REPORT ON THE HEALTH CARE DELIVERY OF THE FLORIDA DEPARTMENT OF CORRECTIONS

Prepared by

The State of Florida

Correctional Medical Authority

December 2005

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STATE OF FLORIDA
CORRECTIONAL MEDICAL AUTHORITY

December 23, 2005

Honorable Jeb Bush
Governor
State of Florida

Honorable Tom Lee
President
The Florida Senate

Honorable Allan Bense
Speaker
Florida House of Representatives

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

Pursuant to s. 945.6031(1) and 944.8041, F.S., the Correctional Medical Authority is pleased to submit its statutorily mandated reports on the health care services delivered by the Florida Department of Corrections and the status and treatment of elderly offenders in Florida's prison system. This year's annual report summarizes focused surveys conducted by the Authority during FY 2004 – 2005 as well as a summary of surveys of institutions with designated close management housing. The report on elderly inmates provides a snapshot of admissions and population during FY 2004 – 2005 and their use of services.

The Authority continues to support the State of Florida in its efforts to assure the provision of adequate health care by identifying issues that could compromise service delivery. This challenging task has required concerted efforts on the part of the Authority, the Department of Corrections and the Legislature. Your support has allowed us to complete this important work successfully.

We invite you to read about the activities of the past year and to question us further as we continue to monitor correctional health care in Florida.

Sincerely,

Murdina Campbell
Executive Director

Enclosure

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TABLE OF CONTENTS

Overview 1

Close Management Surveys 4

Focused Surveys 5

1. Intake and Reception Process 5
2. Intrasystem Transfer 7
3. Prerelease Planning 10
4. Suicide Observation Status 15
5. Psychotropic Medication Administration 17
6. Outpatient Mental Health Care at Lowell Correctional Institution 17

Follow-Up Monitoring 19

Budget and Personnel 20

Quality Management 26

References 33

Appendix 35

OVERVIEW

In 2004, the Governor and the House of Representatives recommended elimination of the Correctional Medical Authority (Authority). The 2004 legislative conference committee opted to continue the Authority's function, but with a fifty percent reduction of staff and budget. As detailed in the Authority's last annual report, this forced a critical examination of the ability, within reduced resources, to meet statutory mandates, including conducting at least triennial surveys at all major correctional institutions statewide.

Focused Reviews

The Authority and the Department of Corrections (Department) entered into an agreement whereby the Department's clinical quality review data were promptly submitted to the Authority for review. The data were then analyzed and compared with the Authority's historical data to identify whether there were systemic issues identified by both groups that might warrant follow-up or further review. The Authority then developed review instruments designed to place more emphasis on a systemic approach, rather than an individual institutional perspective. Recommendations for policy or procedure modifications that would enhance the system by which care is provided, always a goal of the Authority, became more of a focus. This process replaced the Authority's previous mode of operation in which a limited number of institutions surveyed each year worked toward correction of individual deficiencies. Additionally, the Authority began ongoing focused reviews in several areas historically identified as problematic.

FY 2004—2005
Areas of Review

- Intake and reception
- Intrasystem transfer
- Prerelease planning
  - Mental health continuity of care
  - Medical health continuity of care (specifically, HIV/AIDS and chronic conditions)
- Psychotropic medication administration
- Suicide observation status (SOS)
- Outpatient mental health care (Lowell CI)

In total, Authority staff visited 18 institutions to review specific components of care. (See Appendix.) In some areas, the reviews resulted in findings clearly indicating a need for more in-depth examination. In others, the results were less extensive, indicating isolated areas requiring attention by the Department, but probably not having system-wide negative implications. The results of those focused reviews are detailed in the body of this report.

In addition to the focused reviews described above, two other projects underway at the beginning of the fiscal year continued.

- Pursuant to the *Osterback v. Moore* settlement agreement, monitoring of institutions housing close management inmates.
- For triennial surveys conducted during fiscal years 2002—2004, concluding corrective action plans for institutions with unresolved citations.

Close Management Surveys

Authority staff conducted reviews at five close management (CM) institutions as part of the *Osterback v Moore* settlement agreement. (See Appendix.) The outcomes of these evaluations are detailed in the body of this report.

Follow-up Monitoring

Authority staff also continued follow-up monitoring for previously conducted routine triennial and CM surveys. (See Appendix.) Corrective action plan (CAP) assessments were conducted at two CM institutions surveyed during FY 2003—2004 and one CM institution reviewed during FY 2004—2005. Additionally, over 40 corrective action assessments occurred as part of finalizing the routine triennial survey process, with some institutions requiring two or more reviews. Nineteen institutions received an initial follow-up during the fiscal year. All institutional CAPs related to the triennial survey process are closed. More information on follow-up monitoring is included in the body of the report.

Budget and Personnel

The Office of Health Services (OHS) entered FY 2004—2005 with appropriations only minimally larger than the previous year's actual expenditures, while population projections indicated about 3,600 more inmates would require services during the fiscal year. The OHS developed initiatives to reduce hospitalization costs and stabilize its nursing staff in an effort to reduce expenditures, successfully ending FY 2004—2005 with a surplus. The outlook for FY 2005—2006 is more cautious, however, as legislative appropriations, when applied to projected population growth, result in a per diem rate no greater than FY 2004—2005 for the purchase of health care services and supplies. Detailed budget information is included in the body of the report.

Quality Management

Most of the Department's nine clinical quality management (QM) components function well and within expected parameters of an effective quality management program. Institutional reporting of Risk Management data remains inconsistent, not unlike previous years. The time frame to close a mortality review increased over the fiscal year, whereas the Authority had expected it to decrease based on innovative changes initiated by the Department. These innovations were delayed for reasons beyond the Department's control. Despite the increase in population, the Department's rate of death per thousand inmates remains stable. Internal evaluation of the effectiveness of its quality management program continues to challenge the Department due to limited resources within the QM section. Information on the QM program is detailed in the body of the report.

FY 2005—2006 Activities

The Authority again looks to the future. Plans continue to ensure its role remains vital to the Department, the Legislature and the Governor in offering advice on the provision of constitutionally defined and cost effective levels of medical, dental and mental health care to inmates. Six new gubernatorial appointees, who bring a wealth of health care practice, management and administrative skills, fill slots of board members whose terms expired. New leadership at the Chair and Executive Director levels of the Authority brings innovative ideas to the forefront. It is anticipated that over the course of the upcoming fiscal year, projects identified for study, some a continuation of projects begun during

FY 2004—2005, and others, newly selected, but mutually agreed upon by the Authority and the Department, will benefit all stakeholders.

CLOSE MANAGEMENT SURVEYS

In December 2001, the Department entered into a settlement agreement in a lawsuit entitled *Osterback v. Moore*. The lawsuit involved mentally ill inmates in a restricted setting called close management (CM). The purpose of the close management system is to confine inmates, separate from the general inmate population, for reasons of security and for the order and effective management of the institution. These inmates, because of their individual behaviors, have demonstrated an inability to live in the general population without abusing the rights and privileges of other inmates.

Key Department Responsibilities
Per the Osterback Settlement Agreement

- Reduce the number of CM institutions
- Facilitate more uniformity of program operations
- Perform mental health screening before and after CM placement to help ensure timely access to necessary mental health services
- Provide a full range of outpatient mental health services (e.g. group/individual counseling; case management; psychiatric consultation; psychotropic medications; and timely referral to inpatient care)
- Consolidate security, program, and mental health staff resources
- Conduct staff training on mental health issues relevant to the CM population
- Assess behavioral risks for each CM inmate to provide more objective information that will be useful for mental health service planning and administrative decision making
- Provide self-betterment/stimulation programming to CM inmates such as reading materials and social phone calls

The *Osterback* agreement included a stipulation that the Authority monitor provisions of the agreement. Monitoring efforts by the Authority began shortly thereafter. Detailed reports of all monitoring and corrective action assessment visits conducted by the Authority are provided to the Department. These reports can be found on the Authority's web site.

Monitoring visits were conducted at each close management institution during this fiscal year. A listing of the institutions surveyed and the dates of the visits can be found in the Appendix. Most findings were isolated to individual institutions and did not reflect trends that affected the CM system as a whole. Generally findings involved inconsistency in preparation or updating of behavior risk assessments or inconsistency in documenting requirements pertaining to suicide observation status.

During FY 2005—2006, Authority staff conducted follow-up visits at CM institutions to assess progress toward addressing deficiencies cited during the review process. At the four institutions reviewed thus far, all findings identified had been addressed by institutional staff to the extent the corrective action plans could be closed.

FOCUSED SURVEYS

1. Intake and Reception Process

According to the Bureau of Justice Statistics, Florida has the fourth highest prison incarceration rate in the United States. As of June 30, 2005 (FY 2004—2005), the Department reports 84,895 inmates were housed in Florida's correctional facilities.

Admission statistics for that same period indicate 3,527 female inmates and 28,677 male inmates entered the correctional system through a reception center. By Florida law, all inmates entering the state correctional system, whether a first time incarceree or a recidivist, must process through a reception center. The Department receives inmates on a regular basis from county jails through several reception centers located throughout the state.

Reception Centers
Male

- Reception Medical Center, Lake Butler (Bradford County)
- Central Florida Reception Center, Orlando (Orange County)
- South Florida Reception Center, Miami (Dade County)

Female

- Lowell Correctional Institution, Lowell (Marion County)
- Broward Correctional Institution, Ft. Lauderdale (Broward County)

Upon arrival at a reception center, an inmate is in-processed, evaluated by health services, assessed for program needs, and his/her custody (security risk) is determined. Custody is determined by reviewing the seriousness of the inmate's offenses, length of sentence, time remaining to serve, prior criminal record, escape history, prison adjustment, and other factors. The most serious offenders with the longest sentences and those least likely to adjust to institutional life are placed in more secure facilities. Based on the results of this process the inmate is assigned to a permanent institution commensurate with his/her security risk, medical/psychological level, special program needs, etc.

