HEALTH CARE IN FLORIDA PRISONS

A LEGISLATIVE STUDY

Prepared By

THE SENATE STANDING COMMITTEE ON
CORRECTIONS, PROBATION, AND PAROLE

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SENATE
CORRECTIONS, PROBATION & PAROLE COMMITTEE
The Capitol, Tallahassee, Fla. 32304

December 3, 1976

Honorable Lew Brantley
President
The Florida Senate
The Capitol
Tallahassee, Florida 32304

Dear Mr. President:

Enclosed for your review is a report entitled "Health Care in Florida Prisons" prepared in accordance with your request. The report represents the joint efforts of staff from the Committees on Corrections, Probation and Parole, Judiciary-Civil, Health and Rehabilitative Services, and Appropriations. It presents findings and recommendations on the delivery of health and medical services to inmates in Florida's prison system.

We shall be happy to respond to any questions you may have or supply additional information you may require on this matter.

Sincerely,

Raymond S. Wilson
Staff Director

RSW/dk

Enclosure

PREFACE

This is one of seven reports on projects undertaken on an experimental basis by the Senate professional staff during the interim prior to the 1977 legislative session. Seven topics were selected in areas of interest where a diversity of expertise could be applied to analyze issues, reach factual conclusions, and, where needed, recommend legislation.

The seven project topics are:

1. A Report on State Fixed Capital Construction Administration in Florida

2. Supported Work Assistance Project: A Work Program for Florida's Welfare Recipients

3. Health Care in Florida Prisons

4. An Evaluation of Florida's Drinking Water Supply Program

5. Analysis of State Transportation Revenues Required to Match Federal Transportation Funds

6. Evaluation of Florida's Pari-mutuel Tax Structure

7. A Limited Examination and Evaluation of the Decision-making Processes Within the State University System to Implement Legislative Priorities Relating to the Education in General Budget Entity

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I. SUMMARY

State legislatures are facing mounting pressures for overhaul of their health care delivery systems. The costs of health care, distribution of health personnel, and access to treatment are recurrent themes affecting all Floridians. For those persons confined to institutions under judicial edict in Florida these issues are no less real. The pressure for the maintenance of routine health care requirements is being increased through judicial scrutiny of the delivery apparatus and the state's support for it. Although Florida currently spends in excess of $6 million annually for health care for its adult offenders it is under suit in federal court. Current appropriation levels indicate a 50% increase in the amount budgeted for this year alone.

Although courts have grown increasingly sensitized to inmate demands that medical and health treatment be reasonable and not shocking to the conscience, the standards proposed have been very general. This still affords correctional administrators flexibility in the design of a system which meets the unique demands of an institutional population approaching 16,000. Nonetheless, the organization of health care delivery in the Florida prison system is characterized by management inefficiencies. For too long it has been made subservient to the dictates of population management and custody with little focus being given to broadly based issues. Solutions have been tailored to specific crises and institutions.

The organization of health policy within the Department of Offender Rehabilitation lacks specific management direction and has been influenced heavily by medical considerations. Large numbers of personnel assigned to the delivery of primary care fail to meet the minimum standards promulgated by law for licensure within their respective health professions. The services delivered are patchwork in nature and are not integrated within a system-wide medical services plan. Medical records for individual patients are not organized in an orderly fashion. And little focus has been given to the valuable role that university affiliated medical centers in Gainesville, Tampa, and Miami can play in providing essential services and competently trained health personnel. Properly structured, these resource alternatives can avoid reliance upon expensive capital expenditures for equipment which cannot receive optimum utilization. Such arrangements, utilized elsewhere, have proven themselves to be valuable adjuncts to a basic medical services capability within penal institutions.

The 1976 Florida Legislature mandated a review of health care delivery with Florida's prisons through the Board of Regents. Only incremental progress has been achieved at this juncture in the fulfillment of the mandate for an evaluation of alternative modalities of health care for the confined adult offenders.

II. INTRODUCTION

Increasingly, state legislatures are being asked to address themselves to the immediate and prospective health care needs of their citizens. For many individuals, the dialogue has assumed the character of a protracted debate with a number of issues phrased in terms of demands for human services deserving of public enforcement.

While there may be conceptual agreement on principles, programmatic efforts designed to implement these issues remain isolated and unclear. Part of the reason may be that health care itself is at best an imprecise term: it implies an achievement of a desired end state but does not provide a linkage specifying means. For some it implies a hospital, for others personal contact with a physician - each of these reflects a time-honored view of health care reinforced by friends, the professions, and the media.

Even the sum of these parts, however, does not always equal the whole. Recent legislative studies have indicated that for sizeable segments of the Florida population, a gap exists between the need and supply of essential health services.[1] Traditional marketplace forces were reported to not appreciably affect the supply, demand, or costs associated with the provision of health care in the open market.[2] Thus, Florida is experiencing the anomalies of having a surplus of hospital beds and physicians and yet the inability to assure health service delivery to the elderly, infirm, and poor.[3]

For those confined under judicial edict, be they the retarded, the mentally ill, or as is the subject of this report, the criminal offender, there is a similar closure of the market. Gaps in the free world become voids in the institution. The ability of the confined to pick and choose is restricted such that there can be no assurances that factors of distribution, access, and quality are in any way appropriate to actual needs. Insulated from the services available to their free world peers the confined have repeatedly sought judicial relief for the problems thought to be exacerbated by their confinement. Attorneys General are now finding themselves devoting substantial amounts of time to the defense of actions of administrative agencies against inmate allegations of improper or outright negligent medical care. For Florida alone this means assignment of a half dozen attorneys to the handling of a score of inmate lawsuits alleging poor medical treatment.

Past practices, organization, and funding are being called to question as conventional responses to the health care requirements of the confined are being examined. Ironically, increased inmate awareness of their accessibility to the courts in the role of patient has placed the confined in the relatively advantaged position of being able to judicially influence the character of the health care delivery process which a free world population finds seemingly unattainable.

For Florida, the luxury of prospective planning for the health requirements of the confined has been foreshortened by judicial review of the very legality of its tax-supported delivery apparatus. Serious policy questions have been raised and commitments made both in and out of court which may restrict the state's ability to develop an independent health policy for the confined.

Long shrouded in terms of overcrowding, understaffing, or the more encompassing "lack of resources", the actual components of institutional organization are receiving closer scrutiny from the judiciary and other quarters. Legislatures are beginning to inquire into the effects past appropriations of tax dollars have achieved. Administrators are being called upon to bring their forecasts of what they proposed to do in line with what has in fact happened. This in itself behooves a critical review of the current state of the art in the organization and delivery of what for Florida has become a multi-million dollar annual operating expense of government. While trends indicate a consistent escalation in the public financial commitment to health care, the nature of the services themselves has escaped scrutiny. In the same sense that justice delayed may be justice denied, poor health care may exact a price far more expensive than the costs now being borne by the taxpayer.

III. PURPOSE AND SCOPE

This report has as its objective a review of the present state of the art in the delivery of health care for the largest segment of the involuntarily confined: adult inmates of the Florida prison system.

