



State of Florida
Correctional Medical Authority

2009-2010
Annual Report
and
Report on Aging Inmates

December 2010

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., Chair
Representative
Licensed Mental Health Professionals

David Abercrombie, F.A.C.H.E.
Representative
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**STATE OF FLORIDA
CORRECTIONAL MEDICAL AUTHORITY**

December 31, 2010

The Honorable Charlie Crist
Governor of Florida

The Honorable Mike Haridopolis, President
The Florida Senate

The Honorable Dean Cannon, 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 2009-10 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 2009-10 which included on-site physical and mental health surveys of 15 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.

Over the last few years, Department staff put great effort into implementing practices to control the escalating cost of inmate health care. From the perspective of the CMA, these efforts have been generally positive in that they have been implemented in concert with a focus on ensuring quality and appropriateness of care consistent with constitutional standards. Through the survey process, review of department utilization and cost data, and tracking trends in inmate correspondence, the CMA continues to monitor how these management strategies affect the quality of care provided to inmates and the efficiency of 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".

Murdina Campbell, M.S.W.
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). In the final order closing the *Costello* case, Judge Susan Black noted that the creation of the CMA made it possible for the Federal Court to relinquish the prison monitoring and oversight function it had performed for the prior twenty years. In light of "Florida's affirmation of its continued commitment to the CMA's independence" and the support from the Defendant and the State of Florida the Court found that the CMA was capable of "performing an oversight and monitoring function over the Department in order to assure continued compliance with the orders entered in this case." The independence of the CMA is reaffirmed in the authorizing statute which locates the agency in the Department of Health (DOH) for administrative purposes (s.945.602, Florida Statutes). To assure the independence of the Authority, the Board has a contract with DOH which specifies the administrative services to be provided and affirming its independent status. 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. Three new appointees were confirmed by the Senate Ethics and Elections Committee during the 2010 legislative session. Five serving members were reappointed and also confirmed by the Senate. Three members of the current board have served as CMA surveyors participating in all components of the survey process. By continuing to ensure 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 and one-third of those with active tuberculosis (TB) pass through the jail or prison system annually.¹ Inmates are also disproportionately affected by HIV/AIDS; the prevalence among prisoners is more than three times that of the general U.S. population² and it is estimated that one fourth of the people living with HIV in the U.S. pass through a correctional facility each year.³

Many inmates come into prison with poor health status due to lack of preventive medical and dental care, untreated chronic disease, mental illness, years of substance (alcohol, drugs, tobacco) abuse, and the effects of previous incarcerations. The generally poorer health status of inmates and the aging population combined with the increasing cost of health care has resulted in medical care being a primary contributor to steadily increasing correctional budgets. The logistics of providing care to inmates has also been

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.

2. Maruschak LM, *HIV in Prisons, 2005*, Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Bulletin, September 2007, Washington, D.C. U.S. NCJ 218915 @: <http://www.ojp.usdoj.gov/bjs/pub/pdf/hivp05.pdf>.

3. Spaulding AC, Stephenson B, Macalino G, Ruby W, Clarke, JG, Flanigan TP, Human Immunodeficiency Virus in Correctional Facilities: A Review, *Clinical Infectious Diseases*, 2002;35(3):305-312.

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.

Several states have recently been faced with legal challenges involving prison health care. In March 2006 the U.S. Department of Justice began investigating health care in Delaware’s prisons which resulted in the appointment of an independent federal monitor. Although the monitor has recommended that the state resume monitoring health care, no date has been set for ending federal oversight.⁴

The state of Wisconsin recently settled a lawsuit involving health care at its women’s prison. The suit was filed on behalf of the 700 inmates at the women’s facility alleging that the consequences of inadequate physical and mental health care included an extensive outbreak of staph infection, needless long-term health problems, and suicides. The settlement will require construction of a new facility for female inmates, the addition of full-time medical staff, and additional mental health staff.⁵

4. *Delaware Online* @ <http://delawareonline.com/article/20100918/NEWS02/9180333/Federal-monitor>, accessed 9/20/10.

5. *Wisconsin settles prison health lawsuit*, UPI.com, published August 19, 2010 @ http://www.upi.com/Top_News/US/2010/08/19/Wisconsin-settles-prison-health-lawsuit/UPI-69621282261672/ accessed August 23, 2010.

The state of Mississippi and the American Civil Liberties Union (ACLU) recently came to an agreement ending a suit filed in 2002 challenging conditions and lack of health care and mental health care at Unit 32 of the Mississippi State Penitentiary at Parchman. In 2006 the state entered into a consent decree that resulted in significant changes in Unit 32. To settle the suit, the state agreed to transfer the entire population of the unit to other facilities, move all seriously mentally ill inmates to the mental health facility in Meridian, and to provide adequate medical and mental health care at Unit 32 as long as any inmates remain there. As part of the agreement, the ACLU will monitor the medical and mental health care provided at all facilities to which Unit 32 inmates are transferred for the next year.⁶

In July 2010, the state of Nevada and the ACLU submitted a proposed agreement to settle a 2008 lawsuit which charged that a pervasive pattern of grossly inadequate medical care at the Ely State Prison created a substantial risk of serious medical harm for every prisoner in the facility. If it is approved by the U.S. District Court, the agreement requires an independent medical expert to be appointed to monitor the prison's health care system and submit regular reports evaluating prison officials' compliance with medical care provisions. As part of the agreement, the state agrees to build a better system of ensuring that medications are timely provided, to develop health care treatment plans for inmates with chronic illnesses requiring ongoing medical care, and to provide inmates with access to qualified medical staff seven days a week for routine or emergency care.⁷

In 2001, a federal class action suit was filed against the California Department of

6. <http://www.aclu.org/prisoners-rights/presley-et-al-v-epps-et-al-agreement-seek-dismissal> accessed July 22, 2010.

7. <http://www.aclu.org/prisoners-rights/aclu-agrees-settle-lawsuit-charging-inadequate-medical-care-nevadas-ely-state-prison>, accessed July 22, 2010.

Corrections and Rehabilitation (CDCR) alleging that the medical care provided in its institutions was so inadequate that it violated the Eighth Amendment. The state agreed to remedy the conditions in a settlement in 2002. However in 2006 after years of insufficient progress toward a constitutionally adequate system, the federal court removed control of the prison health care system from the state and appointed a federal Receiver to take over the system.⁸ The CDCR is still involved in four separate 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*). 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.”⁹ Although immediate release of prisoners was not ordered, 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. On September 16, 2009 the state filed a request in federal court requesting that the Receivership be terminated. On April, 30, 2010 the Ninth Circuit Court of Appeals denied a request to terminate the Receivership. On June 3, 2010 the Governor signed legislation that funded construction of additional beds for medical and mental health care pursuant to a plan negotiated between the state and the Receiver. On November

8. *California Prison Health Services fact sheet* accessed @ <http://www.cprinc.org/> on August 27, 2010.

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

30, 2010 the U. S. Supreme Court heard oral arguments and was asked to decide if the three-judge panel had jurisdiction to order the release of prisoners and if the court had jurisdiction, did it properly find that a prisoner release order was the only possible remedy and give appropriate weight to public safety concerns. The Court's decision is expected in Spring 2011.

The CMA was established in the wake of a similar class action suit over conditions of confinement. 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.
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- Determining whether the Department incorporates all health care 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 2009-10 including the findings of fifteen on-site institutional surveys and quality management and budget review activities.

CMA Staff Activities

During FY 2009-10 the CMA continued to implement the objectives of the three-year strategic plan adopted in July 2009 to monitor and promote the delivery of cost-effective health care that meets accepted standards of care for inmates.

Survey Process

During most of the FY 2009-10 survey year, the CMA had only three dentists available to conduct surveys. During the last year, the CMA staff worked with the Florida Dental Association and recruited an additional 14 dentists to be available for surveys.