The health appraisal portion of the inmate's reception process is guided by the Department's technical instructions. This process includes, but is not limited to:

- Laboratory testing and x-rays
- Current and past illnesses (with special attention to communicable diseases), health conditions, or special health requirements
- Past or current mental illnesses, including hospitalizations
- History of or current suicidal ideations
- Dental problems
- Allergies
- Legal and illegal drug use
- Appearance (sweating, tremors, etc.)
- Behavior (calm, disordered, etc.)
- Ease of movement (body deformities, gait, etc.)
- Breathing (persistent cough, hyperventilation, etc.)
- Skin (lesions, jaundice, rashes, infestations, bruises, scars, tattoos etc.)
- Current or recent pregnancy

Because of the complexity and importance of effective and timely screening of inmates entering the correctional system, the Authority undertook a project during the current fiscal year in which informal visits were made to Reception and Medical Center (RMC), Central Florida Reception Center (CFRC), and Lowell Correctional Institution (Lowell) to

view the reception process. These visits were designed as part of an ongoing project. Additional visits are anticipated during the upcoming fiscal year. The primary goal of these visits is to evaluate whether there are significant concerns warranting a more detailed, focused review project of the entire reception process.

During the visits to the three reception centers, Authority staff informally interviewed correctional and health care staff and inmates, toured the facilities, and observed portions of the reception process.

Generally, it appears the reception process at the centers visited is complex and often bogged down with an overwhelming number of inmates. It should be recognized, however, that this observation is based on information gathered from only informal, cursory reviews and interviews.

At this stage of the Authority's review, five areas seem to rise to a level that warrants a more in-depth evaluation. Should a more in-depth review process be undertaken by the Authority in the future, several other reception processes not reviewed during this preliminary stage would also be considered.

Intake and Reception Process Review Components

- Accuracy
- Completeness
- Timeliness
- Comparisons to the processes in place at other reception centers
- Adequacy (size and layout) of the physical plant
- Coordination and cooperation with the county jails transferring inmates
- Privacy issues
- Security of medical information and medications

Intake and Reception Process
Key Areas Identified for In-depth Evaluation

- Physical plant design and limitations
- Medication management (including the receipt and processing of medications transferred with inmates from county jails)
- Infection control practices
- Privacy/confidentiality
- Transfer and security of medical and mental health information (including medical records) from county jails

Additional Areas Warranting Evaluation

- The assignment of physical and mental health levels including:
  - initial physical, dental and mental health screening
  - diagnostic testing for physical and dental concerns
  - mental health evaluations and treatment planning
  - self and family histories of current or previous diseases/treatments
- Unique needs specific to age (including youthful and elderly offender), gender, and ethnicity
- Cognitive functioning
- Acclimation to the correctional setting
- Propensity for self harm or violence to others

It is anticipated at least some of the issues identified above will be captured in part during FY 2005—2006 focused reviews of the Department's health care system. The Authority also expects that other upcoming focused reviews will contain components that loop back to the reception process. Should this prove to be the case, or if enough issues are

surfaced during the remaining informal reception center visits to warrant a project specifically focusing on all components of the reception process, such a study will be undertaken.

2. Intrasystem Transfer

Intrasystem transfer is the process by which inmates are transferred between facilities within the system. These transfers occur for a variety of reasons including, but not limited to, the inmate's medical condition, availability of work and/or education programs, custody level and behavior. Any transfer has the potential to impact the continuity of the inmate's health care. The American Correctional Association (ACA), the National Commission on Correctional Health Care (NCCHC) and the American Public Health Association (APHA) have all developed standards specific to transfer procedures. While each body defines its standards differently, the common theme is the maintenance of continuity of care.

Intrasystem Transfer
Expectations for Continuity of Care

- Medical staff is given timely notice of the anticipated transfer to prepare records, medications and follow-up referrals.
- A medical evaluation will determine the inmate's suitability for travel.
- The health record will accompany the inmate and its confidentiality will be maintained.
- Attention is given to communicable disease clearance and transportation officers observe medical precautions when transporting inmates.
- If necessary, transporting officers will be provided necessary information to ensure medication or health interventions required enroute will occur.
- The record or a summary will be reviewed within 12 hours of arrival at a receiving institution.
- The review is conducted by a registered nurse, physician, ARNP or PA.

The Department has enacted several rules, procedures and forms relative to the transfer of inmates within the system. These are listed in the accompanying box. Additionally, Department Procedure 401.016, *Transfers for Medical Reasons*, refers the reader to four additional documents related to transfers.

Department Policies/Documents

- Rule 33-601.215, F.A.C., *Classification – Transfer of Inmates*
- Rule 33-603.201, F.A.C., *Transfer of Inmates*
- Department Procedure 401.016, *Transfers for Medical Reasons*
- Department Procedure 401.017, *Health Records and Medication Transfer*
- OHS Technical Instruction 15.02.02, *Health Care Clearance/Holds*
- OHS Technical Instruction 15.03.04, *Periodic Assessments/Examinations/Screenings*
- Form DC4-760, *Health Information Transfer Summary*
- Form DC4-760A, *Health Information Arrival Summary*

Regardless of reason for an inmate's transfer, the Department has adopted several actions, described in the accompanying box, that apply to all transfers.

- To ensure confidentiality of medical history and conditions, medical records are to be packed in clear plastic bags visibly labeled "*Sensitive Medical Data. To be opened by Medical Personnel Only.*" Single-dosed medications are to be packaged separately in a brown envelope.
- To ensure continuity of care for an inmate requiring medical care while in transit, the transport status is to be coded "T-3" and the inmate's records are to be packed and flagged with a red identifier (form DC4-743B, *Confidential Refer to Medical Immediately*) indicating the inmate has a medical condition that calls for immediate review. Single dosed medications, packed separately as indicated above, are to be placed in the plastic bag with the current health record.
- For an inmate with a medical condition or prescription, keep-on-person medications are not to be confiscated, but kept with the inmate.
- A Health Information/Transfer Summary is to be completed by the sending institution. This form is completed based on a review of the inmate's record and documents the current medical status and needs of the inmate.
- A Health Information Arrival Summary is to be completed by the receiving institution. The first page of the form is completed during a face-to-face encounter with the inmate, usually conducted in the visitation building at most institutions, and generally documents self-reported information from the inmate. The second page includes a combination of a face-to-face assessment by staff and a review of the Transfer Summary prepared by the sending institution.

The Authority contacted several states and found similar policies and procedures are in place in Arizona, California, Oklahoma, and Pennsylvania. Several site visits were also conducted to view the process of transferring inmates between Florida's correctional institutions and to evaluate the adequacy of the information contained on the transfer forms.

At Central Florida Reception Center, in addition to observing the process for incoming jail arrivals discussed earlier, the process for in-transit inmates being transferred from north Florida institutions to south Florida institutions with a several hour lay-over at CFRC was observed. Upon learning that Columbia Correctional Institution was being used as an intrasystem transfer lay-over stop, relieving Reception and Medical Center of the responsibility for intrasystem transfers due to the volume of new admissions, the transfer process at Columbia was also observed.

One thing that is clear from a review of intrasystem transfer forms is the need for the sending institution to share a significant amount of pertinent medical information and for the receiving institution to document review of that information. California uses a transfer form that is prepared by the sending institution and signed and signature stamped by staff reviewing the form at the receiving institution. Like California, Oklahoma uses a medical transfer summary form prepared and signed by staff at the sending institution and reviewed and signed by staff at the receiving institution to document that review. Oklahoma also uses an intrasystem transfer health screening that is used in a face-to-face encounter at the receiving institution to document health status upon arrival. Pennsylvania uses multiple forms depending on the inmate's reason for transfer.

Florida's current transfer summary (DC4-760) completed by the sending institution includes a host of medical, dental and mental health information configured on the front page of a two-sided form. The reverse side allows for additional comment. This design results in a "busy" front page and a reverse that is seldom used. The current arrival summary (DC4-760A) is also a two page form. The first page reflects questions asked the inmate about his/her health status

upon arrival at the institution. The reverse side reflects staff assessment of the inmate's orientation (to person, place, time and situation) and behavior (agitated, anxious, cooperative, etc.) and re-documents information contained on the DC4-760 with respect to suicide precautions, passes and overdue/pending appointments.

Record reviews were conducted at four institutions. Fifty-eight records and 150 transfer forms were reviewed. Records selected represented transfers from a reception center to a permanent institution; transfers from one permanent institution to another; and transfers returning to a permanent institution from a medical procedure. For medical transfers, two sets of forms were reviewed; the set for the transfer from the permanent institution to the medical institution and the set for the return from the medical institution back to the permanent institution. For other transfers, the form prepared by the sending facility, whether a reception center or other permanent institution, and the form prepared by the receiving facility were reviewed. This process consisted of verifying and comparing the information noted on the transfer forms with documentation included in the medical record.

Intrasystem Transfer Findings

- Transfer summaries prepared by sending institutions generally were adequate and documented necessary medical information.
- Arrival summaries, regardless of whether the receiving institution was the medical facility or other institution, were incomplete or incorrectly completed.
- Items documented by clinical staff at the receiving institution varied from institution to institution.

In addition to reviewing how transfer and arrival forms were completed, the medical record was checked for documentation the chart had been reviewed by a clinician at the receiving institution. This examination looked for a note indicating the clinician checked for clinical conditions, abnormal laboratory results and/or outstanding consultations. These reviews found two instances where inmates with scheduled specialty appointments were transferred prior to the appointment, and the outstanding appointment was missed by both the health care screener at the receiving institution and the clinician reviewing the records. Review and consolidation of existing intrasystem transfer policies, and clarification of documentation requirements, might alleviate the inconsistencies found with respect to form preparation and medical record review upon arrival.

This focused review also identified "best practices". At one institution, subsequent to the arrival screening assessment, the records are brought to the medical unit where several staff meet to review the record for specific concerns, e.g., outstanding consultations, abnormal laboratory results, clinic appointments, etc. At another institution the physician and/or a mid-level practitioner conduct the intake assessment screening. This process helped to timely identify inmates requiring medical intervention.

As discussed in the Quality Management portion of this report, the OHS slated intrasystem transfer issues for an investigational study during FY 2005—2006 fiscal year. The Authority is hopeful the data and information gained during that process will form a basis for review of the entire intrasystem transfer process and the sharing of medical information between facilities.