The objective so stated, there was an easy temptation to expand the scope of the project incrementally as additional information was gathered. Hopefully this temptation has been resisted successfully without detracting from the overall thrust of the project. Limitations of time did not allow for review of several important aspects of health care in a prison setting. A parallel inquiry by the Board of Regents was thought to provide the opportunity for a more in-depth analysis of factors left unaddressed by this report. A later section of this report details this separate undertaking and inventories its progress to date.

Realistically, this juncture may be an appropriate point at which to note some emphases and disclaimers as to what this report includes and does not include. It attempts to review the salient operating characteristics of institutional health care delivery in the Florida Department of Offender Rehabilitation by focusing attention upon such issues as the legal obligation of the state to provide care; the organization, staffing, and financial management of the services provided; and extramural proposals for revisions of the system. The sixty-day study phase for the project did not allow for review of specific inmate medical histories, for the health care requirements of those inmates under community supervision, or for an in-depth

view of ancillary health services in the fields of mental health, retardation, or health education. The narrative thus circumscribes health care within the context of the physical infirmities of inmates within major prison facilities.

In reviewing the present system, three institutions were visited: the Reception and Medical Center (RMC) in Lake Butler, Union Correctional Institution (UCI) in Raiford, and Florida State Prison (FSP) in Starke. These three institutions were selected because they:

1) comprise approximately 65% of total expenses for health and dental care in DOR;
2) have a total of 239 of the entire 334 hospital/infirmary beds in DOR;
3) are allocated approximately one half of the total authorized health positions in DOR;
4) house approximately 50% of the total inmate population.

In addition, RMC was designed to be the central location for providing health care services to the inmates. The close proximity of UCI and FSP to RMC makes inclusion of these institutions logical. These three institutions, though atypical of the rest of the institutions, directly influence the character of health care delivery system-wide.

Section VII reviews the legal requirements incumbent upon Florida in the organization and funding of health care in prisons. The obligations of statute and case law are outlined for a perspective on the options available to policy makers.

Attention is devoted to what may be a landmark court case currently being litigated in federal court on this subject. The findings and recommendations of other states and organizations are reviewed for a perspective on prison health care as analyzed by others.

Section VIII presents the major findings of the report across several dimensions: organization, personnel and staffing, medical records, health care costs, drugs and prosthetic devices, and extramural proposals affecting the delivery of health care.

Section IX summarizes the conclusions from the analysis and makes recommendations for action.

Although this document reports findings and makes recommendations, it is itself a response to concerns by the Florida Senate that more comprehensive assessments be made of ongoing publicly funded programs. Only in recent years has there been an emphasis upon the analysis of the programmatic issues which previously have been subject to simple budgetary review.

This report represents a concentrated effort by staffs of the Committees on Appropriations; Judiciary-Civil; Health and Rehabilitative Services; and Corrections, Probation, and Parole, to the issues expressed in the title of the report. It is but a partial response to many of the issues affecting health care in an institutional setting. Nonetheless, it is a first step in reviewing the performance of publicly funded agencies of Florida government.

IV. METHODOLOGY

In the assembly of the materials for this project, several approaches were utilized for the collection of the required information.

An extensive data collection instrument was sent to the Department of Offender Rehabilitation for its completion. Contained in this document, appended at the end of this report, were questions which attempted to elicit measurable operating characteristics of the agency along such health dimensions as personnel and staffing, medical records, patient profiles and medical services components. Staff members of several Senate committees were assigned particular subject areas for review. The Committee on Judiciary-Civil, together with this Committee, briefed the legal issues involved in the provision of inmate health care; the Committee on Appropriations completed a financial analysis of health care costs in the DOR and gathered data on allied medical training programs in the State University System; and the Committee on Health and Rehabilitative Services reviewe . dical services themselves in the institutions. Complementi. ·is research endeavor were on-site visits to medical facilities: the Reception and Medical Center, Florida State Prison, and Union Correctional Institution. There, interviews with senior health officials of the agency were conducted.

Bibliographic background was obtained through research in the literature in criminology and health care with assistance obtained in this endeavor from the American Medical Association and the Council of State Governments.

V. MAJOR BACKGROUND ISSUES

A. HEALTH CARE AND THE LAW

The obligation of the state to provide medical care for prisoners is derived from the common law duty of care owed by sheriffs and jailers to persons in their charge. A recent case from Michigan perhaps best explains this common law obligation placed upon the state:

> When government imprisons people, it deprives them of freedom to look after their own health and safety. In the free community the man may run from his assailant. In the jail, flight is not possible. In the free community, a man may see his own doctor at his own convenience. In jail, he must see the jail physician under the rules prescribed by the institution. In the free community, he is not exposed to hardships of confinement which may bring out suicidal tendencies. Since the prisoner is very much at the mercy of his jailers, no one should be surprised that the common law recognizes the duty on the part of the jailer to give confined persons reasonable protection against assault, suicides, and preventable illness.[4]

Although it is well established, therefore, that the common law imposes an obligation upon the state to provide medical care for those persons incarcerated within the state's prisons, the parameters of the obligation and the degree of care which the state is obligated to provide is not so clearly defined. Many states have more specifically defined this common law obligation by statute and regulation. Florida, however, has not defined its obligation statutorily, and thus Florida Statutes make very few references to the obligation of the Department of Offender Rehabilitation to

provide medical services to those persons under its jurisdiction. Section 945.025(2), Florida Statutes, for example, states that "[m]edical, mental, and psychological problems shall be diagnosed and treated whenever possible" by the Department of Offender Rehabilitation. This section itself was derived from legislation passed only in 1974.

Since common law and statutory law provide no basis for determining the standard of medical care Florida is obligated to provide to the state's prison population, case law remains the primary area from which the state's obligation can be drawn.

Until very recently, medical problems, like other prisoner grievances, were summarily dismissed by the courts. Inmates were left to the mercies of the administrators under the "hands-off" doctrine, which presumed expertise on the part of prison officials in the handling and care of inmates. The justifications for such a rule are outmoded today and thus the "hands-off" doctrine has met its demise.

Although courts have recently refused to follow the hands-off doctrine, they have continued to encounter difficulty in formulating a test for deprivation of medical treatment which rises to the level of a constitutional violation. One of the most frequently applied tests is that the deprivation must be "shocking" to the conscience of society in order to deprive the inmate of rights secured by the constitution. In applying this standard, many courts began to make a distinction between a total denial of medical treatment and medical treatment which is merely inadequate or improper.

It is clearly established that the courts will grant relief to an inmate where an intentional denial of medical care is alleged. Thus, when no medical assistance was made available to Arkansas prisoners, a federal court required that reasonable medical care should be made available at reasonable times.[5] In another case, this principle was enumerated: "The intentional denial to a prisoner of needed medical treatment is cruel and unusual punishment."[6]

Not until fairly recently have courts begun to speak in terms of a prisoner's right to adequate medical care.[7] Most of the latest cases recognize that where prison officials deny medical treatment which has been ordered by a physician, there has been a denial of the prisoner's right to adequate or reasonable medical attention.[8] Courts are still reluctant to interfere, however, when a difference of opinion exists between the lay wishes of the patient and the professional diagnosis of the doctor.[9] Thus, only in extreme cases will the courts second guess the physician as to the propriety of treatment.[10]

A number of recent cases, however, indicate that the courts are tending to more closely scrutinize the general adequacy of medical care being provided for inmates.

