmates, which included 14,502 days of scheduled and emergency hospitalizations, 2,857 ambulatory surgeries, and 2,237 emergency room visits. Of the 516 individuals who had multiple admissions to community hospitals, nearly half (46 percent) were older inmates. Inmates over the age of 50 accounted for 37 percent of all episodes of care, 42 percent of all hospital days, and 34 percent of ambulatory surgeries although they represent only 15.1 percent of the total prison population. For all inmates length of stay (LOS) is longer for emergency admissions than for scheduled admissions and the longest LOS for all categories is 5.9 days for emergency admissions of inmates age 50 and older.

Prescription Drugs

In FY 2008-09 the Department dispensed 1,989,219 prescriptions to inmates in its custody. This is an average of 14 prescriptions per inmate for the 138,395 inmates in custody over the course of the year. The 20,150 inmates age 50 and older in custody during the year were dispensed an average of 31 prescriptions per inmate. For psychiatric drugs a total of 303,880 prescriptions were dispensed with an average of two prescriptions per inmate; for older inmates the average was three per inmate.

In FY 2008-09, the total prescription drug cost for inmates was \$76,281,873. This includes all regions, stock pharmaceuticals, and costs paid to DOH for HIV drugs. Of that amount, 26 percent (\$19,972,747) was spent on drugs for inmates age 50 or older. Psychiatric drugs constituted 12 percent (\$9,388,010) of the total expenditures for pharmaceuticals. Psychiatric drugs constituted 9 percent (\$8,801,219) of total drug expenditures for inmates age 50 and older.

Conclusions and Recommendations

The demands of caring for aging and elderly inmates will continue to have a significant impact on prison health care expenditures. It is evident from the data presented here, from previous CMA reports, and reports from correctional professionals around the country that older inmates have more health problems, generally consume more health services, and are prescribed more medications than younger inmates. These inmates also have different housing needs and have the potential for creating management issues in a prison setting by virtue of their vulnerability and medical conditions and many of them will never leave the prison system by virtue of sentence length. Regardless of the increased demand these individuals place on the system, their numbers are steadily increasing and they will continue to consume a disproportionate share of the limited resources available for health care and programmatic enhancements.

Although the prison population is increasing, the resources to support this population have remained stagnant. Funding has been provided only to continue existing programs and to support population growth projections. When combined with steady increases in population, this has not been sufficient to allow for creation of new programs or substantial modifications to facilities for older inmates. Much of the literature on aging inmates reports that these inmates cost an average of three times as much as younger inmates. This serves to emphasize the importance of preventive care, early intervention through careful monitoring of chronic illness, and planning for the health care needs of an older population. The resources required to care for this population will continue to strain correctional systems and will be especially challenging in the current fiscal environment. Some states have expanded statutory authority for alternatives to incarceration of elderly inmates to divert these individuals before they are incarcerated in an attempt to reduce the impact of older inmates on the prison system.

Previous reports have made a number of recommendations including specialized training programs, designating specific institutions for elderly inmates, instituting preventive health measures focused on older inmates, regular assessments, special security reviews, and citizen volunteer programs. Within the resources available, the Department has taken steps to develop some approaches to address the needs of older inmates such as designating housing units for them at certain institutions and developing palliative care units. There has also been an enhanced focus on preventive care for all inmates which will benefit older inmates.

Previous reports by the CMA and the Department on aging and elderly inmates have presented a substantial volume of information regarding the status of older inmates in Florida and nationwide. Consistent with the findings reported here and in previous reports, the CMA recommends:

- The Department should consider working with a university program or department with expertise in aging research to conduct a study of the current and long-term needs of older inmates.
- The Department should continue to work on developing a data system with the capacity to collect data on the costs of health services provided in-house. Analysis of utilization data and expenditures for older inmates, female inmates, and other populations with special needs would be useful for planning and budget purposes.