Intrasystem Transfer
Potential Areas for Improvement

- Update, consolidate and restructure existing policies, procedures and technical instructions
- Revise intrasystem transfer forms

The Authority's review of policies and procedures relating to intrasystem transfer and focused review of medical records and transfer forms identifies two areas for potential improvement in this important area. The Authority looks forward to working with the OHS to improve and simplify the sharing medical information between institutions. The information gained by the Authority during its focused reviews and by the OHS from its QM investigational study has the potential to greatly impact continuity of care for all inmates, but especially so for inmates with medical conditions.

3. Prerelease Planning

During fiscal year 2004 - 2005, 31,537 inmates were released from Florida's prisons. This is a substantial number of individuals, who tend to be sicker on average than the U.S. population, released to a community setting. Over 12,000 of these releases had at least one visit to a chronic illness clinic during the fiscal year. One-fourth were enrolled for hypertension. The NCCHC reports the increased prevalence of infectious diseases among inmates ranges from four times greater for active tuberculosis to nine times greater for hepatitis C. The prevalence of mental illness, such as schizophrenia and bipolar disorder, is one to five times that of the U.S. population. With certain exceptions, the majority of Florida's releases are provided little assistance in coordinating medical and mental health care upon release. Without health care coverage, access to community-based programs, or assistance and support upon re-entry into a community setting, there is a danger of declining health. This has potential implications for community health and safety concerns, as well as financial issues. By adequately addressing these issues, possible benefits include improved individual health, improved public health, increased re-entry success, and cost avoidance.

The APHA and the NCCHC have adopted standards regarding discharging medically needy inmates to the community. These standards require a plan for continuity of care for the inmate being released, including providing sufficient medication and arranging for necessary follow-up services prior to release. The NCCHC cites the state of North Carolina as a "best practice" for aftercare planning. The Authority contacted North Carolina to inquire about their prerelease planning activities. North Carolina implemented a standard requiring a comprehensive, collaborative, cooperative aftercare plan completed and placed in the health service record no later than 30 days prior to the anticipated date of release for every inmate who is identified as a recipient of mental health or developmental disabilities services and those inmates identified as medically needy by definition with release anticipated within 90 days. This aftercare plan is prepared in conjunction with a social worker or case manager.

The Authority recognizes the Department requires the commitment and cooperation of the community and its sister agencies to address many of these issues.

Continuity of Medical Care

During the fiscal year, informal reviews were conducted at five institutions regarding prerelease planning for medically needy inmates. The purpose of this undertaking was to determine how inmates were being prepared medically for their discharge from prison to the community. This was done through informal staff interviews at each institution.

The Department's prerelease planning efforts are governed by two technical instructions—15.03.04, *Periodic Assessment/Examinations/Screenings* and 15.03.29, *Prerelease Planning for Continuity of Health Care*. These

instructions dictate that all inmates approaching their release date receive a physical examination or assessment. The OHS procedure further requires inmates on prescription medication generally receive a thirty-day supply.

Interviews revealed at two of the five institutions little information was offered on how to access care upon release beyond directing the inmates to establish a relationship with a doctor or go to the county health department. Interviews also confirmed inmates are being released with sufficient medication for maintenance, if a new health care provider contact is established within 30 days. With the exception of HIV positive inmates and inmates with tuberculosis, the process of ensuring appointments are scheduled or arrangements are made to contact a specific health provider appears lacking.

Many inmates are released with limited funds, have no health insurance, and initially seek care through the public health system. To aid in inmates' transition to a community setting, contact information for the county in which they plan to reside could be provided prior to release. Such information as the general location, address and phone number for the county health department, as well as information on that county's process for making appointments and the days of the week care is available could prove extremely valuable in maintaining continuity of care during the transition from a controlled setting to a free-world society. Establishing a more seamless transition between the Department and the public health portal could help maintain health status and prevent a potentially costly exacerbation of the releasee's condition, due to lack of medical follow-up and management by a health care provider. These exacerbations can be costly and are usually borne by the state through the local county health department. Avoiding such exacerbations results in cost avoidance for taxpayers and an overall healthier state for the individual. Adding these or similar requirements to the Department's prerelease planning policies could result in increased efficiencies for public health care in the State of Florida and warrant consideration.

Continuity of Mental Health Care

Public health research identifies continuity of care as a critical component of effective overall mental health treatment. Individuals most in need of mental health and dual diagnosis (mental illness and substance abuse) services often become involved in the criminal justice system. While some may be in treatment at the time of arrest, it is more likely they are untreated or have discontinued treatment. Incarceration may be due to behaviors resulting from their deteriorated psychiatric condition. These individuals often have many cycles of incarceration, release, deterioration, and re-incarceration. Consequently, any effective solution to this problem requires an integrated effort across the boundary between the criminal justice system and the community mental health system.

Prerelease Planning
Reintegration Activities

- Develop and document a continuity of care plan not later than 180 days prior to the projected release date.
- Coordinate with a Department of Children and Families (DCF) client manager in the inmate's home district to determine the proper mental health center or clinic to which the inmate would be referred.
- Complete all necessary forms such as release of information and informed consent.
- Coordinate with the appropriate Parole and Probation Office.
- Coordinate with a District Program Office for Developmental Services for inmates with mental retardation.

Thirteen percent of FY 2004—2005 releases required ongoing mental health services while incarcerated; nearly ten percent required psychiatric services and psychotropic medication. To ensure mental health services are continued following end-of-sentence, the Department outlined

processes institutions are to follow to prepare applicable inmates for reintegration back into the community in TI 15.05.18, *Outpatient Services*.

In last year's annual report, the Authority reported that records of inmates with intellectual functioning deficits, sexual disorders or documented mental illness, and who were within 180 days of release, indicated a lack of documented evidence of effective prerelease planning. Because of these findings and the importance of this component of mental health care, the Authority undertook a project in which focused reviews of prerelease planning were conducted at 12 institutions. The project targeted inmates receiving mental health services who were within 180 days of release. A total of 51 cases were reviewed. The reviews examined a sample of inmate medical records and also included interviews with institutional staff. Identified weaknesses in prerelease planning are displayed in the accompanying box.

Weaknesses Identified in Prerelease Planning Process

During Record Review:

- Documentation of appointment times with community resources was often unclear (either no reference to an appointment, or reference that an appointment was scheduled, but no indication when it was to occur).
- Documentation that prerelease planning occurred was not always available.

During Staff Interviews:

- Coordination with DCF forensic staff was problematic; i.e., DCF staff turnover, inaccurate/outdated resource listings of DCF staff, telephone messages not returned by DCF staff.
- No effort was made to establish an inmate's Medicaid eligibility. (It should be noted, that although this area was identified as a weakness by survey teams, to address this concern the OHS subsequently added a training component for institutional staff.)

During this review of prerelease planning activities, an issue surfaced with system-wide implications. A prerelease plan developed through the Department's classification section called for a female minor inmate to return to her family. The classification section was unaware, due to medical confidentiality, that the inmate reported a significant history of familial sexual abuse. The case surfaced the need for intake, continuity of care, and prerelease planning that takes into account sexual abuse history, common in female offenders. It also surfaced a need for coordination among Department staff involved in prerelease planning. The Department subsequently arranged another placement for the inmate. Further, the Department committed to review and revise its policies and procedures regarding intake, treatment planning, and end-of-sentence prerelease planning to include sexual abuse histories. The Authority commends this commitment and is eager to assist in any way that may be helpful.

Continuity of Mental Health Care and Interagency Collaboration

What remains under consideration is whether the guidelines set forth by the Department are sufficient to provide the greatest benefit to inmates who need community mental health services following release. A workgroup was convened by the Department of Corrections and the Department of Children and Families at the request of a member of the Florida Senate.

Workgroup Members

- Department of Corrections
- Department of Children & Families
- Agency for Health Care Administration
- Medicaid Program Office
- Florida Mental Health Institute
- Florida Council for Community Mental Health
- Florida Council for Behavioral Health Care
- Advocacy Center for Persons with Disabilities
- Staff of the Florida Senate

The workgroup studied aftercare planning for inmates with severe and persistent mental illnesses who are released to the community from state correctional institutions. The workgroup recognized that even under optimal conditions, developing and implementing effective discharge plans for mentally ill inmates is challenging. The workgroup's report to the Florida Legislature indicated there are major gaps in the current aftercare planning process.

Workgroup Recommendations

- Develop an Interagency Agreement between DC and DCF to:
  a. Strengthen the linkages between the two systems of care;
  b. Incorporate DCF target populations and priority clients in the agreement and achieve mutual agreement regarding identifying and addressing inmate service needs while still in the prison population;
  c. Share information and data through the identification of state-level contract liaisons;
  d. Develop stronger linkages with the Social Security Administration;
  e. Arrange in-service training on applying Social Security benefits; and,
  f. Conduct on-going evaluations of the effectiveness of aftercare planning for inmates with severe and persistent mental illnesses.
- Initiate a process of joint planned in-service training events and ongoing technical assistance to DCF districts/regions staff and providers, and selected DC staff.
- Educate the courts to use split sentences for individuals with severe and persistent mental illnesses to ensure community supervision and follow-up with treatment.
- Update and revise both Departments' release planning procedures to ensure alignment with the proposed interagency agreement.
- Establish and maintain a current directory of community-based providers on the DCF internet.
- Where indicated and practical, assign a DCF case manager prior to release.

Workgroup Findings

- There is no current interagency agreement or memorandum of understanding between the two Departments that specifies roles for each Department in aftercare planning for inmates with severe and persistent mental illness.
- There is a lack of role delineation between DCF districts/region and their contracted community mental health providers for aftercare services to inmates with severe and persistent mental illnesses.
- There is a history of failed first appointments by inmates with severe and persistent mental illnesses with no identifiable mechanism for follow-up prescribed in mental health statutes, rules or contracts

Other initiatives are underway in Florida to assist in establishing an effective system of prerelease planning for inmates with mental illnesses. One is the Florida Substance Abuse and Mental Health Corporation, a non-profit group designed to examine the myriad of issues faced by Departments, agencies (governmental and community-based), and providers of care as they attempt to provide necessary mental health and substance abuse services.