Indeed, the suit filed by Michael Costello against Louie Wainwright, Secretary of Florida Department of Offender Rehabilitation, analyzes the very adequacy of medical care within Florida's penal institutions.[11] Although the district court's order was fashioned in terms of overcrowding, the overcrowded conditions were shown to result in medical care that fell below

constitutional requirements of "adequacy." The Fifth Circuit's remand to Judge Scott in the district court on September 27, 1976, was primarily on quasi-procedural grounds and thus did not address or reverse the lower court's finding on general inadequate medical care within Florida's prisons due to overcrowded conditions. Consideration must be given to the fact that Florida, as the defendant in the suit now pending in federal court, is in the position of having stipulated all of the factual arguments alleged by the plaintiffs.

Other cases that have investigated the general adequacy of medical care have noted that "deprivation of basic elements of adequate medical treatment" is unconstitutional[12] and improper or inadequate treatment which violates the Eighth Amendment "must be continuing, must not be supported by any competent school of medical practice and must amount to a denial of needed medical treatment."[13]

In the case of Jackson v. Kendrick,[14] the court found the entire Philadelphia prison system constitutionally inadequate, including its medical facilities. "The health of the prisoners is . . . in jeopardy. . . . Upon being committed to the prisons, the prisoners do not receive a prompt or adequate medical examination. . . . Once committed, prisoners receive medical and psychiatric care below minimum acceptable standards." The court thus held that one full-time doctor and seven part-time doctors were insufficient to provide adequate medical care for 2,500 inmates in the city's prisons.

In Newman v. Alabama,[15] inmates of the Alabama Penal System filed a class action seeking relief from deprivation of proper and adequate medical treatment in violation of their rights guaranteed under the Eighth and Fourteenth Amendments. The court agreed and in so deciding examined all facets of medical care. The court placed its greatest emphasis on the inadequate, unqualified nature of the staff. It further found that doctor's orders were rarely carried out, doctors were frequently unable to give timely and thorough care; the physical plant and equipment were inadequate; the treatment program was poorly administered; and the inmates were intentionally denied treatment in many instances by correctional staff members. "The result is a degree of neglect of basic medical needs of prisoners that could justly be called 'barbarous' and 'shocking to the conscience.'"

To correct these "barbarous" conditions, the court ordered compliance with the regulations of the Federal Bureau of Narcotics and Dangerous Drugs to limit access to drugs, and inspections by the Fire Marshal and State Board of Health. The court also directed the State of Alabama to draw up a plan for updating equipment and increasing the staff of the medical facilities. Prison officials were directed to insure that inmates were promptly diagnosed and treated by qualified medical personnel and that they received medication and treatment prescribed by physicians. Furthermore, the court ordered the state to implement the federal government's standard for Participation of Hospitals in Medicare Programs.

In Gates v. Collier,[16] the federal district court ordered even more specific relief on the issue of medical facilities than in Newman. The court concluded that the 1900 inmates in the Mississippi State Penitentiary often failed to receive "prompt or efficient medical examination, treatment or medication." To rectify their difficiencies and abuses, the court ordered that minimum health care requirements be met. Mississippi State Penitentiary was ordered to employ at least three full-time physicians, two full-time dentists, two full-time trained physician assistants, six full-time nurses certified as RN or LPN, one medical records librarian and two medical clerical personnel. In addition, the court instructed the prison to provide the services of a qualified radiologist and pharmacist on a "regular basis." To meet constitutional requirements, medical services were ordered to comply with those general standards proposed by the American Correctional Association.

The implications of Newman, Gates, and similar cases for Florida prisons are not entirely clear. The courts have been unable to define "adequate medical treatment." This is due in large part to the subjective analysis involved in Eighth Amendment cases, which most of the decisions have relied upon. Rather than setting a uniform standard, the decisions indicate a case-by-case approach limited to the factual situations at hand. The courts have applied the "I know it when I see it" maxim in determining what is or what is not adequate medical treatment. Those cases that have attempted to set specific

standards such as Gates, have utilized an arbitrary numerical approach and have ordered the states to employ more medical personnel based on the number of inmates incarcerated.

So far there is no U.S. Supreme Court decision on point, but the Court has agreed to hear this fall a Texas case involving the adequacy of prison health care. Though Estelle v. Gamble is based on the procedural issue of whether a complaint attacking adequacy of health care, rather than the denial of it, can be brought under the civil rights statute, the Court's ruling may well have substantive implications.[17]

For now, until there is a Supreme Court decision, one must look to the federal circuit court' decisions for standards--and those standards are nebulous and undefinite. Thus, one is forced to examine each case individually and avoid those medical practices which have been held inadequate.

Funding issues have also surfaced as paramount concerns as an increasingly sensitive judiciary re-examines its traditional "hands-off" approach to intervening in state matters affecting the raising of revenue for the funding of institutional health services:

> Sound medical judgment results from a fair and uninfluenced analysis and determination based only on physical condition and needs and potential benefits, not on extraneous factors and certainly not on the inflexibility of a budget. Such sound judgment was not exercised in this case.[18]

B. COMMENTARIES ON HEALTH CARE

In addition to case law, another source of medical standards for prisons are recommendations from various national and international organizations. It is possible that the courts, in attempting to formulate standards for their Eighth Amendment analysis of prisoner's cases, will in the future rely upon the recommendations of these and other organizations. Indeed, in Gates v. Collier,[19] discussed above, the federal court ordered Mississippi State Penitentiary to bring its medical services up to the level recommended by the American Correctional Association. Similarly, Newman[20] required the Alabama Penal System pharmacy to conform with the regulations of the Federal Bureau of Narcotics and Dangerous Drugs.

Included herein are brief summaries of the recommendations of the Fourth United Nations Congress on Prevention of Crime and Treatment of Offenders, the American Correctional Association, the National Advisory Commission on Criminal Justice Standards and Goals, the National Sheriff's Association, the United States Bureau of Prisons and the Association of State Correctional Administrators. The entire texts of the recommendations of these organizations are appended at the end of the report.

The standards of the United Nations Congress on Prevention of Crime and Treatment of Offenders[21] require that at least one qualified medical officer be available for

daily sick call and treatment of special illnesses. Responsibilities include physical examinations of newly admitted inmates, segregation of contagious conditions, determining fitness for work or degree of physical deterioration due to confinement, and monitoring general hygiene and sanitation. Dental, pre- and post-natal services, nursing and psychiatric care are to be available. Health services are to be organized "in close relationship to the general health administration of the community or nation" with transfers to specialized institutions or civil hospitals when required.