Staff is also working with the Florida Medical Association to recruit additional physician surveyors. A similar effort to recruit psychiatrists for future surveys is in process with the Florida Psychiatric Society. There are four physicians on contract for physical health surveys this year and eight clinical associates (physician assistants and advanced registered nurse practitioners) are available to assist physicians on CMA surveys. There are currently five psychiatrists and five psychiatric advanced registered nurse practitioners available for mental health surveys.

On-site surveys were conducted at 15 correctional facilities. The results of the surveys are presented later in this report.

Policy Review

During FY 2009-10 OHS continued a review of all policies, procedures, and Health Service Bulletins (HSB's) which govern provision of health care and are the primary way consistency in practice among health care staff is assured. The CMA is required to "review OHS policies pertinent to health care and provide qualified professional advice regarding that care." Several CMA surveyors and board members who are physicians, dentists, and nurses provided input on proposed policy changes in clinical practice protocols during the past year. In addition, CMA staff updated medical, nursing, mental health, and administrative survey tools as indicated to maintain consistency with DC policies and procedures and community standards of care.

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 2009-10, 329 inmate letters from 222 inmates were reviewed and responses were provided to inmates. Within the last two years there has been a 95 percent increase in inmate letters and a 119 percent increase in the number of inmates writing; in FY 2007-08 the CMA received 169 letters from 101 inmates.

Inmates who write to the CMA were referred first to the DC grievance process to attempt to resolve their problems if they have not already filed a grievance on the issue. In some cases, grievances have been denied and inmates write requesting the CMA's help in addressing their concern. Because the CMA is not authorized to direct staff in DC institutions or to require that specific actions be taken by the Department, inmate letters relating to health care issues were sent to OHS for investigation and response. In cases relating to security or other issues, the letters were referred to the Department's Inspector General or General Counsel. The CMA responds directly to inmates and 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.

2009-10 Survey Activities

Introduction

During FY 2009-10 CMA staff conducted 15 on-site institutional surveys to evaluate the provision of both physical and mental health services. The table below displays the correctional institutions (CI) and facilities (CF) surveyed by region:

Region 1 Calhoun (CALCI) Apalachee East & West Units (ACI) Century (CENCI) Bay (BAYCF) Okaloosa (OKACI)	Region 2 Lancaster (LANCI) Mayo (MAYCI) Lawtey (LAWCI)
Region 3 Lowell Main & Annex (LOWCI) Brevard (BRECI) Polk (POLCI)	Region 4 Hardee (HARCI) Indian River (IRCI) Glades (GLACI) Charlotte (CHARCI)

Generally, institutions were selected for surveys based on the date of the most recent 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>.

The CMA contracts with a variety of licensed community and public health care practitioners, including physicians, psychiatrists, dentists, nurses, psychologists, and other mental health professionals to conduct surveys. The survey process includes a clinical review of the physical, dental, and mental health care provided at each institution. Cases selected for review are representative of inmates who were receiving mental and/

or physical health services (or who were eligible to receive such services). In order to appear in the final report, there must be a finding of non-compliance with the standard in at least twenty percent of records reviewed in the selected sample to which the standard applies. Administrative issues such as the existence and application of written policies and procedures, staff credentials, staff training, and confinement practices are also reviewed.

Survey Findings, FY 2009-10

For the purpose 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. This may be reflected in documentation of quality management activities, intra-system transfer processes, Offender-Based Information System (OBIS) updates, physical plant issues, or mental health logs not consistently completed.

As reflected in the following tables, in no cases were all institutions found to have deficiencies in all the areas identified. The findings that required corrective action are identified below and represent only those that were noted at three or more institutions

except that all female-specific findings at LOWCI were included. It is important to note that of the 15 institutions surveyed only five house S3 grade inmates and are staffed to provide psychiatric services. Inmates at the remaining 10 institutions may receive psychological services only and must be transferred if psychotropic medications are needed. All mental health findings for inpatient services were included since CHARCI was the only institution providing inpatient services that was surveyed this year. Also, since LOWCI was the only reception center surveyed, all mental health findings related to reception screening were included.

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.
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Physical Health Clinical and Administrative Findings	
Medication Administration	Medication orders were not consistently signed, dated, and/or timed. (POLCI, LANCI, CALCI, HARCI, LOWCI ANNEX AND MAIN, CENCI, ACI EAST & WEST)
Administrative Systems	Problem lists were not consistently current or complete. (CALCI, MAYCI, LANCI, LOWCI ANNEX, CENCI, CHARCI, ACI EAST & WEST, OKACI, BRECI)
Infirmary	Discharge summaries were either not in the record or did not consistently contain required information. (LANCI, CENCI, CHARCI)
General Record Review	Records contained significant legibility issues. (OKACI, CHARCI, ACI WEST)
Cardiovascular Clinic	Annual fundoscopic examinations were not consistently documented. (LANCI, LOWCI ANNEX, CENCI, ACI EAST)
Neurology Clinic	<p>Records lacked clear, consistent evidence that:</p> <ul style="list-style-type: none"> • laboratory results were available prior to clinic visits; • test values were reviewed in a timely manner and abnormalities were addressed; and, • patients were considered for tapered medications either because of sub therapeutic values and/or patient was seizure-free for six months or more. <p>(POLCI, HARCI, CHARCI)</p> <p>Records lacked clear, consistent evidence that the type and/or frequency of seizure and/or cause of any acute complications were consistently documented. (POLCI, ACI EAST & WEST, HARCI, CHARCI)</p>
Preventive Care	Baseline mammography studies, the current mammogram, and pap smears were not consistently found in the current volume of the record. (LOWCI ANNEX)

Discussion – Physical Health

The FY 2009-10 survey schedule was revised to include a survey of LOWCI. The three units that comprise LOWCI (Lowell Main Unit, Lowell Annex, and Lowell Work Camp) house approximately 2,800 women, 44 percent of the entire DC female population. Because of the large population, the characteristics of the inmates at LOWCI, the findings identified in previous surveys dating back to 2006, and recent monitoring reports from OHS, a survey was conducted in February 2010. After the scheduled survey, the CMA staff followed up with a corrective action plan (CAP) assessment in September 2010. While many findings were closed, several remain open including timely follow-up on consultation reports which has been an ongoing issue at LOWCI.

Mental Health Clinical and Administrative Findings	
Psychiatric Restraints	<p>Records did not consistently contain adequate documentation to warrant the use of restraints. (CHARCI)</p> <p>Records did not consistently contain adequate documentation of the restraint episode. (CHARCI)</p>
Inpatient Psychotropic Medication Practices	<p>Initial laboratory reports and/or follow-up for abnormal laboratory results were not consistently completed as required. (CHARCI)</p> <p>Physician's orders for Emergency Treatment Orders (ETO) were not consistently timed or dated. (CHARCI)</p> <p>Psychiatric evaluations or admission notes were not consistently completed within the required timeframe. (CHARCI)</p>
Outpatient Psychotropic Medication Practices	<p>Physician's orders were not consistently dated, timed, and/or stamped. (LOWCI ANNEX, ACI EAST & WEST)</p> <p>Initial laboratory reports and/or follow-up for abnormal laboratory results were not consistently completed as required. (LANCI, LOWCI MAIN & ANNEX, ACI EAST, CHARCI, BRECI)</p> <p>Assessment of Involuntary Movement Scale (AIMS) testing at appropriate levels (required to ensure no adverse reaction to medications) was not consistently documented. (LOWCI MAIN & ANNEX, CHARCI, ACI EAST & WEST)</p> <p>Inmate signatures were not consistently documented on medication consent forms. (LANCI, LOWCI MAIN & ANNEX, CHARCI)</p>