The provision of services and prerelease preparation for female inmates is another important area. While females are a smaller portion of the inmate population their health and mental health needs are often more severe and complex. Their histories of trauma and abuse are reportedly high. The prevalence of prior physical and sexual abuse, rape and trauma found among female inmates can be staggering. Given the high rates of trauma and violence in these women's lives, the policies, practices and programming addressing their needs must be appropriate to and mindful of their histories. The paths that lead women to incarceration are very different from men and must be addressed with gender appropriate environments, systems, policies and practices. For these reasons another work group was formed, consisting of senior Department staff, representatives from the OHS, the executive director of a community-based sexual/domestic violence prevention program, and the Authority's executive director. The work group's goal is to strategize solutions to the unique challenges faced by female inmates.

The Authority recognizes that inmates with mental illnesses present special problems to correctional administrators and staff. Left untreated, they are at increased risk of suicide, victimization, causing disturbances, and disciplinary infractions. Appropriate services must, therefore, be provided during the period of time the inmate is the responsibility of the state. Even more problematic to our communities, though, is that after release, these problems persist, along with increased risks of homelessness, health problems, and violence.

Discharge planning is clearly complicated. Prisons are often located far from the inmate's home community and formal or informal relationships are difficult to develop between correctional staff and sometimes distant community providers. The Department should be commended for their recent collaboration with DCF to improve the planning process prior to an inmate's release to help ensure adequate continuity of mental health care. Continuity of care planning can be described as a "moving target". However, it requires constant surveillance; continued investigations for funding sources; frequent review and revisions of policies and procedures, as needed; and, the development of effective clinical guidelines.

4. Suicide Observation Status

The Department defines suicide observation status (SOS) as a clinical status that provides for safe housing and close monitoring of inmates who are determined suicidal or at risk of serious self-injurious behavior. While inmates may be suicidal at any point during their incarceration, there are several well-known higher risk periods. Inmates in specialized single-cell housing are also at increased risk of suicide. Additionally, inmates in the early stages of recovery from severe depression may be at increased risk.

Crisis intervention and management is available at all facilities for all behavioral and/or psychiatric emergencies. Inmates assessed by health care staff as at-risk for suicide or self-harm are placed on SOS in a "safe" or suicide resistant cell/room. These rooms may be an infirmary isolation management room (IMR) or, if there are no infirmary IMRs available, a certified observation cell (OC) that meets IMR standards. Observation cells are generally located in confinement dormitories. IMRs and OCs are designed to provide a safe and appropriate setting for initial housing and observation of inmates presenting impairment that cannot be managed within the general population. This placement involves rapid assessment, close observation, and institutional-based intervention. The Department has specific standards regarding the placement of an inmate in an IMR or OC.

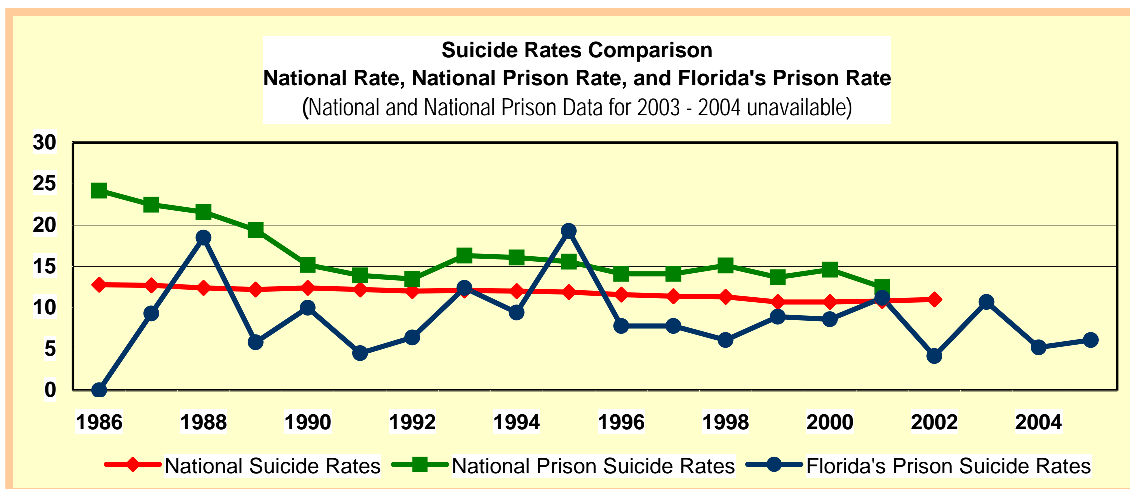
Occasions at High-Risk for Suicidal Behaviors

- Upon initial admission or transfer to a different facility
- Following new legal problems (e.g., new charges, additional sentences, institutional procedures, denial of parole)
- After the receipt of bad news regarding self or family (e.g.; serious illness, the loss of a loved one)
- After suffering some type of humiliation (e.g.; sexual assault) or rejection

Suicide Observation Requirements

- Monitoring no less that every 15 minutes with observations documented on the "Observation Checklist", DC4-650
- An IMR is the primary housing location. Certified OCs used for overflow purposes only.
- An infirmary record is opened regardless of inmate's housing location.
- Referral to a Crisis Stabilization Unit within 72 hours, if still at risk for suicide or self-injury.
- Transfer to a higher level of care within 120 hours if the crisis is not resolved.

The Department's policies outline a process allowing successful management of crisis events as evidenced by the Department's low rate of inmate suicides as compared to the community setting and other correctional systems throughout the United States. The following chart demonstrates a comparison of these rates.



Notwithstanding the Department's success at maintaining a low suicide rate, suicide and self-harm is a critical area of care because it involves life or death. Because it is so important, this area requires continual review. This year the Authority conducted focused reviews at twelve sites to assess the process for placing an inmate on SOS. Two key areas of concern surfaced during the review process.

- Use of a status not defined by policy.
  - Some inmates at risk of suicide or self-harm were placed on "23 hour observation" status instead of SOS and did not receive nursing and psychiatric assessments and frequency of observation required for SOS.
  - Some inmates were discharged from SOS, placed on "psychiatric observation" and monitored hourly as opposed to every 15 minutes as required by SOS. The psychiatrist determined they were not ready to return to their previous housing assignment, yet they were not referred to the CSU.
- Some inmates were not referred to a CSU within the required 72 hour time frame.

The above concerns appear to correlate with a system-wide issue identified by the Department, a lack of available CSU beds. Waiting lists for the CSU are long and inmates remain on SOS much longer than policy allows. This creates problems for institutions that are not equipped or staffed to handle prolonged serious mental health issues. At one point, the OHS suspended the time frames for transfer to a higher level of care due to the lack of available beds in its CSUs. The OHS later issued a clarifying directive stating "23 hour observation" and "psychiatric observation" were not to be used for inmates at risk of suicide or self-harm. In addition, staff was reminded that, when clinically indicated, inmates are to be referred to a CSU within 72 hours of being placed on SOS, and should remain on the waiting list until a bed is available.

Incarceration rates of the mentally ill are rising due to their deinstitutionalization and release to communities ill prepared and lacking resources necessary for their treatment. Restricted access to community services led to decompensation and for many, their eventual involvement in the criminal justice system. Aufderheide and Brown (2005) observe "Inmates are spending more time behind bars as states adopt truth-in-sentencing laws, which require inmates to serve the vast majority of their sentence behind bars." Many have multiple disorders, often coupled with substance abuse. Many are unable to comply with following rules and are disruptive, displaying behaviors that result in disciplinary action. Others engage in self-mutilation or other self-harm behaviors. As a result, correctional staff is increasingly required to provide mental health crisis intervention. It appears there is a need for additional long and short-term inpatient beds to accommodate the increasing number of severely mentally ill incarcerees. These individuals are often unable to demonstrate adequate institutional adjustment and are among those who are at risk for suicide or self-harm. The Authority plans to study the need for inpatient beds in collaboration with the Department.

5. Psychotropic Medication Administration

During FY 2004—2005, focused reviews were performed at eight institutions in which psychotropic medication is prescribed. In the clinical management of mentally ill inmates the use of psychotropic medication may be indicated. The Department routinely assigns a medical classification of S3 to inmates who are determined to need psychotropic medication, even if the inmate may be exercising the right to refuse the medication. Identified issues regarding psychotropic medication practices are being addressed by OHS. The Authority recognizes the Department's diligence in working to correct these matters.

Psychotropic Medication Administration Issues

- Some laboratory studies were not appropriately ordered or abnormal laboratory results lacked follow-up.
- Some medication interactions and side effects were not addressed.
- At all institutions reviewed, sedating medications that should be taken at bedtime were administered too early in the day (generally 5 – 6 p.m.)
- Some practitioners changed/discontinued antipsychotic, antidepressant, and mood-stabilizing medications without clinical justification.

6. Outpatient Mental Health Care at Lowell Correctional Institution

The Authority noticed the number of women receiving psychotropic medication at Lowell was significantly declining. In March 2004, the Authority initiated a narrow review of outpatient mental health care at Lowell. The nature of the issues identified resulted in an emergency notification to the Secretary of the Department outlining three emergency findings. Four lesser findings were subsequently included in the Authority's written report.

On March 8, 2004, the Department submitted a corrective action plan calling for Department psychiatrists to complete peer reviews of each case where psychotropic medication was discontinued. The peer reviews would determine whether sufficient clinical justification existed for discontinuation and whether appropriate follow-up subsequent to discontinuation occurred. The reviews were largely completed by Lowell psychiatrists. In June 2004, the Authority conducted a follow-up monitoring visit that included assessment of the case reviews completed to date. During this assessment visit, one emergency finding was closed as there appeared to be improved coordination of care between the psychiatry and psychology sections of the institution. The two remaining emergency findings remained open.

Emergency Notification Findings

- Psychotropic medication was discontinued without sufficient clinical justification.
- After medications were discontinued, psychiatric follow-up was insufficient.
- Coordination of care between psychiatric and psychology staff appeared to have deteriorated significantly.