The Manual of Correctional Standards of the American Correctional Association[22] lists four essential elements of institutional health and medical care: (1) a sound medical administrative organization with adequate financing; (2) qualified medical, dental, nursing, laboratory and support personnel; (3) institutional services characterized by the best medical knowledge, personal attention and coordination of medical and social treatment; and (4) medical facilities and equipment meeting high technical standards. Each element is discussed in detail in the Manual and rather specific manpower standards are suggested: a basic medical staff for every institution of 500 inmates which includes one full-time chief medical officer, one full-time psychiatrist, one full-time dental officer, and five full-time medical technicians (with suggested increments for larger facilities).

The National Advisory Commission on Criminal Justice Standards and Goals[23] enumerates four minimum criteria for prison medical care to be comparable to that generally available: (1) a prompt examination by a physician at commitment; (2) medical services and trained personnel supervised by a licensed physician; (3) 24-hour emergency medical treatment; and (4) access to an accredited hospital. To ensure physical, mental and social well-being and treatment, outside services are to be used, complete records kept, drugs controlled strictly and governmental medical or health programs made available where applicable to the general public.

The recommendations of the National Sheriff's Association[24] require fundamentals such as 24-hour availability of a doctor, entry examinations, sick call, mental health diagnosis and treatment, control over drugs, and up-to-date medical records. Emphasis is alsc placed on maximum use of community health facilities, supplying necessary prosthetic devices, and assuring overall jail sanitation.

In its publication entitled The Jail - Its Operation and Management,[25] the United States Bureau of Prisons prepares a jailer to judge whether a prisoner should be admitted first at a hospital; discusses the jailer's role in delivery of medical services and keeping medical records; provides rules on the use of physical and chemical restraints; and provides detailed information on care of the alcoholic, mentally ill,

addicted, depressed, diabetic, epileptic or injured prisoner and of the sex offender.

The Association of State Correctional Administrators makes various recommendations, including the establishment of a medical director to administer the total health program, proper diagnostic and treatment services, emergency treatment, control of drugs, adequate record keeping procedures and appropriate facilities. The recommendations relating to health care are contained in its publication entitled Uniform Correctional Policies and Procedures.[26]

Perhaps the most definitive review of health care in Florida penal institutions was derived from Dr. Kenneth Babcock's court-ordered 1973 medical care survey of the Division of Corrections, predecessor agency to the present[27] Department of Offender Rehabilitation. This document extensively inventoried services and procedures agency-wide and made critical comments on deficient practices. In its response to the survey the then Division of Corrections noted a need for a broad spectrum of specialized equipment and services. This need was later translated into a budgetary request item in the succeeding year's appropriation request.

Echoing many of the concerns of the Babcock Report was the 1973 staff report of the Florida Senate Criminal Justice Committee.[28] The report summarily noted practices which fell below an ordinary standard of medical care and called for corrective measures particularly in the areas of personnel licensure and adequate distribution of health personnel.

The states of Pennsylvania, Michigan, Illinois, Massachusettes, Kentucky, and Province of Ontario have also conducted studies of their respective jurisdictions' prison health care delivery mechanisms. Each concluded that there were noticeable deviations in the qualitative and quantitative aspects of the care delivered. Their separate recommendations called for upgrading of personnel, equipment, and for organizational visibility of health care in the corrections agencies.

VI. FINDINGS

As with most legal issues, therefore, there are no clearly defined parameters or standards within which the state must conform its actions in order to provide medical services to inmates which meet the test of constitutional acceptability. Perhaps the most useful tool for determining the level of care mandated by these cases is to review the substantive issues to which courts have most frequently addressed themselves when analyzing medical care in prisons throughout the United States. Within this format, the ability of the Department of Offender Rehabilitation to function can be selectively reviewed.

A. THE ORGANIZATION OF HEALTH CARE

Along with a counterpart facility for women in North Central Florida at Lowell, the Reception and Medical Center (RMC) at Lake Butler, Florida stands as the major entry point for adult male inmates placed in the custody of the Department of Offender Rehabilitation. While its functions encompass more than those which ordinarily would be found in a community hospital by virtue of its unique clientele, its overt health role is two-fold: first, to serve as a screening and diagnostic facility during in-processing of the inmate from court; and second, to be responsible for the medical management of inmates requiring chronic, acute medical/surgical, or psychiatric care referred to it from surrounding penal facilities. Although classified as a hospital, RMC and

its ancillary facilities system-wide fall short of meeting the standards of the Joint Commission on Accreditation of Hospitals to which its peers in the free world strive as an index of minimal professional acceptability.

Because the Florida prison system is far-flung, its penal institutions stretching the breadth of the state from Pensacola to Key West (Appendix Chart 1), the geographic isolation of one institution from another has prompted administrators to incorporate a medical component within the operations of each major institution. As chart 2 indicates, each major institution retains the capability of providing basic clinical management for its population although there are considerable differences in the nature of the services provided. The DOR budgets for the staffing of 334 beds for an institutional population of some 16,000 which makes this one of the most advantageous patient/bed ratios in Florida. By any index of bed needs, the DOR is well endowed.

Moreover, inmates in road prisons or community correctional centers cannot avail themselves of routine institutional services and thus must look to outside medical sources funded by the Department. Offenders on probation or parole supervision are independent of all DOR direct health services.

Unlike a community hospital in which there is a clear-cut organizational relationship that differentiates administrative from medical responsibilities, other patterns emerge with health care in a prison setting. Management considerations are imbued with both medical and custodial overtones.

This impacts upon the organization of care in two ways: first, inmates, though theoretically classified at entry on the severity of medical and dental problems (Appendix Chart 3), frequently see themselves assigned to institutions on the basis of other factors such as custody classifications or availability of bedspace. This distributes inmates in such a fashion as to virtually require a medical component within each institution. Secondly, decision-making responsibilities are clouded by the complex organizational relationships in the agency. A Health Program Office in Tallahassee theoretically articulates policy for the Department, but the bulk of all practices appears to flow from each institution with solutions tailored to meet individual facility needs. The flexibility inherent in such a decentralized approach disappears as each institution attempts to provide a total medical care component independent of a broadly based plan that would integrate services and be cognizant of factors such as geography, patient needs, and utilization. One institution reported in an April, 1976, survey initiated by DOR that its health needs could be met through purchases of large amounts of medical equipment. Yet a 1975 Department of Health and Rehabilitative Services medical services plan had predicated substantial economies for penal institutions by coordinating medical services on a regional basis.

B. PERSONNEL AND STAFFING

The Department is authorized a total of 512 health care positions to staff 21 major institutions during fiscal year 1976-77. (Appendix Chart 4) This figure represents all authorized personnel involved in the delivery of care and operation of medical facilities and includes 5 surgeons, 21 physicians, 93 registered nurses, 206 medical technicians, and 6 medical technologists. Of the 512 positions, 12 have been vacant for 6 months or more and 7 have never been filled. (Appendix Chart 5)

According to the Manual of Correctional Standards,[29] "[e]fficient usage of medical personnel requires that the staff be geared to the population level and commensurate with its needs." An elementary determination of need by institution can be made by looking at the size and age of the population and the medical classification assignments which are based on the physical condition and needs of the individual inmates. Thus, the allocation of personnel should reflect to some degree the nature of the health needs of the inmate population at each institution with an institution having a population assigned medical grades 3 and 4 being allocated a greater number of positions to provide for greater and more acute care needs than an institution whose population has less acute needs and is therefore classified as 1's and 2's.