Mental Health Clinical and Administrative Findings	
Outpatient Psychotropic Medication Practices (cont'd)	Psychiatric evaluations were either not consistently present in the record or completed within the required timeframe. (LOWCI MAIN & ANNEX, ACI EAST, BRECI)
Reception	<p>Medications prescribed at the county jail were not consistently continued until the inmate could be seen by the psychiatrist. (LOWCI ANNEX)</p> <p>Inmates were not consistently evaluated by the psychiatrist within the required timeframe. (LOWCI ANNEX)</p> <p>The suicide profile was not consistently completed. (LOWCI ANNEX)</p> <p>Past treatment records were not consistently requested from community providers. (LOWCI ANNEX)</p>
Inpatient Mental Health Services	<p>A risk assessment for violence was not consistently completed within the required timeframe. (CHARCI)</p> <p>Weekly group notes documenting the inmate's participation were not consistently completed. (CHARCI)</p>
Outpatient Mental Health Services	<p>Individualized Service Plans (ISP) were not consistently completed and/or reviewed within the required time frame. (LANCI, LOWCI MAIN, CHARCI, ACI EAST)</p> <p>ISPs did not consistently contain staff or inmate signatures. (LANCI, LOWCI MAIN, CHARCI, ACI EAST & WEST)</p> <p>ISPs were not consistently individualized. (LOWCI ANNEX, CHARCI, BRECI)</p>

Mental Health Clinical and Administrative Findings	
Outpatient Mental Health Services (cont'd)	Case managers were not consistently assigned to eligible inmates within the required time frame. (LOWCI MAIN & ANNEX, CHARCI)
Special Housing (Confinement)	Mental health status exams were not consistently completed within the required time frame. (POLCI, CHARCI, ACI EAST) “Mental Status of Confinement Inmates” (Form DC4-528) was not consistently completed after each mental status exam. (POLCI, ACI EAST, BRECI)
Access to Care	Inmate requests were not consistently answered. (LOWCI MAIN, CHARCI, ACI EAST) Consent for treatment was not consistently obtained prior to conducting an interview in response to an inmate request. (POLCI, CENCI, OKACI)
Self-Harm Observation Status	Notes and/or orders were not consistently signed and/or dated. (CALCI, LOWCI ANNEX, CHARCI, BRECI)
Administrative Issues	Mental health logs were not consistently complete. (LOWCI MAIN, CHARCI, BRECI)

Discussion – Mental Health

On July 1, 2009 Correctional Medical Services (CMS) assumed responsibility for the provision of mental health services in Region IV. The Department requested that scheduled surveys in Region IV be postponed to 2010 so that CMS would have an opportunity to complete the transition from the previous provider. The survey of CHARCI originally scheduled for October 2009 was rescheduled for January 2010. Prior to the CMA survey, the OHS completed a monitoring visit at the institution in November 2009 and required corrective action. The January 2010 CMA survey resulted in 31 mental health findings and many are included in the table above. Findings were related to the disorganization of medical records, inconsistent completion of required assessments, and poor documentation of treatment planning activities. Because of the number of findings related to inadequate documentation at Charlotte CI, surveyors recommended that CMS evaluate staffing levels to ensure inmates have adequate access to mental health services. An on-site CAP assessment at CHARCI was conducted on July 9, 2010. Of the 31 original findings, 19 were closed. The second CAP assessment of CHARCI was conducted on October 15, 2010. Four of the original findings remain open. A third CAP assessment and review focusing on inpatient services will be conducted in approximately three months.

Recommendations FY 2009-10

Based on survey findings the CMA makes the following recommendations:

Physical Health

- Ensure medication orders are signed, dated, and timed by the ordering clinician.
 - Determine a method to guarantee that problem lists are current and complete to provide an ongoing guide for reviewing the health status of patients and planning appropriate care. (Also a finding in FY 2008-09.)
-

- Ensure that hypertensive inmates enrolled in cardiology clinic receive annual fundoscopic examinations.
- Ensure training is provided on the need for consistently writing complete discharge planning summaries for those inmates admitted to the infirmary.
- Emphasize the importance of legible handwriting for accuracy of treatment.
- Provide additional training to clinicians providing care for inmates enrolled in neurology clinics, including documenting the type and frequency of seizures and the cause of any acute complications.
- Provide training to ensure that baseline and current mammograms and pap smears are documented in the current volume of the medical record.

Mental Health

- Due to the increasing number of women entering the correctional system, consider increasing the number of inpatient beds for female inmates.
 - Ensure department procedures are followed when utilizing emergency treatment orders and psychiatric restraints.
 - Ensure indicated laboratory studies are ordered for inmates prescribed psychiatric medication and steps are taken to address abnormal results in a timely manner. (Also a finding in FY 2008-09.)
 - Ensure inmates in the reception process receive all required assessments and services.
 - Ensure timely and specific documentation of inmates' participation in group activities in inpatient units.
 - Ensure timely assessment of inmates for risk of violence upon admission to inpatient units.
 - Ensure complete and timely documentation of ISPs, psychiatric follow-up contacts, and AIMS testing. (Also a finding in FY 2008-09.)
-

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 of the publication of the report the Department submits a CAP to the CMA. 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 continues to encourage regional management and institutional health care staff to successfully close CAPs during the CMA's first review. Through the CAP process, central office, regional, and institutional OHS staff have fostered a positive atmosphere, focusing on the process of quality improvement as an opportunity for growth rather than a punitive exercise.

2009-2010 CMA CAP Monitoring Schedule

Institution	Survey Date	1st CAP Date	2nd CAP Date	3rd Cap Date	Open / Closed
Mayo	July 13-15, 2009	No findings	N/A	N/A	N/A
Polk	August 11-14, 2009	January 21, 2010	N/A	N/A	Closed
Calhoun	September 22-25, 2009	March 15, 2010	N/A	N/A	Closed
Lancaster	October 21-23, 2009	April 6, 2010	N/A	N/A	Closed
Bay	November 16-18, 2009	March 29, 2010	N/A	N/A	Closed
Lawtey	December 9-11, 2009	April 27, 2010	N/A	N/A	Closed
Charlotte	January 12-15, 2010	July 9, 2010	October 15, 2010	March 2011	Open
Century	January 26-29, 2010	June 29, 2010	December 17, 2010	N/A	Closed
Lowell	February 23-26, 2010	September 3, 2010	January 2011	N/A	Open
Apalachee	March 9-12, 2010	October 28, 2010	February 2011	N/A	Open
Hardee	April 13-16, 2010	September 13, 2010	N/A	N/A	Closed
Okaloosa	May 11-14, 2010	December 16, 2010	N/A	N/A	Closed
Indian River	June 7-8, 2010	No findings	N/A	N/A	N/A
Glades	June 8-11, 2010	November 18, 2010	N/A	N/A	Closed
Brevard	June 22-25, 2010	December 10, 2010	March 2011	N/A	Open

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 is in the process of completing a major revision of its entire quality management process. This has involved developing monitoring tools that will provide more meaningful data, including corrective action plans, as well as updating all related HSB's. All proposed revisions were provided to the CMA for the QMC to review. In May 2010 a special meeting of the QMC occurred specifically to discuss the proposed QM revisions. The Department also piloted their new quality management tools at a few select institutions in order to receive feedback from the field prior to

implementation. One of the recommendations in last year's annual report was that revisions to the Department's quality management program be completed and implemented prior to the end of FY 2009-10. Although the process is not complete yet, the revisions to the quality management process are expected to be in place by January 2011.

In addition, OHS is analyzing selected quality indicators in an effort to validate clinical approaches and to target areas needing improvement. For example, in January OHS conducted a study comparing results from Endocrine Clinics at nine DC correctional institutions with community health plans in the Southeast United States as reported through the National Committee for Quality Assurance's HEDIS (Healthcare Effectiveness Data and Information Set). The HEDIS is used by more than 90 percent of health plans to measure performance. In the study, DC outperformed the national average for three major quality indicators:

1. Patients receiving HbA1C testing (DC – 98 percent, Southeast U.S. top 25 Health Plans – 90 percent).
2. Patients whose HbA1C control (>9 percent of all patients) was poor (DC – 6 percent; Southeast U.S. top 25 health Plans – 27 percent).
3. Eye Exam testing (DC – 74 percent; Southeast U.S. Top 25 Health Plans – 51 percent).