Subsequently, in August 2004, the Department submitted a second corrective action plan to the Authority. The second plan called for an outside consultant to conduct a complete psychiatric evaluation for all inmates from Lowell removed from medication between October 1, 2003 and March 05, 2004, (approximately 523 inmates). These independent psychiatric evaluations were completed between July 2004 and April 2005. Inmates transferred to other institutions were assessed at their current institution. All applicable inmates received a complete baseline psychiatric evaluation

and follow-up of the original decision to discontinue psychotropic medications. Thus, the two remaining emergency findings were closed.

Meanwhile, two follow-up monitoring visits subsequent to the Department's August 2004 CAP submission identified nine additional deficiencies in the outpatient mental health program at Lowell. One finding from March 2004 also remains open. Continued resolution of identified deficiencies is necessary to ensure the outpatient mental health system at Lowell meets all applicable standards. The Authority plans to again assess Lowell's progress toward correcting deficiencies in its provision of outpatient mental health care during FY 2005—2006.

FOLLOW-UP MONITORING

The Department is statutorily required to develop a corrective action plan (CAP) addressing any deficiencies the Authority identifies at an institutional survey. These plans must be submitted within 30 days of the release of the Authority's formal report. The Authority generally returns to the institution about seven months later to review documentation of corrective action implemented to resolve deficiencies. Issues that are not adequately addressed remain open. The Authority continues to monitor those issues, generally through a desk audit, until there is sufficient documentation correction has been achieved.

At the beginning of FY 2004—2005, eight institutions surveyed in FY 2002—2003 had unresolved deficiencies requiring continued monitoring. Additionally, the Authority reviewed the corrective action assessments for 21 institutions surveyed during FY 2003—2004. (See Appendix.) Initial assessment reviews were conducted for 19 institutions. Eight institutions (42%) demonstrated successful correction of deficiencies upon initial assessment. The Authority reviewed 17 institutions for a second time, closing 12 CAPs (71%). Nine institutions submitted closure files for a third review. Six received notification of closure of all deficiencies. Two institutional CAPs were closed after the fourth Authority review. All corrective action assessments relating to the triennial survey process are now closed.

As mentioned earlier, follow-up monitoring related to the *Osterback* settlement agreement closed four of the corrective action plans by the time this report was compiled.

BUDGET AND PERSONNEL

The Wexford Health Sources contract in Region 4, the nursing shortage and health care expenditures continued as the main discussion topics for the work group during FY 2004—2005. The impact of aging offenders on the system was also considered.

Region 4 Wexford Health Sources Contract

Analysis of the Department's monitoring of Wexford's provision of services in Region 4 continued to reveal issues related to contract compliance. Members expressed concern about repetitive deficiencies at institutions and suggested the Department consider invoking contract provisions relating to non-compliance.

Over the course of the year, it appeared the Legislature also may have had concerns about the Region 4 contract, as proviso language for FY 2005—2006 directed the contract for health care services in Region 4 be re-bid.

FY 2004—2005 Health Care Expenditures

Admissions and releases, their impact on the status population, and their potential impact on the cost of providing health care services, continued as a topic of discussion.

Beginning with No Growth

As FY 2004—2005 commenced, the OHS was ending a deficit year in which General Revenue expenditures for provision of health care totaled $306.4 million, exceeding legislative appropriations by $10.7 million. This equated to $11.15 per day for the average daily population (ADP) of 75,089 inmates for whom the Department directly provided care or for whom care was contracted through Wexford Health Sources and Prison Health Services. Key contributors to the deficit were community hospital costs and the concomitant community physician fees related to those hospitalizations; contract agency employees, mainly for nursing staff; and pharmaceuticals.

The Department's October 2003 Legislative Budget Request for FY 2004—2005 outlined issues anticipating a need for $325.9 million in General Revenue funds. The Governor's recommendation, released in January 2004, provided General Revenue of $325.7 million for the OHS. In May 2004, the Legislature enacted an appropriations bill that initially provided $319.0 million in General Revenue, choosing not to fund an issue for a price level increase for the Wexford Health Sources contract; funding only a portion of the $9 million requested to cover the previous year's deficit, and taking an across-the-board reduction in OPS, Expense and OCO of approximately $1 million.

After adjustments for one-time employee bonuses and increases in the state's share of health insurance premiums, the OHS realized legislative General Revenue appropriations of $320.0 million. Population was expected to increase by nearly 3,600 over the course of the fiscal year. Based on this population influx, the rate of funding for FY 2004—2005 was essentially flat, and contained no allowance for inflationary indexes that showed medical costs increasing at a rate greater than other areas.

Initiating Cost Avoidance Measures

During the fiscal year, the Department undertook several actions in an attempt to contain costs and remain within Legislative allocations. In October 2004,

the Department implemented a pilot program granting a salary additive to nursing staff at select institutions. This additive also had the effect of increasing the salary range offered to temporary non-agency (OPS) nurses. The pilot was initiated in four institutions where maintaining staff was problematic and nearly 60% of the Department's expenditures for agency nurses occurred. These institutions, all located around the Gainesville area, included three institutions housing males, Reception and Medical Center, Florida State Prison and Union Correctional Institution, and one housing women, Lowell Correctional Institution. This initial effort to stabilize nursing staff in those institutions appears successful and the pilot program was extended for FY 2005—2006. Expenditures for contracted agency employees declined by $4.6 million; nearly $3.3 million was directly attributable to fewer agency nurses. Expenditures for OPS employees increased by nearly that amount, $4.4 million, but those dollars provided more nursing staff.

As nursing staff became more stable at RMC, the Department aggressively applied its utilization management program to reduce length-of-stay in community hospitals and increase use of the hospital at RMC for tertiary care. UM efforts addressed making beds available at RMC by transferring patients requiring step-down or non-critical care to other institutional infirmaries when medically appropriate.

While attempting to control pharmaceutical expenditures as much as possible, the Department expended $46.8 million, 15% of its total expenditures, on pharmaceuticals in FY 2004—2005. This was $5.3 million more than it expended the previous fiscal year.

Cost Avoidance Efforts Succeed

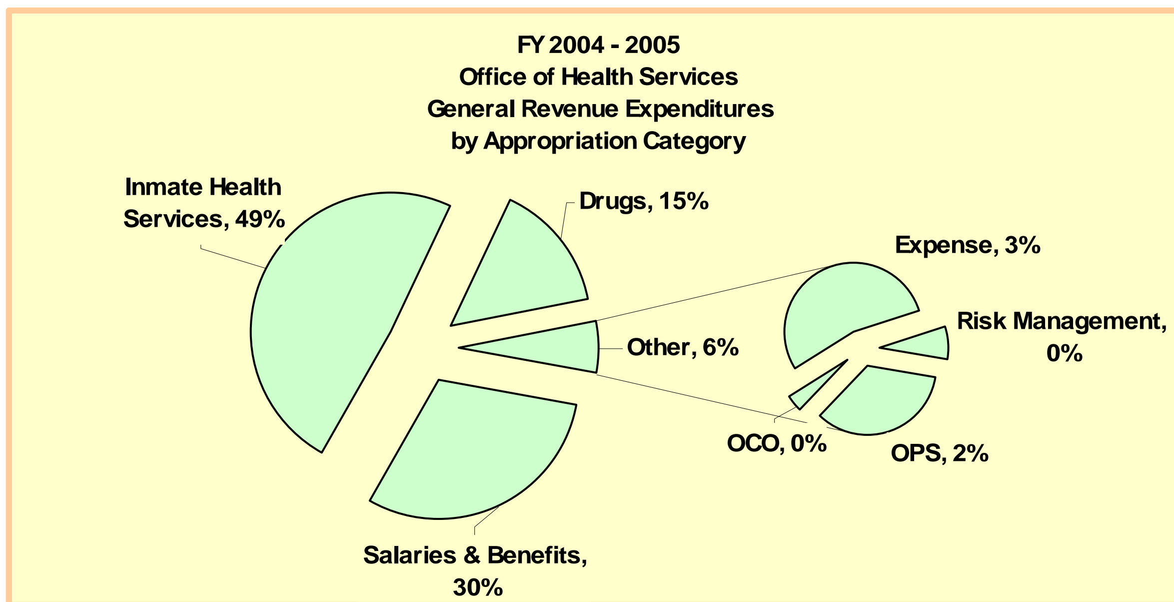
The Department also encouraged institutions to become better managers of the resources available to provide care. Department expenditures totaled $314.9 million for the 78,640 ADP provided care by the Office of Health Services or its contractors, about $5.1 million less than appropriations and $200,000 less than actual approved budget authority at year end. General Revenue per diem was $10.97, $.18 less than the prior year. At the close of the fiscal year, despite the increase in expenditures for pharmaceuticals, the Department found its UM efforts, in combination with tight management controls and reduced use of agency personnel, had paid off.

A summary of Legislative General Revenue appropriations, budget Authority approved by the Executive Office of the Governor (EOG) and OHS' actual expenditures, as well as the relationship between expenditures and budget Authority, is outlined in the chart on the following page.