Six of the institutions with population figures varying from 195 to 549, but with the same medical grade composition, are each authorized the same number of direct care positions: one registered nurse, 5 medical technicians, and, in all but two cases, one physician.

According to the Department, there is no formula or standards used in the allocation of positions; however, an attempt is made to insure that each institution has medical coverage 24 hours a day, 7 days a week. In order to achieve this objective, 5 medical technicians are required for each institution and, as noted above, 5 medical technician positions are exactly what the 6 institutions with from 195 to 549 inmates are authorized. Additional positions are allocated based on request of the institution and need which is determined by the institution. Also considered are any recommendations that may have been made by consultants.

Although the mission of Union Correctional Institution is (as stated by Dr. A. Gonzalez, DOR Medical and Surgical Director) the care of chronic cases and although the institution is located approximately 15 miles from RMC which is staffed and equipped to handle acute medical care and emergencies for both UCI and Florida State Prison, UCI is authorized 2 surgeon positions. The Department's Medical and Surgical Director, in the 1974 Response to General Summary Remarks as Detailed by the Babcock Commission Report, [30] proposed that UCI possess outpatient clinic capa-

bilities and an emergency room because of the potential for a riot at UCI and FSP. There is no operating room staff standing by at UCI, however, so emergencies such as stab wounds are sent to Shands Teaching Hospital, 25 miles away. Additionally, UCI's nurse anesthetist position is chronically vacant and the facility has not been able to meet the requirements for licensure as a hospital.

Whether or not the Department's clinics, infirmaries and hospitals are adequately staffed, existing staff are ineffectively utilized. The most obvious example of this is the practice of using physicians to perform the routine physical examinations of all inmates processed through the Reception and Medical Center, an activity that does not require the skills of an M.D. Consequently, the professional skills of the physicians are not being focused where they could be better utilized resulting in lower productivity at a higher cost. Either physician's assistants or nurse practitioners could perform this function more than adequately.

Of the 21 physician positions authorized and filled, only 12 are filled with physicians licensed to practice in this state. (Appendix Chart 6) Although Chapter 458, Florida Statutes, exempts physicians employed in state institutions from the requirements of licensure, licensure is one objective measure of quality of especial value in cases of litigation. One of the questions most frequently asked

by the courts is the number of personnel and staffing of institutions. Although this approach is somewhat arbitrary, it is a question that is posed in the majority of cases and is perhaps the easiest standard for the court to apply. Along with this question the courts also require the health personnel to be "qualified." A number of cases have determined that "qualified" entails satisfaction of the appropriate state licensing requirements. Peer review, another method used to evaluate the quality of care provided, does not exist.

A cultural barrier that exists between a number of the physicians and other staff and between physicians and inmates creates a lack of communication and fosters resentment and suspicion of the physicians. It is also interesting to note that 85 of the 87 filled nurse positions are filled by licensed Registered Nurses; however, they are working in the institutions under the supervision of physicians, the majority of whom do not themselves meet the requirements for licensure.

In reviewing the salary schedule for health services positions, job descriptions and the organization chart of the Reception and Medical Center, it was noted that although the responsibilities of the Hospital Administrator are greater than those of the Nursing Director, and although the minimum training and experience requirements are greater for the Hospital Administrator position, the Nursing Director position is two pay grades higher. The position of Assistant Nursing Director, of which there are 4 authorized to RMC,

requires even less training and experience than that of the Nursing Director, and is the same pay grade as the Hospital Administrator. Although the Department treats RMC and UCI as hospitals, it has not given visibility to the management of these facilities as hospitals. The two Hospital Administrator positions are classified lower than Nursing Director and the same as Assistant Nursing Director although the requirements are greater. (Appendix Chart 7)

C. MEDICAL RECORDS

Complete and accurate medical records, a visible means by which quality of care can be assessed, are necessary both to provide information for the medical staff to use in their treatment of the inmate and to protect the staff in cases of legal action. The judge in Newman was appalled at the lack of systematic record keeping in Alabama prisons. Newman and numerous other cases ordered that more detailed and systematic records be kept. The medical records of Florida's inmates also vary markedly in content, format, and quality which make them, at best, difficult to review for any purpose.

Upon entering the prison system, the majority of inmates are processed through the Reception and Medical Center, and it is at this point that their medical records are initiated. In addition to recording the results of the physical examination and laboratory tests, the inmate's medical history is

taken and, if there is a history of illness, the inmate's records prior to his confinement are requested. After the inmate leaves RMC, however, any consistency in the contents or format of his medical record is coincidental. No standard medical form exists within the Department. Each institution develops its own forms and secures them independently of any other prison medical facility. If the institution has a print shop on the grounds, the forms are usually printed there; if not, the forms are printed at other institutions or, in some cases, purchased outside of the Department. Additionally, no standard policy for the maintenance of records exists. Of the eight institutions whose written policies and procedures were reviewed, only two contained a section specifically relating to medical records or medical record office procedures.

The records themselves are generally not well maintained. In those reviewed, contents were not securely fastened and were not presented in any discernable order, either chronologically or by subject of form. Entries are generally handwritten and thus difficult to read. With the lack of standard forms, if an inmate is transferred to another institution during his confinement, his medical record becomes even more unique and difficult to review.

In April, 1974, the Department's Response to the Babcock Commission Report[31] indicated that all medical record forms would be standardized and a standard policy for their use developed. More than two years later, this has not been accomplished.

D. HEALTH CARE COSTS

The financial commitment for the support of inmate health care is a substantial one. In fiscal year 1975-76 expenditures approached $6.3 million. Nonetheless, wide disparities were evidenced in the per capita costs being experienced across the several institutions. (Appendix Chart 8) A cross sectional analysis of the institutional expenditures reveals that inmate health care costs are appreciably affected by the volume of services purchased from outside sources. These services themselves are in excess of $1.1 million annually. (Appendix Chart 9) When subjected to a linear regression statistical test, these data indicate that there are some potential economies of scale that can be derived from using other sources as providers of health care. Although the relationship tends to be a weak one, it does provide at least a preliminary indication that the goal of making each institution self-sufficient in health care delivery may be accompanied by unacceptable economic consequences.

Though substantial in their own right, these figures do not reflect the apportionment of costs entirely. Factors such as custody, maintenance, utilities and ancillary medical services spread across other budget components confound attempts at estimating total costs involved in

health care. One of the revelations of this project has been that the agency has not refined its cost accounting procedures to the extent of isolating program costs which treat health care as a totality.