During the course of the study, the Department also discovered the rate of lipid level screening (LDLC) at the selected DC institutions was significantly lower than the community health plan average (DC-42 percent; Top 25 Plans – 85percent). As a result, the Department initiated a training program for chief health officers, physicians, ARNPs and clinical associates that stressed the importance of providing annual basic metabolic panel (BMP), lipid profile, urine dipstick and fundoscopic exams for diabetic inmates.

Mortality Review Process

The primary focus of the CMA QMC during FY 2009-10 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 standard meetings in FY 2009-10, 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 the review, whether there was any difference of opinion among reviewers), and any corrective actions taken based on the review outcome.

Suicide Mortalities

The CMA QMC reviewed six suicide charts in June 2010 as part of the yearly mortality review process. The format of the meeting is similar to the regular mortality review process, except that a psychiatrist reviews and presents the information for the committee. During FY 2009-10 the Department reported eight deaths by suicide. Although recent national data are not available, historically the Department has had a suicide rate significantly lower than the national rate for both prisons and the general public.

Budget and Personnel

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.

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 Reception and Medical Center at Lake Butler (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 as recommended 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 workgroup 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.

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.

Legislation Relating to Health Services

During the 2009 Session, the Department proposed two substantive legislative issues relating to health services, both 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 Expenditures

Over the last three years thorough operational control, implementation of proven cost control strategies, and diligent management of contracts, OHS has managed to make a dramatic difference in expenditures for health services. This is demonstrated in the shift from a budget deficit of \$55 million in FY 2007-08 to a \$26 million surplus in 2009-10. The per diem cost of health care has declined since a ten year high of \$13.04 per inmate in FY 2007-08 to last fiscal year's per diem of \$12.17. In spite of a slight increase in per diem from FY 2008-09 to 2009-10, there was still a 6.67 percent decrease over two years.

Fiscal Year	Per Diem	Percent Increase or (-Decrease) from Previous Year
2002-2003	\$10.91	
2003-2004	\$11.18	2.5%
2004-2005	\$11.44	2.32%
2005-2006	\$11.54	0.87%
2006-2007	\$12.23	6.26%
2007-2008	\$13.04	6.62%
2008-2009	\$11.84	(-9.20%)
2009-2010	\$12.17	2.79%

OHS Legislative Budget Request for FY 2010-11

The workgroup convened in November 2009 to review the DC budget request for FY 2010-11 and to develop recommendations for the CMA to submit to the Legislature and Governor. The Department submitted a FY 2010-11 OHS budget request for \$448,005,711. In light of the current fiscal situation and per instructions from the Director of the Governor's Office of Policy and Budget, this request included only

annualization of health care costs for new beds brought on line last year and workload for new beds opening during the 2010-11 fiscal year. Included in the request were 197 FTEs for health services. These positions required an allocation of FTE's and a fund shift from expenditure categories in Inmate Health Services to Salaries and Benefits. The conversion of these positions would allow OHS to continue to reduce reliance on contract agency health care personnel for nursing services.

Also included in the Fixed Capital Outlay portion of the budget was a request for a 200-bed female mental health inpatient unit at Lowell Correctional Institution. This unit would provide 200 specialized beds for mental health treatment of female inmates. Currently DC has only one inpatient mental health facility for women, located at Broward CI. The Department reports that this facility is inadequate to meet the future needs of female inmates requiring inpatient treatment. The Council of State Governments Justice Center reports that the rate of serious mental illness among female offenders is more than double the rate among male offenders. In the DC, over 42 percent of the female population suffers from a serious mental illness that requires ongoing mental health treatment.

According to the Department, the female population has increased nearly 20 percent over the past three years and as of September 2009 there were 7,028 female inmates in custody. Based on Criminal Justice Estimating Conference projections (February 2009), the Department estimates that there will be approximately 8,944 female inmates (7.2 percent of the total inmate population) by June 2014. Meeting the mental health needs of female inmates will become increasingly difficult without sufficient inpatient beds. Currently there are 1,083 inpatient beds for male inmates and 27 for female inmates. Taking into account only those inmates who are assigned psychiatric grade S3 or higher,

the ratio of inpatient beds is one bed per 11 male inmates and one bed per 37 female inmates. This indicates that women have significantly poorer access to inpatient care, especially given the higher incidence of mental illness in the female inmate population. The need for this unit was further demonstrated by the CMA survey of Lowell Correctional Institution completed in February 2010. At the time of the survey, 103 of the 151 confinement beds were occupied by inmates classified as psychological grade 3 – the highest outpatient classification. Further, all 12 of the isolation management rooms (IMR) were occupied; in one case the inmate had been in the IMR for 58 days awaiting transfer to a CSU. Combined with the number of psychological emergencies at Lowell, this indicates a serious unmet need for inpatient psychiatric care. Inmates with serious mental illness frequently present management problems on the compound and without access to appropriate alternate housing, such as a transitional care unit or crisis stabilization unit they are at risk for placement in confinement. Confinement settings are unsuitable for long term placement of inmates with mental illness and create increased demand on health care providers and security staff as well as placing inmates at higher risk for self harm.

Based on the progress OHS has made in addressing clinical and management issues in Region IV through the conversion of contracted positions to Department employees, the CMA supported the request for allocation of 197 FTE's and the fund shift. In addition, the Board expressed their strong support for consideration of the request for additional inpatient beds for female inmates noting that these beds are necessary to ensure access to appropriate mental health care for these inmates.

FY 2010-11 Appropriations Act

The final total appropriation to OHS was \$410,171,084 and 2,951.5 FTEs. The

requested 197 FTEs to reduce the use of contract staffing were funded by a transfer of \$14,214,562 to salaries and benefits. Other than annualization and health services workload for new facilities, there were no other additional issues funded. Rather there were significant reductions due to estimates of a slower increase in the prison population, policy decisions regarding opening new facilities, and to account for savings based on successful cost containment activities. The \$33 million in reductions to health services included:

Reduced funding based on CJEC estimates:	\$5,940,264
Deduction for opening of Blackwater CI by private vendor:	\$7,518,012
Savings from health services efficiencies:	\$17,500,000
Savings from drug repackaging contract with DOH:	\$1,500,000

Although OHS was appropriated 197 FTE's for conversion of contract employees to state employees, these positions and 11 additional positions were transferred from health services to other budget entities in DC before they were converted. Position cuts across the entire Department, especially in security-related functions, necessitated the transfer of these FTEs to areas of critical need.

Health Services Management and Cost Containment

The Department is continually challenged to provide health and mental health services to over 100,000 inmates in its custody. Meeting the health care needs of this population is complicated by the increasing numbers of older inmates (16 percent of the population in June 2010 up from 11.6 percent in June 2005), the number of inmates with a serious mental illness, and the escalating cost of health care.¹⁰ The Bureau of Labor Statistics

10. Florida Department of Corrections, Office of Research and Data Analysis, Population projection -ad hoc report via personal communication, August 2010.

reports that from July 1, 2009 through June 30, 2010, medical care costs increased overall by 3.5 percent and hospital and related services increased by 7.4 percent.¹¹ In spite of steadily increasing health care costs, the Department has been successful in controlling increases in health care 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. During FY 2009-10, OHS implemented a number of new initiatives and continued to partner with public and private sector organizations on projects designed to improve clinical outcomes and make the most efficient use of limited resources. Through informed cost management leadership, these changes have been generally successful in reducing or controlling expenditures and have been implemented in concert with a focus on ensuring quality and appropriateness of care consistent with constitutional standards.