FY 2004—2005
Office of Health Services
Appropriations – Budget Authority – Expenditures
General Revenue Fund

Appropriation Category	Legislative Appropriation	EOG Approved Budget Authority	Actual Expenditures	Expenditures O/(U) Appropriation	Expenditures O/(U) Budget Authority
Salaries & Benefits	$107,491,773	$94,429,766	$94,240,066	($13,251,707)	($189,700)
Other Personal Services	$1,473, 969	$6,623,969	$6,607,586	$5,133,617	($16,383)
Expense	$7,640,683	$11,964,983	$10,709,914	$3,069,231	$1,255,069
Operating Capital Outlay	$382,229	$840,229	$819,301	$437,072	($20,928)
Risk Management Insurance	$1,506,604	$1,506,604	$1,506,604	$0	$0
Inmate Health Services	$156.811,875	$152,907,427	$154,187,517	($2,264,358)	$1,280,090
General Drugs	$13,784,294	$17,357,294	$17,357,368	$3,573,074	$74
Psychotropic Drugs	$11,974,197	$9,124,197	$9,129,571	($2,844,626)	$5,374
Infectious Disease Drugs	$18,944,056	$20,344,056	$20,338,450	$1,394,394	($5,606)
Total	**$320,009,680**	**$315,098,525**	**$314,896,377**	**($5,113,303)**	**($202,148)**

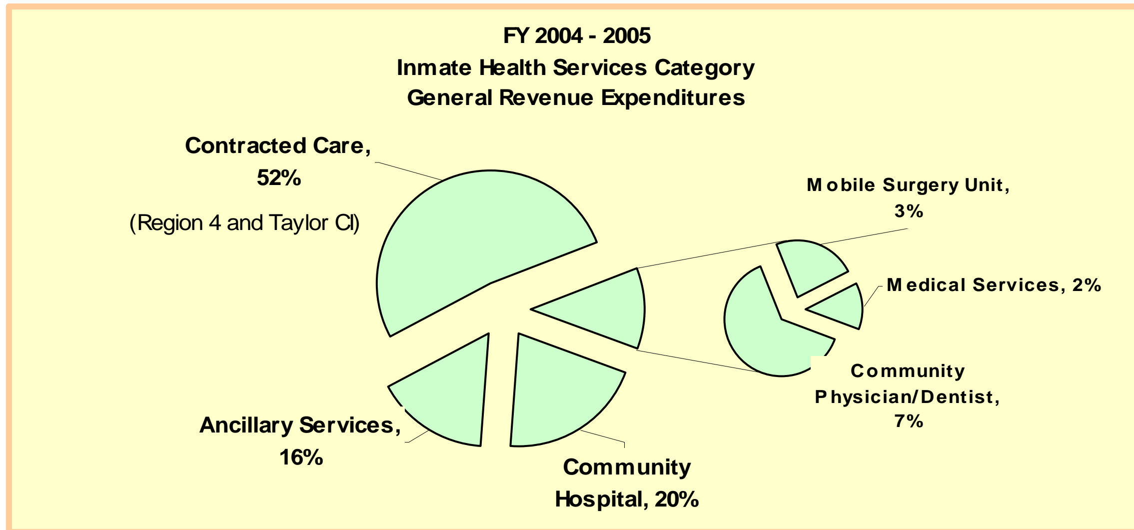
The chart displayed below portrays the expenditure of General Revenue funds for FY 2004—2005 by appropriation category by percentage. A comparison of these percentages to three previous fiscal years reveals only small variations. That data is demonstrated in the accompanying table.



Percent of General Revenue Expenditures by Appropriation Category				
Category*	FY 2004 - 2005	FY 2003 - 2004	FY 2002 - 2003	FY 2001 - 2002
Salaries & Benefits	30%	30%	32%	35%
Other Personnel Services	2%	1%	1%	1%
Inmate Health Services	49%	53%	50%	47%
Expense	3%	3%	3%	2%
Drugs	15%	14%	14%	14%

*OCO and Risk Management Insurance are not included as their individual portions are each less than 1%.

The largest category of expenditure, as shown in the above chart and table, is Inmate Health Services. Over the previous four years these expenditures ranged from 47% - 53% of total expenditures. The key areas funded by this category include hospitalization and its associated services, and payments to vendors for privatized health care. The following chart breaks out expenditures for Inmate Health Services for the most recent fiscal year. The accompanying table displays expenditures as a percentage of the Inmate Health Services category for the four most recent fiscal years.



Inmate Health Services Category Percent of General Revenue Expenditures by Type				
Type*	FY 2004 - 2005	FY 2003 - 2004	FY 2002 - 2003	FY 2001 - 2002
Community Hospitals	20%	25%	23%	20%
Community Physicians/Dentists	7%	9%	8%	11%
Mobile Surgery Unit	3%	3%	2%	3%
Ancillary Services	16%	18%	18%	17%
Medical Services	2%	2%	2%	2%
Contracted Health Care	52%	44%	46%	48%

FY 2005—2006 Health Care Expenditures

During FY 2004—2005 the work group devoted significant consideration to a funding recommendation for the Office of Health Services during FY 2005—2006. The Department's original General Revenue request, in September 2004, totaled $346.0 million. Meeting in October 2004 the work group found it had insufficient information to develop a recommendation due to the impact of hurricanes in August and September on first quarter expenditures. The work group decided to defer a recommendation until after the close of the second quarter in December 2004. The Governor in his January 2005 bill recommended $339.0 million in GR funding. In developing its recommendation for FY 2005—2006 to the Authority, at a January 2005 meeting the work group decided to apply varying price-level adjustments, based on the most recent CPI information available to date, to selected medically-related components of FY 2004—2005 expenditures. At that time, December 2004 expenditure history projected an $11.06 per diem based on an ADP of 79,097 in publicly operated facilities. After calculating those projected expenditures, an adjusted per diem of $11.39 for that ADP was derived. Applying that per diem to an anticipated ADP for FY 2005—2006 of 82,415 inmates housed in publicly operated facilities resulted in a recommendation for $342.6 million in GR funds. The Authority adopted that recommendation and submitted it to the Legislature in February 2005. Ultimately, in May 2005, the Legislature provided $329.6 million in GR funding for an ADP of 86,615 inmates. Distributions for the state's contribution for retirement and for the FY 2005—2006 salary package brought the OHS' final appropriations to $333.8 million in GR funds. Approximately 82,415 inmates are anticipated to receive health care services at public institutions or publicly run facilities with contracted health care providers, resulting in a per diem of $11.09. The remaining inmates will receive health care services from the companies holding contracts at the privately operated facilities where they are housed. (Corrections Corporation of America and the GEO group.)

Legislative Budget Request Process
(General Revenue Funds in millions)

Agency Request - September 2004 - **$346.0**

Governor's Recommendation – January 2005 - **$339.0**

Authority's Recommendation – February 2005 - **$342.6**

Legislative Appropriations – May 2005 - **$333.8**

Per Diem for Inmates in Public Facilities

Actual:
FY 2003 – 2004: **$11.15**

FY 2004 – 2005: **$10.97**

Appropriated:
FY 2005 – 2006: **$11.09**

The chart below compares the per diem rates by selected categories directly related to purchasing medical services and supplies for provision of care. The actual expenditures during FY 2004—2005 and the appropriations provided for FY 2005—2006 are displayed. On a per diem basis, the Department received an additional $.02 per inmate for those categories, or a 0% increase. The per diem for staffing and other administrative areas is $.12 more than the previous year's expenditures, a roughly 3% increase, or about the percentage of the 3.6% salary adjustment provided employees in August 2005.

COMPARISON OF APPROPRIATION CATEGORIES DIRECTLY RELATED TO PURCHASE OF MEDICAL SERVICES AND SUPPLIES

Appropriation Category	FY 2004—2005 Actual Expenditures/Per Diem ADP: 78,640		FY 2005—2006 Appropriations/Per Diem ADP: 82,415	
Inmate Health Services	$152,687,517	$5.32	$162,659,660	$5.41
General Drugs	$17,357,368	$.60	$14,411,251	$.48
Psychotropic Drugs	$9,129,571	$.32	$12,493,009	$.42
Infectious Disease Drugs	$20,338,450	$.71	$19,723,578	$.66
Total	**$199,690,708**	**$6.95**	**$209,287,498**	**$6.97**

The Authority recognizes the Department and the OHS have a challenging year ahead providing health care for the inmate population for which they have financial responsibility. Recent publications note that after years of growth and a short term deceleration in 2004, health care costs have flattened, but at levels higher than previous ones. Total health spending for privately insured persons increased 8.2% in 2004, while hospital spending increased 10.1% and physician care and other services increased 6.4%. The OHS acts as the Department's managed health care provider and its insurer, referring patients for care outside the "plan" when necessary. Advances in medical technology and their acceptance into mainstream medical practice result in a continually more sophisticated community standard of care. Uncertainty in the trends of health care spending is the only certainty. The federal Centers for Medicare and Medicaid project health care costs to double by 2014. Prescription drug spending alone is projected to grow 11.6% in 2006.

The Department will be challenged in its efforts to provide care from the funds available for purchase of care, as appropriations in these categories have no allowance for increases in the cost of purchasing medical supplies and services in the market place.

Aging and Elderly Inmates

The remaining issue extensively discussed during the fiscal year involved aging and elderly inmates. The impact of current criminal justice policy clearly has an effect on sentencing and a resulting impact on the future admission and population growth of the elderly in the system. The medical implications of an older inmate population are being felt across the country. Florida, with an elderly population greater than the average, finds its elderly inmate population is also greater than the national average. The fiscal implications of treating this population are expected to be significant. Detailed information on the aging and elderly population in Florida's institutions and their need for services are discussed in detail in the Authority's report specific to the aging inmate population.

QUALITY MANAGEMENT

Oversight and assessment of the Department's clinical quality management program by the Authority's quality management committee (AQMC) continued during FY 2005—2006. During the fiscal year, three physicians, two registered nurses and one psychologist served as reviewers of the OHS program, meeting three times. Conflicts due to Florida's unusual hurricane season and member availability affected the committee's ability to meet on its usual quarterly schedule.

The OHS Quality Management Program

The OHS clinical quality management program consists of nine components.

QM Program Components

- Credentials Review
- Clinical Quality Assessment
- Peer Review
- Infection Control
- Clinical Risk Management
- Program Evaluation
- Mortality Review
- Utilization Management
- Continuing Health Care Provider Education

As reported in previous years, the OHS continues to have adequate policies and procedures describing and setting forth the parameters of the clinical QM program. The challenge lies in implementing statewide policy at an institutional level. Also as reported in prior years, some components of the program function smoothly, but in others institutional participation and implementation is less than optimal. Participation has consistently been a concern in the risk management component. Implementation of the program evaluation component has not met AQMC expectations.

The Authority previously commented on the delay in distribution of policy modifications and revisions to field staff. This was of concern again during FY 2004—2005. A medical peer review policy revision was released nearly six months after the committee was initially informed it had been finalized and was ready for distribution. Delays of this nature have been routine and the Authority continues to encourage the OHS to promulgate written documentation of program changes promptly.

Clinical Quality Assessment

The Department's annual clinical quality reviews (CQR) of care conducted during the first quarter of a fiscal year began as scheduled. Due to the active hurricane season, the time frame for conducting reviews was extended until October 31, and all institutional CQRs were completed by that date. The Department initiated regional monitoring of institutional corrective action to ensure institutions addressed findings in a timely fashion. In designing the FY 2005—2006 CQR program, based on last year's data and the data from the two prior years, the OHS modified the program to eliminate most clinical indicators consistently scoring above 90% for the three year period. Exceptions were made for indicators routinely expected to be measured despite compliance rates, such as use of restraints. Other exceptions included indicators identified by Department management. Additionally, the FY 2005—2006 program includes statewide investigational studies looking at specific areas of concern identified by the Department and the Authority. Authority staff collaborated in the update to the CQR program.