In comparing Florida's budgetary expenditures in this area with those of other states some interesting patterns emerge. A study performed by DOR in June, 1976, on Florida's support of inmate health care concluded that Florida's expenditure per inmate visit in the area of health care was below the average for the surveyed states. Definition of terms, however, proved to be a key problem. In Colorado, mental health costs are included in the health budget, whereas in many states, such as Florida, the bulk of the mental health costs are not included in the health budget. In Maryland, the cost of treating prisoners at the University of Maryland Hospital is absorbed in the university budget, whereas in a similar situation in Florida, involving Shands Teaching Hospital in Gainesville, the costs are a significant slice of the correctional health care budget. As before, the statistics do not necessarily reflect the level of health care being given to inmates in Florida; the comparisons suffer from methodological gaps which do not present a true picture of actual costs. (Appendix Chart 10)

Lending support to the conclusion that Florida's cost experience is high are figures from the Department of Health Education, and Welfare which report that per capita health care expenditures for Florida and the Nation as a whole are

substantially lower than in Florida's major penal institutions. Where Florida spends $255.81 and the Nation $256.89, the state spends $551.58 on its prison inmates.[32] The factors influencing this variation are complex. Some consideration should be given to the requirement that institutions must supply routine "home remedy" care, aspirin, cough syrups, and the like, which a free world population could obtain on its own.

E. DRUGS AND PROSTHETIC DEVICES

The most recent drug formulary distributed to the institutions stated in the introduction that the hospital formulary system minimizes duplication, lowers the hospital drug inventory and allows for quantity purchasing.[33] This in turn reduces the costs for packaging, labeling and storage. The formulary was distributed in 1972 by the Department of Health and Rehabilitative Services and, according to the several institutions consulted, is generally not used. A number of the institutions have developed their own formularies independently of each other; others have none. Further, procedural requirements for approval of deviation from the formulary vary from institution to institution but if a physician orders a drug not on the formulary, most institutions automatically purchase it. The majority of medications are purchased by each institution through state contract; however, local community pharmacies are used for medications not available through the contract. Since there

is no established utilization review mechanism, either internally or externally, the only control is fiscal limitations.

Similarly, prosthetic devices are obtained on the order of a physician with no discernable restrictions or requirements for approval. Local suppliers of the institution's choice are used and the inmate is fitted either at the institution or he is transported to the supplier for fittings. A supplier also visits Reception and Medical Center every two weeks to fit the inmates there.

F. EXTRAMURAL PROPOSALS FOR UPGRADING PRISON HEALTH CARE

The literature surveyed thus far has concentrated on reporting the research which has documented the inner workings of institutional health care delivery and its associated problems.

A less substantial, though no less significant, body of literature has risen to the fore on the role of medical and health services purchased from outside vendors. In the Michigan study, mentioned earlier, the authors outlined the potential financial advantages of structuring prison health care along the lines of a health maintenance organization wherein health care is purchased on a group basis for a fixed fee.

Materials from the United States Law Enforcement Assistance Administration[34] call attention to similar contractual

arrangements nationwide noting that administrators should be mindful of the favorable cost comparisons which can be realized. The advantages of this method are the deferral of large capital expenditures for services which cannot receive optimum use.

A recently completed project by the University of Miami illustrated the benefits which can be derived from extra-mural health care delivery for detainees in a county jail system. The Miami study[35] reported that significantly greater utilization of personnel could be achieved and the volume of patients increased, with attendant reductions in cost, by using nurse practitioners and allied health personnel in the place of traditional medical practitioners. Although the inclusion of television hook-ups to a neighboring medical center did not prove cost effective, it did underscore the ability to achieve rapid medical care absent the traditional hands-on physician-patient contact.

"Contracting out" as it is sometimes referred has been part of the general policy of the DOR in such areas as pharmacy, emergency services, clinical laboratories, and optometry, notwithstanding institutional variations. Appendix chart 8 reflects the scope of the Department's involvement in such arrangements. Annual operating expenses system-wide exceed $1.1 million and are distributed across nearly all of the facility components of the agency. A sizeable portion of these expenses is allocated for reimbursement

of the state university system for the services it delivers through RMC.

Even these costs reflect only part of the picture. Each time an inmate is referred for treatment outside the institution, he must be accompanied by at least one guard. To the $366,482 in expenses at RMC for consultants, radiological services and laboratory services for the last fiscal year, then, $358,496 must be added for the costs of supervision and transportation.[36]

In spite of large expenditures for outside laboratory services ($70,000 during 1975-76) which would seem to have justified a review by the Department of policies governing the utilization and purchase of those services, no uniformity exists among the institutions. Those procedures an institution cannot perform are purchased from commercial laboratories of the particular institution's choice. RMC and UCI, although located 15 miles apart, each have laboratory capabilities and both use outside commercial laboratories to supplement their own services. Neither, however, purchase services from the same laboratory. The provision and purchase of radiological services reflects the same lack of planning and standardization.

Optometric services also reveal a patchwork organization with the costs being experienced defying standardization. By the DOR's own figures, in some cases, glasses being prescribed

exceed the inmates screened. (Appendix Chart 11) Moreover, the presence of an optometric capability at each institution would appear inconsistent with the mandate of the RMC to perform an initial comprehensive diagnostic and screening role. Hence, purchase of services arrangements can be fraught with diseconomies if they are structured to meet the localized needs of a finite population and fail to be integrated into a comprehensive medical services plan.

Available to the DOR, but utilized principally for specialty care only, are the facilities and programs of the University of Florida's J. Hillis Miller Health Center in Gainesville, some 25 miles distant from RMC. The Health Center has as part of its responsibilities the conduct of medical training curricula in three areas: medical education for the M.D. degree; post-graduate clinical education; and technical training programs for allied health professions. Appendix chart 12 presents a detailed breakdown of the scope and content of each of these program areas. Although students in these programs are required to undergo varied periods of clinical experience in partial fulfillment of their degree requirements, noticeably absent is the mention of DOR facilities as locations for the clinical training. Thus, the routine assignment or rotation of health personnel through RMC or allied facilities has not been accomplished although the Department spends several hundred thousand dollars annually for university affiliated services. Conceivably, a constraint to this arrangement may

lie in the lack of accreditation of DOR medical facilities and the inability of students to receive credit for the time spent at the institution. Certainly, this has been one of the more frequently voiced comments made by agency and university officials when this subject has been discussed. The problems engendered by the lack of accreditation do not appear to be substantial, however, and could be corrected with nominal expenditures by the DOR. This would open the door for concerted participation by the university across all of its business administration, medical, and social science curricula. Current involvement of the university community is restricted to a "Deans Committee" forum of major medical department heads and periodic clinics held at RMC by visiting university physicians.