Reduction in Use of Contracted Staff

During FY 2009-10 the Department continued its efforts to reduce the use of temporary nurse staffing. Use of private agency nursing staff costs between \$8 and \$10 more per hour than regular full-time state employees in comparable positions. By employing a more consistent, stable workforce, OHS is better positioned to implement evidenced-based medicine approaches and improvements in utilization management that improve care and reduce costs. During FY 2009-10, OHS reduced spending for nurse agency staffing by more than \$1.6 million from FY 2008-09 levels. The Department procured a nurse scheduling software system to help standardize the scheduling of health services nursing staff. This software will improve the efficiency of the scheduling process at each institution and provide tools (reports, etc.) to help management oversee nurse utilization throughout the state.

11. US Dept. of Labor, Bureau of Labor Statistics, Consumer Price Index, June 2010 at: http://www.bls.gov/news.release/archives/cpi_07162010.pdf

The OHS also reorganized its nursing staff to create a more effective and comprehensive infection control program. The responsibility for oversight of the TB Program was transferred from the assistant director of nursing to the infection control RN Consultant. Regional RN Specialist positions were established for all four regions to work with institutional staff on infection control and provide technical assistance and consultation on infection control standards and policies. The infection control RN specialists facilitate contact and outbreak investigations, communicate with outside agencies, collect and report data, train new institutional infection control nurses, attend regional and institutional meetings, make presentations on a variety of infection control issues, and conduct quarterly site visits.

Community Providers

During the 2009 Session, the Florida Legislature enacted legislation providing that when the Department does not have a contract with hospitals, health care providers, diagnostic services, emergency transport services, and ambulatory surgical centers the reimbursement rate could not exceed 110 percent of the Medicare allowable rate. The only exception to this limit 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 FY 2009-10, the Department realized savings of more than \$24 million over the previous year as a result of this statutory provision.

Utilization Management

Inmates who require specialty care or surgery that cannot be provided on-site at their assigned institution may be transferred to RMC, the Department's licensed hospital. When inmates require a more intense level of care or highly specialized procedures they

are transferred to community hospitals and ambulatory surgical centers. Over the last two years, OHS has revised and strengthened its health services utilization management (UM) program. Several program components including an updated database and new procedures for the management of care were instituted and six new Registered Nurse Consultant (RNC) positions were hired to implement the revised program. The UM program includes increased oversight through improved case management of inmates who require specialty services and medical procedures. A utilization management RNC was placed in each of the four regions 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.

Memorial Hospital of Jacksonville has a 33 bed secure unit entirely dedicated to DC patients and an additional six dedicated critical care beds in the Intensive Care Unit. Memorial Hospital is the largest community hospital provider for DC with approximately \$30 million per year in expenditures. The Department has contracted with hospitalist groups to provide care at both Memorial Hospital and RMC to improve management of care and reduce cost, especially in critical and catastrophic cases. On July 17, 2009, a 24 bed secure medical unit at Kendall Hospital opened to provide care for inmates in the southern region of the state. This required no additional

expenditures by the state as Kendall Hospital covered the cost of renovation of vacant space. The hospital's location in the middle of DC's southeast Region IV western corridor will reduce the security and transport costs associated with transporting severely ill inmates to RMC. Kendall Hospital offers an enhanced network of specialists and higher intensity services, as well as providing a quality of care consistent with community standards in a secure environment. During FY 2009-10 the Department also began a major renovation of F-Dorm at South Florida Reception Center to create 84 additional beds in the correctional system for long-term care. The unit opened on October 11, 2010.

In October 2009, the Department transferred pregnant inmates housed at Lowell CI to Broward CI. Housing all pregnant inmates at Broward CI ensures closer proximity of medical specialists at Kendall to assist with management of complicated pregnancies. In addition, the Regional Medical Executive Director in Region IV, who specializes in OB/GYN care, provides an additional level of oversight for these patients at least one day per week.

Over the past year, through UM efficiencies and continuing to aggressively pursue efficiencies in referral to outside specialty physicians and treatment of inmates at outside hospitals OHS has avoided more than \$8 million in health care expenditures.

Pharmacy Services

Health care providers in DC write approximately two million prescriptions in a given year for the over 138,000 inmates in their custody during that period. 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 contracted with a private company that repackages bulk drugs into bingo cards. On July 1, 2009 the Department began an interagency agreement with the Department of Health's (DOH) Statewide Central Pharmacy to provide pharmaceutical repackaging services for DC pharmacies transitioning these services from the private vendor to DOH. This transition was completed in February 2010 saving approximately \$1.4 million on drug repackaging costs during FY 2009-10.

The Department has also upgraded pharmacy software with bar code scanning to increase efficiency and accuracy for both pharmacy and nursing staff. In addition, pharmacy information has been interfaced with the eOHS (electronic OHS) record using a nightly download of patient pharmacy profiles. This assists the prescribers in monitoring drug compliance of patients and gives them a history of medications prescribed. Implementation of the bar coding system in the RMC hospital is also in progress to improve accuracy and accountability for medications given to inpatients.

STD/HIV Program

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 with the Department.

Services to inmates are rendered through local DOH county health departments (CHD), 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 2009-10 teams at the Alachua and Jackson CHDs 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 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. In FY 2009-10, 1,199 inmates known to be HIV-infected returned to their communities after release from DC custody. Inmates who are HIV positive or who have communicable diseases 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. 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 are expected to be expanded statewide after the pilot sites are evaluated. The Department reports that net savings of \$4,902,457 in pharmacy costs were achieved in FY 2009-10 as a result of this partnership. Proposed expansion of this program to four more CHDs to cover 20 additional institutions is projected to save an additional \$600,000 monthly (\$7.2 million annually).

Under a grant from the Department of Health, DC continues to support inmates with HIV/AIDS who are reaching their end-of-sentence. The HIV Pre-Release Planning Program counselors provide counseling and education to inmates informing them about their rights and options and encouraging them to continue to seek appropriate medical care after release. In south Florida, a linkage coordinator follows up with inmates after their release to determine if they have sought care, and to provide additional information on local community resources if needed. This program involves partnerships with hundreds of community organizations that provide services to ex-offender patients with HIV/AIDS.

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. During both the 2009 and 2010 Legislative session, FTE positions were created in OHS to complete the 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. On September 25, 2009 the conversion of all other contracted health services staff in Region IV was completed when medical staff at the remaining eight institutions in the region became DC employees. Mental health services in Region IV continue to be provided by a private contractor.

Mental Health

The Department is tracking self-injurious behavior with no/low suicidal intent and

reporting incidents daily to raise awareness of this critical issue. Work has begun on developing a database of inmates that have been transferred for outside hospital care for their repeated self-injurious behaviors. This initiative is designed to quantitatively and objectively identify the multiple characteristics (psychological, demographic, etc.) of inmates who engage in serial self-injurious behaviors, and to create a Self-Injury Profiling System (SIPS).

During FY 2009-10 the Department executed a Memorandum of Agreement with the U.S. Department of Veterans Affairs. Under the terms of the agreement DC and the VA will collaborate to implement re-entry programs and services for inmates identified as military veterans potentially eligible for VA care upon release from incarceration and veteran ex-offenders on community supervision. Programs and services for these veterans may include mental health services, medical care, substance abuse treatment, and housing assistance. Mental health staff from OHS played a key role in developing the agreement with the VA, which was executed by Secretary McNeil on November 12th, 2009 in honor of Veteran's Day.

Administration

The Department's current Offender Based Information System (OBIS) has the capacity to track some basic information about an inmate's health status such as dates of contacts with medical staff, appointments, and status of medical passes. However, when OBIS came on line in the early 1990's it was never intended to serve as a medical record system. Health services employees in DC spend a significant amount of time coordinating the maintenance, transport, and storage of medical records. In addition to being inefficient in a health care system with over 100,000 patients, paper records can be damaged or lost especially given the number of times inmates move among

institutions. Inmates who spend many years in the prison system often have multiple volumes of records. The implementation of electronic health records in a system as large as DC may result in improved patient care, enhanced legibility of record entries, ease of transfer to other institutions, and use of less storage space. To address this challenge, the Department's Office of Information Technology developed eOHS, a windows-based system that allows users to record medical notes, communicate with OBIS and other DC systems simultaneously, and merge the information into one data screen. Because the program is more intuitive and user friendly than the DOS-based OBIS system it is expected to yield substantial administrative and clinical efficiencies for the Department. In late FY 2009-10, OHS staff began implementing this new solution at ten institutions. Pharmacy information has also been interfaced with the eOHS System using a nightly download of patient pharmacy profiles. This assists prescribers in monitoring drug compliance of patients and gives them a history of medications prescribed for patients.