Risk Management

During FY 2004—2005, institutional participation in the reporting of risk management (RM) data was less

than 100%. The reporting of this data has been problematic for years, and while emphasis by central office on reporting data resulted in temporary improvement in institutional participation, that improvement has not been sustained. During the third quarter of FY 2004—2005, the OHS took additional measures to improve reporting of risk management data. The following quarter demonstrated 100% compliance in all state-operated facilities. Privately operated facilities did not demonstrate the same level of improvement in reporting RM data, however. The Authority is hopeful that this improvement effort may achieve the sustained performance both the Department and the Authority desire. The Authority recognizes the Department's efforts to ensure privately operated facilities comply with contract provisions requiring their participation in the clinical QM program.

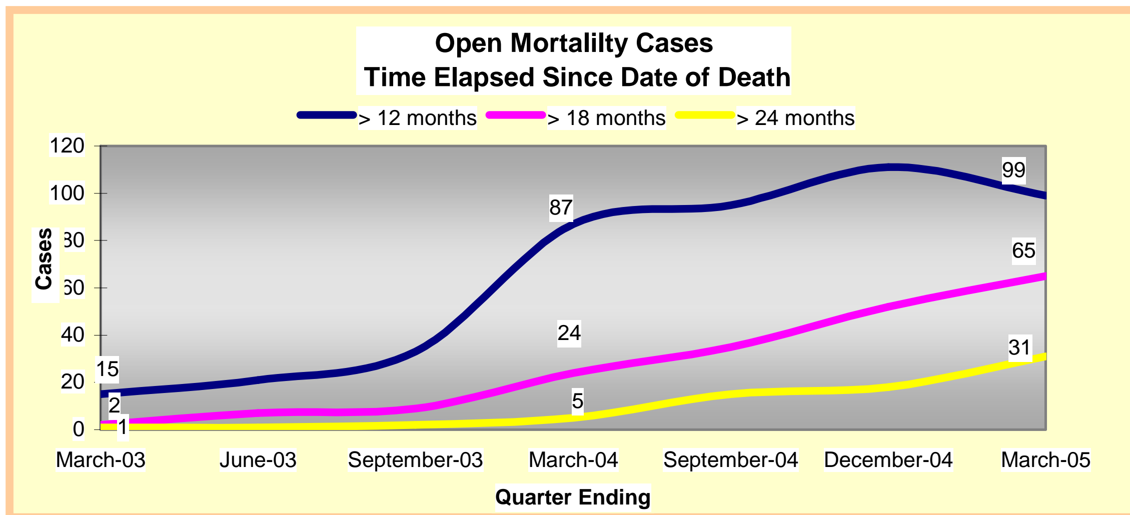
The Authority encourages the Department to return to standardizing the reporting of risk management data. Several years ago the Department responded to this Authority recommendation and briefly reported risk data in a standardized format. Subsequently, the Department returned to reporting the raw data. Institutions report the number of risk events occurring at their facilities without exploring the relationship between the number of events and institutional population. This carries forward to the analysis of statewide data. Without standardizing event occurrences against population growth, the Department cannot determine if risk management events are occurring more or less frequently. While risk events have increased, the population has also increased substantially. It is possible the current rate of risk events is less than that of prior years, but without standardizing the data, that possibility remains unknown.

Infection Control

The reporting of infection control (IC) data improved during FY 2004—2005 due to follow-up efforts on the part of central office staff when institutional IC data was not submitted within required time frames. This effort is recognized by the Authority. The Authority encourages additional management oversight to ensure that IC data is submitted in a timely manner. Data pertaining to infection rates for patients on dialysis was inconsistently reported by the Department's contractor for this service. This area has been problematic with respect to data collection as noted in previous years. Other areas of the infection control program, for example, assisting institutions in management of infectious disease outbreaks, are acceptable.

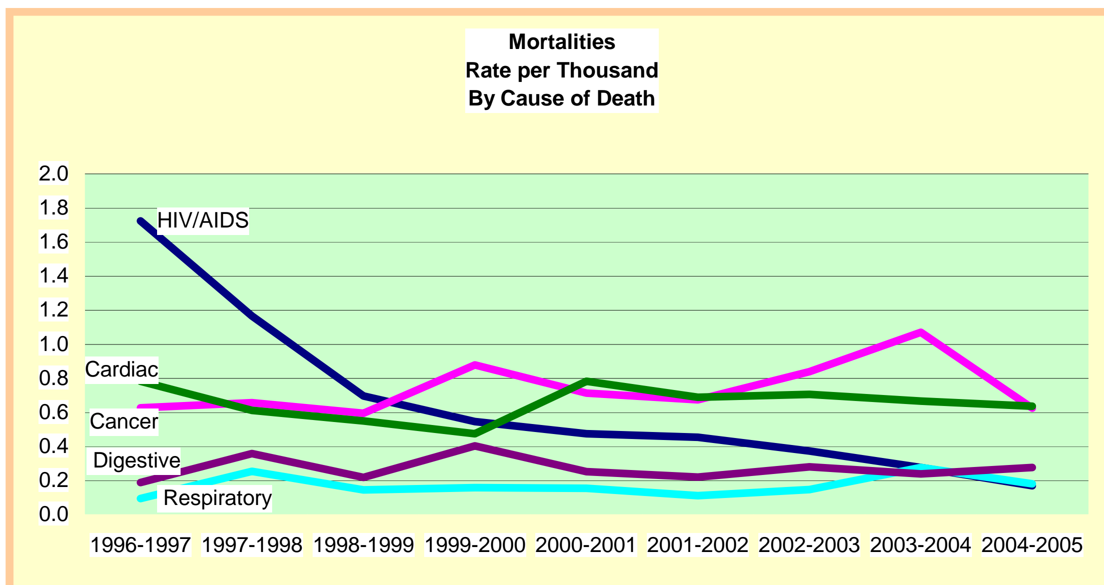
Mortality Review

Last year, based on an agreement to electronically share data between the Department and the Office of Vital Statistics, the Authority reported an expectation there would be an improvement in the number of mortality case reviews remaining open more than one year after the date of the death. Mortality data prior to 2005 was not available in electronic format, however, and the Office of Vital Statistics did not accomplish the data sharing program initiation until May 2005. The number of cases where the mortality remains open more than 12 months since the date of death increased as demonstrated in the chart on the following page.

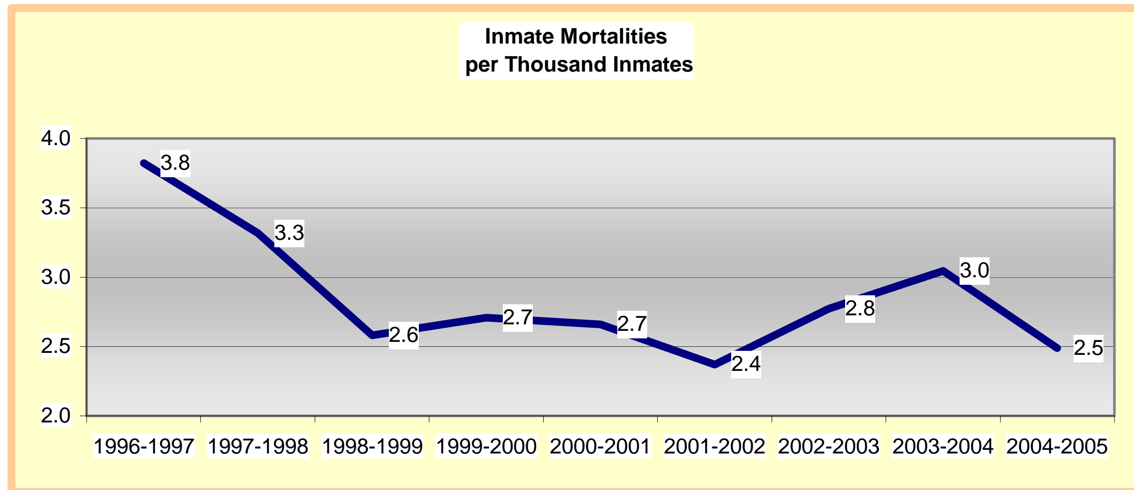


The Department recently added a position to coordinate mortality reviews. In combination with electronic receipt of death certificates, this should improve the time lag in closing cases and result in an improvement in case closures during the upcoming fiscal year.

During FY 2004—2005, the number of deaths in the system totaled 207. Cancer and cardiac-related conditions contributed nearly equally to the three most frequent causes of death (approximately 25% each). The rate of death per thousand inmates due to cancer shows a slight increase, while the rate for cardiac-related conditions remains stable over a nine year period. The third most frequent cause of death, HIV/AIDS, shows a marked decline in rate over that same period. That information is shown in the chart below.



The overall rate of death for FY 2004—2005 was 2.5 per thousand inmates, down from 3.0 in the previous year.



Program Evaluation

The program evaluation component is intended to internally evaluate the effectiveness of the clinical QM program. The AQMC expects a comprehensive evaluation of the QM program that reviews the effectiveness of each component annually. This has not been accomplished since the addition of the program evaluation component in 1998. Failure to conduct evaluations during FY 2004—2005 was reported to the Department's clinical QM committee as being related HIPAA Privacy Officer Duties being assigned to the employee responsible for program evaluation. The Department did report plans to develop evaluation tools for the quality assessment and the mortality review components during FY 2005—2006, two areas previously reviewed.

As a certified Florida Medical Association (FMA) Continuing Medical Education (CME) provider, the Department is required to evaluate its CME program. This was accomplished in preparation for the Department's reaccredidation survey in December 2004. The FMA reaccredidation survey granted the Department exemplary compliance in the areas of evaluation of activities and evaluation of its CME program.