The General Appropriations Act passed by the 1976 Legislature attempted to underscore the concern for the interdependence of state agency programs. Proviso language appended to the appropriation for the Department of Offender Rehabilitation called for a closer working relationship between the Board of Regents and the agency in a review of prison health care programs. Specifically, the language said:

> From the funds provided in items 877-882, the Secretary shall contract with the Board of Regents to study the feasibility of developing an alternative modality of health care delivery for inmates in custody of the Department of Offender Rehabilitation. The findings of the study shall be submitted to the Legislature no later than January 1, 1977.[37]

In the intervening months since the passage of this act, both representatives of the Board of Regents and the DOR have labored to contractually assign responsibilities for this study. It has proven to be a time consuming process with a great deal of time spent in preliminary negotiations on who will do what and for how much. Only on October 15, 1976, was a contract issued and the formal data gathering commenced. The Board of Regents, in turn, on October 20, 1976, subcontracted the bulk of its responsibilities to staff of the University of Miami who had worked on the initial jail health project in Dade County. Thus, the desire for bringing the internal resources of the state university system to bear has been only partially fulfilled. As the deadline for submission of the report approaches the prospects for achieving a document of sufficient breadth and depth are diminished.

VII. CONCLUSIONS AND RECOMMENDATIONS

For years, health care in a penal environment has subsisted as a stepchild to concerns of institutional security and population management. The crisis orientation of most prison systems has permeated health care issues to the extent that proposals for change have come about largely through involuntary, principally court-ordered, means.

The Florida Department of Offender Rehabilitation has functioned within this environment both before and after its creation as a separate entity of government by the 1975 Legislature. Nevertheless, the Department is faced with an ample bibliography of methods for upgrading the quality and quantity of care it does deliver. The recommendations of outside study panels have been much more specific than judicial mandates which still affords the agency sufficient management flexibility in the tailoring of an apparatus unique to its needs.

The present organization of services and personnel is simply not in good shape. Diffusion of management responsibility and a poor allocation of available resources combine to make the agency's multi-million dollar health care budget potentially inadequate. Across the dimensions of the agency's performance selected for review in this report: organization, personnel and staffing, health care costs, medical records, and drugs and prosthetic devices, the

Department is in need of serious management review. Accordingly, the following recommendations are suggested:

ORGANIZATION

1. Immediate clarification of responsibility for health care policy needs to be undertaken. The Department has allowed piecemeal solutions to individual health care issues and has lacked prospective orientation.
2. The Department should take steps to adopt and put into effect a comprehensive medical services plan which would strive to implement the recommendations made nearly two years ago by the Department of Health and Rehabilitative Services. Little evidence of conformance to these recommendations has been evidenced.
3. Steps should be taken to seek the professional accreditation of the hospital and the Reception and Medical Center by the Joint Commission on Accreditation of Hospitals along with other allied health facilities agency-wide to facilitate their utilization through university affiliated training programs in the health and medical field.
4. Greater consideration needs to be given to medical classifications in the assignment of inmates to particular institutions. Inmates who evidence the need for more medical attention should be assigned to centralized medical units in order to avoid costly duplication of service components and the expense of transporting and guarding inmates to RMC.

5. The Department needs to refine its cost accounting system so that more complete detailed information may be determined on its financial expenditures for health care.

PERSONNEL AND STAFFING

6. The Department should strive to eliminate its reliance upon the professional services of health personnel who fail to meet the minimum statutory requirements for their peers in the free world. This reliance creates a double standard which the courts increasingly are looking upon with suspicion. The Department should aggressively seek alternative staffing methods which make greater utilization of allied health personnel to discharge functions now being performed by senior medical personnel.

7. The Department should initiate a comprehensive review of its personnel policies with a view toward correcting discrepancies between classifications and functions.

8. The Department should contract for the continuing external review of the quality of the health care it provides inmates through university affiliated sources, professional medical societies, or medical foundations.

MEDICAL RECORDS

9. The Department should immediately develop standard medical record forms to be used by all institutions. Printing and distribution could easily be accomplished

in-house and complement the agency's existing correctional work programs.

10. Policies governing the organization and maintenance of medical records should be established to insure system-wide uniformity and facilitate data collection.

DRUGS AND PROSTHETIC DEVICES

11. The Department should revise and update its formulary based at least in part on the recommendations of the physicians who will be expected to use it. Strict compliance should be required and policies governing deviation established.

12. The most commonly used drugs should be purchased in volume to take advantage of the maximum discounts available for the funds extended.

13. Mechanisms for utilization review patterned after similar ones in peer review should be developed.

14. Steps should be taken to insure compliance with all federal and state requirements relating to the dispensing of medications.

EXTRAMURAL PROPOSALS FOR CARE

15. The Department needs to investigate the role which university affiliated medical services can play in its programs. As institutions are opened in proximity to the urban centers of Tampa and Miami, consideration needs to be given to contracting for those services

which would complement the internal capabilities of the institutions themselves.

16. The Department should study the feasibility of defining a portion or all of its health care needs in terms of a health maintenance organization.

17. To the extent possible, health care provided by contracted external health providers should be delivered within the confines of DOR's institutions.

FOOTNOTES

[1]Florida Senate Select Subcommittee on Health Care Costs, Summary Report of the Subcommittee, The Rising Costs of Health Care, Senator Jack Gordon, Chairman (Tallahassee, Fla.: 1974).

[2]Ibid., pp. 14-16.

[3]Florida Senate Committee on Health and Rehabilitative Services, The Elderly in Florida: A Legislative Study, Senator Robert Graham, Chairman (Tallahassee, Fla.: 1976).

[4]Wayne County Jail Inmates v. Bd. of Commissioners of Wayne County, Wayne County, Michigan, Circuit Court Opinion of May 17, 1971, p. 32.

[5]Talley v. Stephens, 247 F. Supp. 683 (E.D. Ark. 1965).

[6]Ramsey v. Ciccone, 310 F. Supp. 600, 605 (W.D. Mo. 1970).

[7]Campbell v. Beto, 460 F. 2d 765, 768 (5th Cir. 1972).

[8]Sawyer v. Sigler, 320 F. Supp. 690, 693 (D. Neb. 1970) Aff'd, 445 F. 2d 818 (8th Cir. 1971).

[9]Cates v. Ciccone, 422 F. 2d 926 (8th Cir. 1970).

[10]Haines v. Kerner, 40 U.S.L.W. 4156 (1972).

[11]Costello v. Wainwright, 397 F. Supp. 20 (M.D. Fla. 1976).

[12]Campbell v. Beto, 460 F. 2d 765, 768 (5th Cir. 1972).

[13]Ramsey v. Ciccone, 310 F. Supp. 600, 604 (W.D. Mo. 1970).

[14]Jackson v. Kendrick, 406 SCW 2710 (C.P. Philadelphia County, April 7, 1972).

[15]Newman v. Alabama, 349 F. Supp. 278 (1972).

[16]Gates v. Collier, 501 F. 2d 1291 (5th Cir. 1974).

[17]Estelle v. Gamble, 516 F. 2d 937 (1975), cert. granted, 96 S.Ct. 1101 (1975).

[18]South Carolina Department of Corrections, The Emerging Rights of the Confined (Columbia, S.C.: The Correctional Development Foundation, Inc., 1972), p. 153, citing Sawyer v. Sigler, 320 F. Supp. 690, 694 (D. Neb. 1970).

FOOTNOTES

[19]Gates v. Collier, 501 F. 2d 1291 (5th Cir. 1974).