The Department has acquired computer equipment and information technology infrastructure to support the transition to eOHS in the remaining institutions over the next several years. This will greatly enhance OHS's ability to implement evidenced-based medicine, reduce prescribing errors and repeat procedures, and support improvements in utilization management. Given that resources for development of an electronic medical record are not likely to be available in the near future, the Department has developed a system that will improve both patient care and administrative function.

Summary

Operational and cost-efficiency strategies have shifted a \$55 million deficit in FY 2007-08 to a \$26 million surplus in FY 2009-10. During the last year OHS has continued to

work with regional and institutional health services staff to strengthen the management structure of the service delivery system and to assure that resources are used in the most efficient manner possible in the delivery of medical care to inmates. These initiatives 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.

Aging and Older Inmates in the Florida Department of Corrections 2009-10

The aging prison population and the impact older inmates have on correctional agencies has become one of the more pressing public policy issues facing state governments in recent years. Decades of sentencing reform resulting in harsher penalties and reduction in the use of parole has contributed to growth in the prison population overall and elderly inmates are now the fastest growing cohort of the inmate population in most states. 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 of older offenders this trend will continue.

The Correctional Medical Authority (CMA) is required to report annually on the status of elderly inmates in Florida.¹ 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 of Corrections (DC or 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.²

1. Section 944.8041, Florida Statutes, 2009.

2. Ibid.

This report describes the population of inmates age 50 and over admitted to Florida's prisons during FY 2009-10 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. A discussion of some of the strategies employed in other states to address aging inmates is also included in the report. The DC Bureau of Research and Data Analysis provided the data on Florida inmates used in this report and the DC Office of Health Services (OHS) provided data on health costs and programs for older inmates.

Characteristics of Older and Aging Inmates

The age at which an inmate is considered "older" or "elderly" varies across state and federal jurisdictions. Florida classifies inmates age 50 and older as "aging or elderly."³ 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 (56 percent) of the responding states defined "older inmates" as persons older than age 50.⁴ 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, and in some cases the impact of stress and isolation from previous incarceration.

3. Chapter 33-601.217, Elderly Offender Housing, Florida Administrative Code.

4. 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.

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 2001.⁵ The average age of inmates in the U.S. has increased from 31 to 34.⁶ In Florida the average age of inmates has increased from 34.4 years on June 30, 2000 to 37.0 years on June 30, 2010.⁷ 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 3 times faster than the 9 percent growth in the overall prison population during that same period.⁸

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 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

5. 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.

6. 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>.

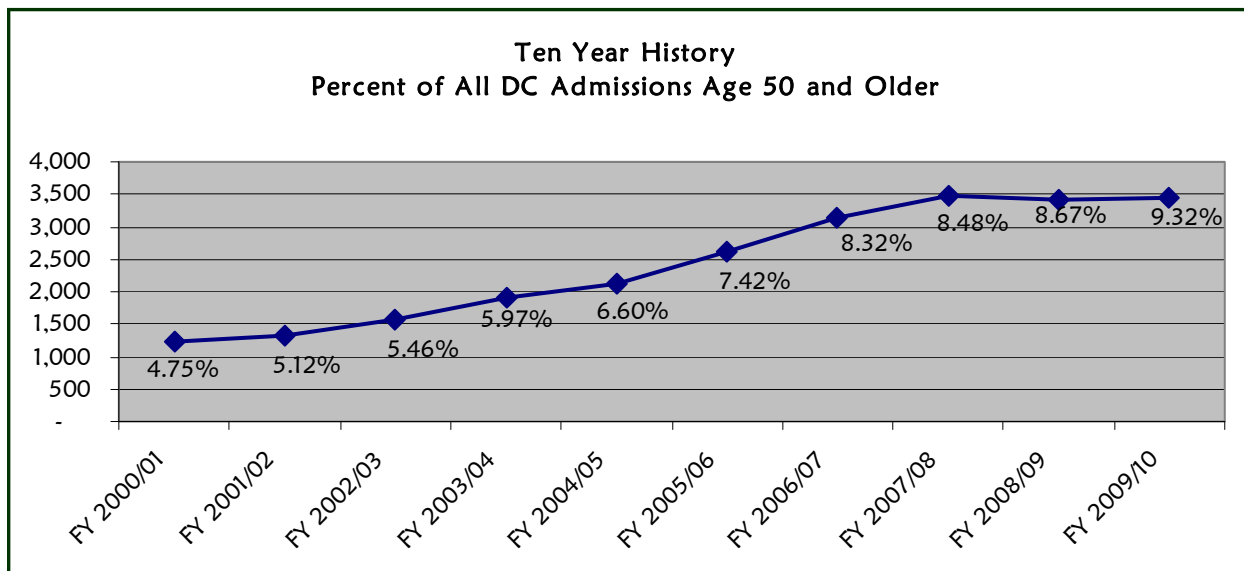
7. Department of Corrections, Bureau of Research and Data Analysis, August 12, 2010.

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

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.⁹

Population and Demographic Trends: Admissions 2009-10

During FY 2009-10 the number of admissions of older inmates to DC continued to increase as a percentage of total admissions. Although the total number of admissions to DC decreased by 6 percent from FY 2008-09, the percent of all admissions that were over age 50 increased by 1 percent. Compared to FY 2008-2009 when the age ≥ 50 admissions accounted for 8.67 percent (3,412) of all admissions, this year they accounted for 9.3 percent (3,448) of the 36,994 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 10 percent of all admissions by mid-year 2010.



9. Southern Legislative Conference, *The Aging Inmate Population: Southern States Outlook*, December 2006.

In FY 2009-10, 84 percent of older inmates admitted were between the ages of 50-59 years. Only 57 admissions, or 1.7 percent, were 70 or older. The average age of the oldest inmates (ten oldest males and ten oldest females) admitted during FY 2009-10 was 74; the oldest male inmate was 84 years old and the oldest female was 70 years old. The average age of the ten oldest male and female inmates admitted stayed the same in FY 2009-10 as it was the previous year; 81 years for male and 66 for females. Sentence length ranged from 1 year to 50 years or more (two male inmates had 50 year or more sentences). None of the females admitted had a sentence longer than 15 years and 11 of the 20 oldest inmates had sentences of 5 years or less.

The average age at admission for inmates age 50 and older for male inmates was 55.7 and 53.8 for female inmates. Older admissions were more likely to be white (55.4 percent) than admissions as a whole (50.5 percent) and older admissions were 91 percent male, slightly more than admissions as a whole (88.7 percent). Older admissions were more likely to have previous prison commitments than admissions as a whole; 76.8 percent of all admissions had only one or no previous commitments, while 58.1 percent of inmates age 50 or older had only one or no previous commitments.