The Authority's Quality Management Committee

Oversight

In addition to evaluating and reporting on the general effectiveness of the Department's clinical QM program components, the Authority's quality management committee (AQMC) also reviews a limited number of mortality cases and evaluates the effectiveness of the Department's review of those cases. The Department's review process requires a mortality review committee, comprised of institutional staff, review the care provided for any death occurring at the institution. The institutional committee includes non-medical and non-clinical staff. The care is evaluated and assigned to a category as to whether it was acceptable, controversial or unacceptable. Additionally, a complete medical record is provided to contracted non-Department physicians and each mortality case receives an independent peer review. Cases are categorized in the same manner by the independent outside reviewer. Should the institution and the contract reviewer disagree as to the quality of care, the regional medical director reviews the record or assigns a peer review committee consisting of only physicians to evaluate care provided.

To assess the effectiveness of the mortality review process, the AQMC selects a purposeful sample of cases where deficiencies were identified either by the institution and/or the outside reviewer. An AQMC physician reviews the care provided to the patient and presents a summary of that care to the AQMC. The peer review materials completed by the institution and the outside contracted reviewer, as well as subsequent reviews conducted or initiated by the regional medical director, are available for each AQMC member's review and consideration. The AQMC assesses whether information contained in the mortality review packet sufficiently summarizes the patient's care and, if appropriate, any necessary corrective action initiated by Department managers.

The AQMC reviewed 11 mortality cases where either the Department and/or the independent outside reviewer identified a deficiency in care. The evaluation of those cases is outlined in the table below.

Authority QM Committee Evaluation	Number of Cases
Care acceptable; Peer review adequate	5
Care controversial or unacceptable; Peer review adequate	3
Care controversial or unacceptable; Peer review not adequate	3

For the cases where the peer review process was determined inadequate, documentation was insufficient to determine if appropriate education or follow-up had occurred. The Department subsequently provided the education and follow-up necessary to address AQMC members' concerns. The AQMC encourages continued focus on the educational opportunities presented through the mortality review process, especially in identifying unusual cases or cases where several mortalities occurring at different institutions reveal a pattern in the deficiencies in care.

Recommendations

One of the recommendations made by the AQMC this year involved the use of a vital signs flow sheet for patients housed in institutional infirmaries. In October 2004, the Department updated its vital signs flow sheet, DC4-716A, *Graphic Chart*, and submitted it to the AQMC in response to this recommendation. In June 2005, the technical instruction related to infirmary services was updated by the Department, but the revision did not contain a reference to the DC4-716A, nor did the narrative specify use of the flow sheet. This form, completed by nursing staff, provides the attending clinician a quick overview of a patient's status over time. While some institutions use the form in the infirmary setting, the Authority encourages the Department to require the use of the form for all infirmary admissions and specify that requirement in the technical instruction.

In October 2004 the AQMC provided findings from a special QM review of infection control activities at a South Florida institution to the Department. The Department effectively responded to the incident leading to the special review by initiating development of an educational program for IC coordinators. The Authority's findings reinforced the Department's recognition that training for infection control coordinators was essential. At its February 2005 clinical QM meeting the OHS announced a schedule for providing a multi-faceted educational IC program in all four regions targeted for IC nurses and institutional nursing supervisors. The program offering included presentations by Department of Health staff who are experts in the fields of MRSA, Norovirus gastroenteritis and foodborne illnesses. The program also included components presented by the Department's central office infection control and tuberculosis program nurses focused on nursing responsibilities at the institutional level. These educational programs were well received by

Department nurses. At one regional program, security staff from one institution also attended. Based on commentary from these individuals, AQMC members recommended the OHS work with security operations to develop an educational program for security officers focusing on transmission routes and signs and symptoms of MRSA and Norovirus gastroenteritis and methods to reduce or lessen risks and outbreaks.

Chicken pox is a previously common childhood disease. Epidemiological changes for this disease include a decrease of the wild virus in the community after a vaccine became available in 1995. The AQMC suggested the Department identify its cohort of unexposed, unvaccinated individuals; those individuals never exposed to or vaccinated against chickenpox and who are potentially susceptible to contracting the disease. This is only a small portion of the population, and the Authority encourages the Department to identify this group and offer or provide vaccination to those individuals. In 1999, the CDC included staff and inmates of correctional facilities as members of high-risk groups that should be vaccinated. While a relatively mild childhood disease, chickenpox is more severe in adults. An unexposed, unvaccinated immunocompromised individual can contract chickenpox from another individual with a shingles outbreak. Due to its spread by airborne and contact methods and the close proximity of individuals in prison housing quarters, a single case of chickenpox requires identification of potentially susceptible contacts, especially immunosuppressed persons. It also requires isolation of the patient while contagious.

Another area the AQMC encouraged the Department to address is the intrasystem transfer process, specifically related to follow-up of identified health care issues. During its review of mortalities, AQMC members noted that in many cases care deficiencies could be linked to inadequately prepared transfer summaries by the sending institution, including reception centers, and/or inadequately prepared arrival summaries and inadequate chart review at the receiving institution. Responding to this concern, the Department included an investigational study of the intrasystem transfer process as part of its FY 2005—2006 clinical quality review. The study will be conducted during the 2nd quarter and repeated the following two quarters. The OHS it plans to share the results of its 2nd quarter study at the AQMC's 3rd quarter meeting.

Special Presentation

Both the state and the federal government want to move medical records management into the information technology age. Governor Jeb Bush's health information advisory board formed a new non-profit corporation, the Florida Health Information Network, Inc. The initiative is to be a model for the nation by creating a medical Internet offering instant access to information about a patient's history. President George W. Bush in his 2004 State of the Union address stated, "By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care." Since the AQMC members view an electronic medical record as having a direct link to improving quality of care, AQMC members requested a presentation on an electronic medical record (EMR) from a vendor whose EMR is designed to interface with an offender information system. The AQMC also envisions exploring other vendor products. The AQMC is of the opinion that an EMR in the correctional setting could be a key element in improving continuity of care. Unlike the free world, where patients often have a long term relationship with their physicians, in the correctional setting, patients are routinely transferred numerous times during incarceration. For inmates with complex medical conditions, pertinent medical information can

be buried in a previous volume of the record or not easily accessible. While there is recognition in the information technology community that an EMR might not save money in the short term, there are other intangible benefits. The potential for reducing or eliminating missing medical records, the ability of multiple users to review and update the same record, and the ability to enhance services through tracking and reporting among them. (cite,page 65) The Authority looks forward to joining the Department in exploring options in the technology area as EMRs become commonplace in medical practice and provision of care.

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APPENDIX

SUMMARY OF SURVEY RELATED ACTIVITIES
FY 2004—2005

Close Management Surveys

Institution	Conducted	Report Issued
Charlotte	November 2004	December 2004
Union	December 20004	January 2005
FSP	January/February 2005	March 2005
Santa Rosa	March 2005	April 2005
Lowell	April 2005	May 2005

Corrective Action Plan (CAP) Assessments Closed
FY 2004—2005

Survey Date	Institution	Type of CAP	Number of Reviews To Close
FY 2002—2003			
October 2002	Broward	PH	3
October 2002	Union	MH	2
January 2003	Hardee	MH	3
January 2003	Century	MH	3
February 2003	Columbia	PH	3
		MH	4
March 2003	Holmes	MH	3
May 2003	Madison	MH	2
June 2003	Indian River	Both	1
July 2003	Santa Rosa	Both	1
FY 2003—2004			
July 2003	Polk	PH	1
		MH	2
August 2003	Lawtey	Both	1
August 2003	Avon Park	PH	2
September 2003	Hernando	PH	1
		MH	2
September 2003	Homestead	Both	2
September 2003	Dade	MH	3
November 2003	Apalachee – West	PH	2
		MH	4
November 2003	Apalachee – East	PH	2
		MH	3
November 2003	Gainesville	PH	2
December 2003	Putnam	Both	1
December 2003	Florida State Prison	CM	Resurveyed
November 2003	Union	CM	2
January 2004	Okeechobee	Both	2
January 2004	Hamilton CI	PH	1
		MH	2
February 2004	New River	PH	1
		MH	2
March 2004	Brevard	Both	1
March 2004	Reception & Medical Center	Both	1
May 2004	Charlotte	PH	1
April 2004	Liberty	Both	2
May 2004	Lake	PH	1
		MH	2
May 2004	Martin	Both	1

CM = Close Management MH=Mental Health PH=Physical Health Both=Physical and Mental Health

Focused Reviews
2004 - 2005

Institution	Area of Review
Apalachee	Intrasystem Transfer Process Mental Health Discharge Planning Psychiatric Medication Administration Suicide/Self-Injury Processes
Calhoun	Physical Health Discharge Planning Chronic Illness Clinics
CFRC	Intake and Reception Process Intrasystem Transfer Process
Columbia	Intrasystem Transfer Process Mental Health Discharge Planning Psychiatric Medication Administration Suicide/Self-Injury Processes
Dade	Mental Health Discharge Planning Psychiatric Medication Administration Suicide/Self-Injury Processes
Everglades	Mental Health Discharge Planning Psychiatric Medication Administration Suicide/Self-Injury Processes
Hillsborough	Mental Health Discharge Planning Psychiatric Medication Administration Suicide/Self-Injury Processes
Jefferson	Physical Health Discharge Planning Chronic Illness Clinics
Liberty	Intrasystem Transfer Process Physical Health Discharge Planning Mental Health Discharge Planning Suicide/Self-Injury Processes
Lowell	Intake and Reception Process Intrasystem Transfer Process Outpatient Mental Health Care Physical Health Discharge Planning Mental Health Discharge Planning
Madison	Physical Health Discharge Planning Chronic Illness Clinics
Putnam	Mental Health Discharge Planning Suicide/Self-Injury Processes
RMC	Intake and Reception Process
Taylor	Mental Health Discharge Planning Suicide/Self-Injury Processes
Union	Physical Health Discharge Planning Chronic Illness Clinics
Wakulla	Physical Health Discharge Planning Chronic Illness Clinics
Washington	Intrasystem Transfer Process Mental Health Discharge Planning Psychiatric Medication Administration Suicide/Self-Injury Processes
Zephyrhills	Mental Health Discharge Planning Psychiatric Medication Administration Suicide/Self-Injury Processes