Population and Demographic Trends: 2009/10 Population Age 50 and Older

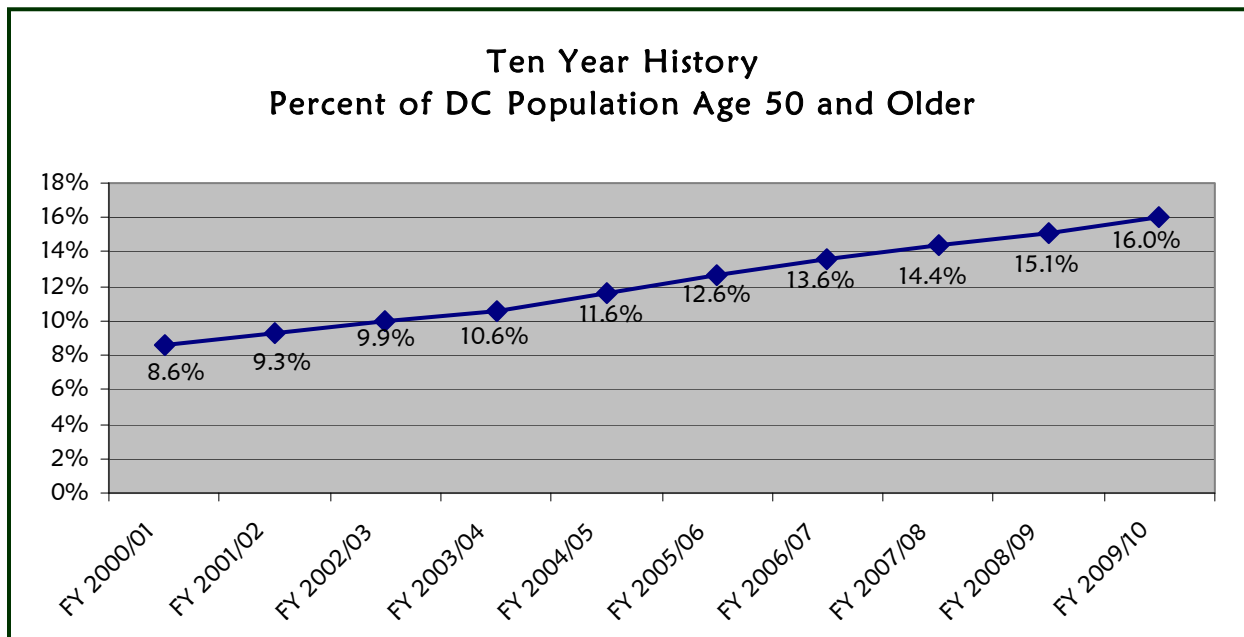
At the close of FY 2009-10 (June 30), the resident population of the prison system was 102,232 individuals. Inmates age 50 and older comprised 16 percent of that population, or 16,386 inmates. This represents a 7.8 percent increase in the older inmate cohort of the prison population over June 30, 2009 when there were 15,201 inmates age 50 and over, representing 15.1 percent of the total prison population. The June 30, 2010 older inmate population consisted of 3,448 inmates ≥ 50 admitted during the fiscal year; for 48 percent (7,858) of these inmates it was their first commitment. At any time during

the course of FY 2009-10 DC housed a total of 138,862 inmates. Of those inmates 15.4 percent (21,385) were age 50 or older.

Typical Inmate Age 50 and Older	
Male	95%
White	54%
Mean Age	56
First Commitment	48%
Median Sentence	15 years
Mean Sentence	24 years
Served less than 15 y	73%
Offenses	
1st Degree Murder or Attempt	11%
Sexual Battery victim < 12 yo	8%
2nd Degree Murder	6%

As of June 30, 2010 the oldest male inmate was 90 and was admitted to DC at age 82 with a 15 year sentence. The oldest female inmate was 91 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 87.5 and seven of the ten are serving a sentence of 50 years or more. The shortest sentence is the 90 year old with a fifteen year sentence. The ages of the ten oldest female inmates range from 76 to 91; the average age is 79.2 and three of the ten are serving a sentence of 50 years or more. The shortest sentence for the ten oldest female inmates is a 79 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 76 year old female inmate admitted at age 35.

Female inmates over age 50 accounted for 12.7 percent of all women in the prison population, 5.6 percent of inmates age 50 and older, but less than one percent (.9) of the entire prison population on June 30, 2010.



Of the 102,232 inmates in prison on June 30, 2010, 12,580 (12 percent) are expected to die during the course of their imprisonment. As could be expected, inmates age 50 and over are far more likely than younger inmates to die in prison. Although older inmates were 16 percent of the June 30, 2010 population, they represent 38 percent of all inmates expected to die in prison. Within the age cohort of all inmates over age 50 (16,386), almost one third (4,819) are expected to die in prison, and more than half (297) of all inmates over age 70 (408) will die in prison.

Housing Assignments

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.

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. Eleven facilities had older inmate populations that exceeded 25 percent of the total population. There has been a steady increase in the number of institutions with 25 percent or more of their population being age 50 or older; last fiscal year seven institutions had more than 25 percent older inmates and in FY 2007-08 it was only four facilities. 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. Of the four institutions with more than 50 percent of their population over age 50, two of those are specialty facilities with either palliative care (South Florida Reception Center) or palliative care and an intensive level of nursing care (Central Florida Reception Center), but this care is not specific to older inmates. One of the four, River Junction CI (RJWC), is a specialty work camp for older inmates who are assigned to work duties on the grounds of Florida State Hospital in Chattahoochee. 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 table on the next page displays the four institutions with the highest percentage of inmates age 50 or older.

Institution	Total Population	Population age 50 and older	Percent total population
CFRC-South	90	52	58%
Union C.I.	1,881	1,344	71%
SFRC South Unit	530	410	77%
River Junction Work Camp	369	320	87%

There are seven other CIs with over 25 percent of their population consisting of inmates age 50 and older. These institutions are Wakulla, Glades, Everglades, Hillsborough, Apalachee West Unit, Polk, and Zephyrhills. Most of these institutions have limited capacity for specialized programs for older inmates. 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.

Health Status of Older Inmates

The Department provided health services to 138,862 inmates (all inmates housed in DC during FY 2009-10). Every inmate is assigned a health classification at the time of his/her admission to the system. This classification includes a medical grade (M1 – M5, 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 or in-patient hospitalization. Impairment grades are assigned based on physical limitations, hearing impairment, visual impairment, or developmental disability. Of the 1,726 inmates with an assigned impairment grade at the end of FY 2009–10, approximately half (49 percent) were inmates age 50 or older.

Impairment	All Inmates with Impairment	Inmates > Age 50
Visual	268	41% (110)
Hearing	209	54% (11)
Physical	1,021	56% (576)
Developmental	228	18% (40)
TOTAL	1,726	49% (839)

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. Almost one third of the inmates issued a special pass are over age 50. The largest numbers of passes issued are for lower bunks (28,199); slightly more than one fourth of these passes are issued to an inmate over age 50.

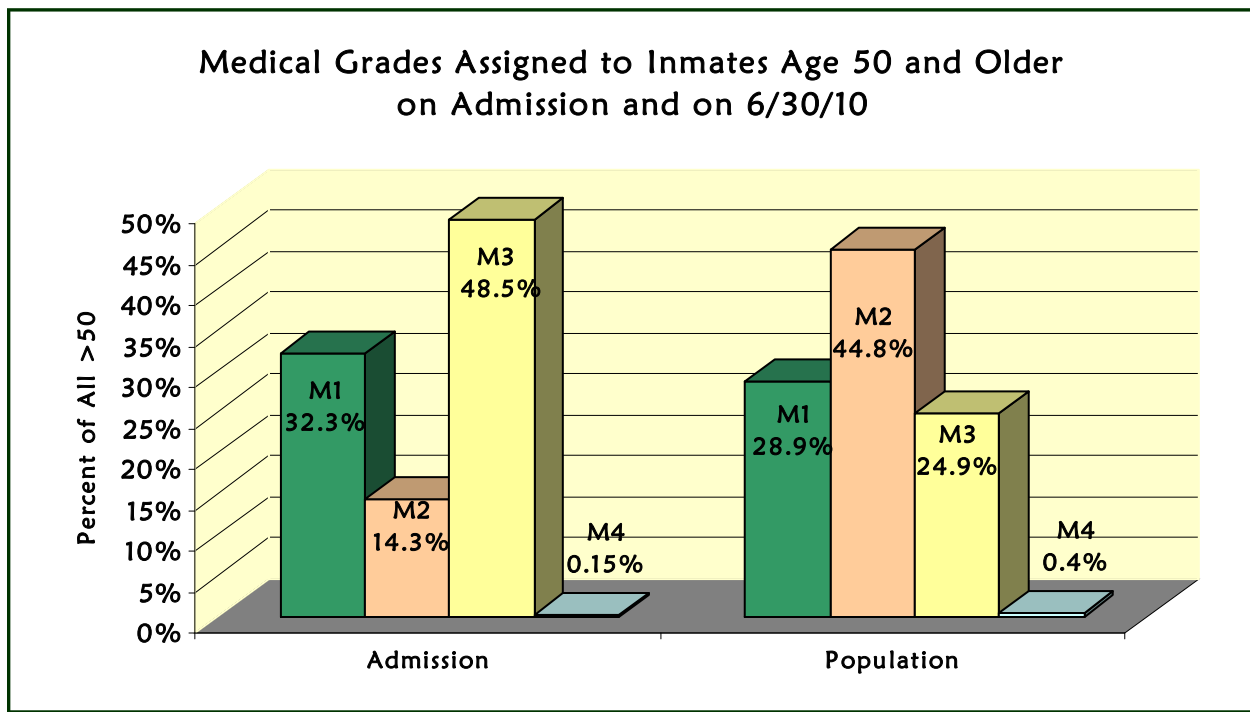
Health Services

In FY 2009-10, 68 percent of all DC admissions were classified as M1. Older inmates were more likely to be assessed as being in poorer health at admission than were inmates under age 50; 71 percent of inmates under 50 were M1 at admission compared to only 32 percent of inmates age 50 and older. Only 15 percent of younger inmates were M3 at admission compared to 49 percent of older inmates.

Although there were fewer older females admitted than younger females (336 versus 3,848), older women were significantly more likely to be M3 at admission versus younger women. Half of all women age 50 and older were M3 at admission compared to one in four women under 50.

There was more similarity between inmate age cohorts in regard to psychiatric grade (S grade) upon admission; 80 percent of inmates under age 50 were admitted as S1 compared to 73 percent of older inmates. Older inmates were only slightly more likely to be S2 or 3 at admission than were younger inmates.

The under age 50 population on June 30, 2010 was significantly more likely to be classified M1 (70 percent) than was the age 50 and over status population (29 percent). The older inmate population was also almost twice as likely to be M2 (45 percent) or 3 (25 percent) than the population as a whole (24 percent M2, 12 percent M3) or the under 50 population (20 percent M2, 9 percent M3).



The shift of older inmates to M2 from both M1 and M3 after initial assessment may be due to 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.

There was virtually no difference in the psychiatric grades assigned to older inmates at admission and the grades assigned in the status population. In both cases, approximately 13 percent of older inmates were S3 and 4 percent were S2.

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 2009-10, there were 1,653,921 sick call encounters for the 138,862 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 Group and Gender				
	All Inmates	Age < 50	Age > 50	Age > 65
Male Inmates	10.9	9.5	18.8	24.7
Female Inmates	22.4	20.8	34.3	40.3
All	11.9	10.5	19.8	25.2

Inmates with chronic illnesses are enrolled in various 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 54,495 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 343,581 chronic clinic encounters in FY 2009-10. Of those, 88 percent were by male inmates and 12 percent were by female inmates. Women utilize health services more frequently than men and this holds true in the correctional setting as well; women represent 8 percent of the number of inmates housed during the year but had 12 percent of the clinic visits as well as using sick call and emergency call at a rate approximately double that of male inmates. Older inmates are also overrepresented in the total clinic contacts; they represent 35 percent of all contacts but comprise only 16 percent of the total prison population.

Clinic Contacts for Inmates Age \geq 50					
CLINIC	Contacts—Inmates \geq 50			Contacts All Ages	Percent of All \geq 50
	Males	Females	Total		
Cardiovascular	49,595	4,560	54,155	124,185	43.6%
Endocrine	13,305	1,608	14,913	34,473	43.3%
Gastrointestinal	15,929	1,342	17,271	39,936	43.2%
Immunity	5,409	385	5,794	26,583	21.8%
Renal	583	8	591	1,250	47.3%
Miscellaneous	4,151	178	4,329	11,164	38.8%
Neurology	2,051	306	2,357	15,111	15.6%
Oncology	1,681	143	1,824	2,794	65.3%
Respiratory	9,038	1,270	10,308	38,556	26.7%
Tuberculosis	8,136	629	8,765	49,529	17.7%
TOTAL	109,878	10,429	120,307	34,3581	35.0%

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 2009-10, the Department paid \$88 million for community health care services to inmates, which included 17,174 days of scheduled and emergency hospitalizations, 2,937 ambulatory surgeries, 5,435 emergency room visits, and 51,415 examinations by specialty providers, and 21,801 ancillary services (laboratory tests, x-rays, EKGs, physical therapy). Of the 679 individuals who had multiple admissions to community hospitals, 42 percent were older inmates. Inmates over the age of 50 accounted for 40 percent of all episodes of care, 47 percent of all hospital days, and 35 percent of ambulatory surgeries although they represent only 16 percent of the total prison population. The average length of stay for older inmates for an emergency hospitalization averaged 1.5 days longer than for inmates under age 50 and 2.4 days longer for scheduled hospitalizations.

Prescription Drugs

In FY 2009-10 the Department dispensed 1,782,564 prescriptions to inmates in its custody. This is an average of 13 prescriptions per inmate for the 138,862 inmates in custody over the course of year. The 21,385 inmates age 50 and older in custody during the year were dispensed an average of 37 prescriptions per inmate.¹⁰ In FY 2009-10, the total prescription drug cost for inmates was \$74,016,821. This includes all regions, stock pharmaceuticals, and costs paid to DOH for HIV drugs. Of that amount, 24 percent (\$17,764,037) was spent on drugs for inmates age 50 or older.¹¹

10. Department of Corrections, Office of Health Services, personal communication, October 21, 2010.

11. Ibid.

Conclusions and Recommendations

The CMA has been reporting on Florida's aging inmates since 2001 and over the years a substantial volume of information regarding the status of older inmates in Florida and nationwide has been presented. For reasons primarily related to lack of resources and absence of public and political support, there has been little change in the approach to dealing with these inmates. For the same reasons it is unlikely there will be any significant change in policy and practice in the near future. The demands of caring for aging and elderly inmates will continue to have an impact on prison health care expenditures. 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.¹² 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. 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.

It is evident from the data presented here 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 because of their vulnerability and medical conditions. 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

12. 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.

limited resources available for health care and programmatic enhancements within the correctional setting. In a 2007 article on the impact of aging inmates on the U.S. criminal justice system, Rikard and Rosenberg noted 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 made 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.
- 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.¹³

The resources required to care for the aging inmate 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. However there are limited options for states attempting to manage the increasing population of older inmates and the concomitant increase in the cost of providing health care to this more at risk population. One frequently discussed but not often implemented strategy is the use of some

13. 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.

type of medical parole or “compassionate” release. Recently the Vera Institute did a statutory review of geriatric release policies in correctional systems. They reported that 15 states and the District of Columbia have some type of compassionate, medical, or geriatric release policy however these provisions are rarely used due to narrow eligibility criteria, complicated procedures and review processes, and political considerations.¹⁴

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 programs that address the needs of older inmates such as consolidation of older inmates at certain institutions and palliative care units. There has also been an enhanced focus on preventive care for all inmates which will benefit older inmates. Without a substantial increase in resources, it is unlikely that DC could implement significant program modifications or develop other specialized facilities specifically to meet the needs of older inmates. It is recommended that DC continue to develop facilities such as the palliative care units and the Zephyrhills unit as these programs can meet the needs of both aging inmates and other inmates with serious and terminal diseases.

14. Chiu, Tina, *It's About Time: Aging Prisoner, Increasing Costs, and Geriatric Release*, New York, Vera Institute of Justice, 2010.