[20]Newman v. Alabama, 349 F. Supp. 278 (1972).

[21]American Bar Association Commission on Correctional Facilities and Services, Medical and Health Care in Jails, Prisons and Other Correctional Facilities: A Compilation of Standards and Materials (hereinafter referred to as A Compilation of Standards), published in conjunction with American Medical Association (Washington, D.C.: American Bar Association, 1973), p. 7, citing Fourth United Nations Congress on Prevention of Crime and Treatment of Offenders, Standard Minimum Rules for the Treatment of Prisoners.

[22]A Compilation of Standards, p. 9, citing American Correctional Association, Manual of Correctional Standards, 3d ed.

[23]A Compilation of Standards, p. 16, citing National Advisory Commission on Criminal Justice Standards and Goals: Corrections Task Force Report.

[24]A Compilation of Standards, pp. 19-27, citing The National Sheriff's Association, Manual on Jail Administration.

[25]A Compilation of Standards, pp. 28-40, citing United States Bureau of Prisons, The Jail: Its Operation and Management.

[26]A Compilation of Standards, pp. 41-43, citing Association of State Correctional Administrators, Uniform Correctional Policies and Procedures.

[27]Kenneth B. Babcock, Medical Survey of Florida Division of Corrections As Ordered by Judge Charles R. Scott, (Tallahassee, Fla.: Division of Corrections, 1973).

[28]Senate Committee on Criminal Justice, Staff Report on Corrections, Parole and Probation, Senator Richard A. Pettigrew, Chairman (Tallahassee, Fla.: 1974).

[29]A Compilation of Standards, p. 11, citing American Correctional Association, Manual of Correctional Standards, 3d ed.

[30]Department of Health and Rehabilitative Services, Division of Corrections, "Response to General Summary Remarks as Detailed by the Babcock Commission," Tallahassee, Fla., 1974, Attachment 2, p. 7. (Typewritten.)

FOOTNOTES

[31]Ibid., Attachment 8.

[32]U.S. Department of Health, Education, and Welfare Baselines For Setting Health Goals and Standards (Washington D.C.: September 1976), pp. 94-95

[33]Department of Health and Rehabilitative Services, Division of Corrections, "Drug Formulary," Tallahassee, Fla., 1972, p. i. (Typewritten.)

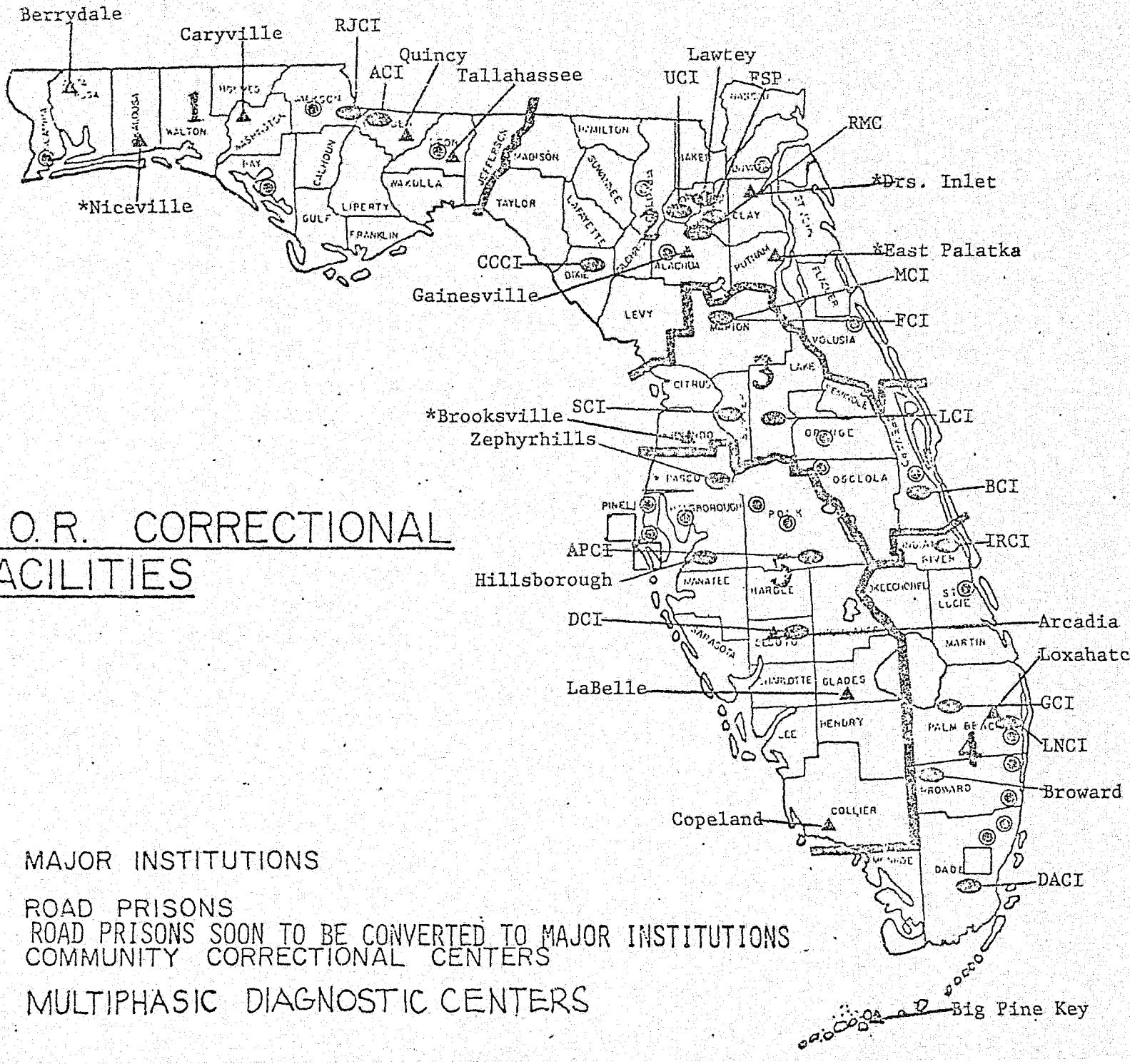
[34]Edward M. Brecker and Richard D. Della Penna, Health Care in Corrections, Prescriptive Package (Washington, D.C.: Law Enforcement Assistance Administration, 1975).

[35]Glen E. Hastings and Louis Sasmor, "The Primary Nurse Practitioner and Telemedicine in Prison Health Care: An Evaluation" (paper presented at the Third Annual Conference on Advances in Patient Care, February 23 - March 1, 1976).

[36]J.B. Godwin, interview held at Reception and Medical Center, Lake Butler, Fla., October, 1976.

[37]Appropriations Act, Chapter 76-285, Laws of Florida, p. 877.

D.O.R. CORRECTIONAL FACILITIES



MAJOR INSTITUTIONS

ROAD PRISONS

* ROAD PRISONS SOON TO BE CONVERTED TO MAJOR INSTITUTIONS

COMMUNITY CORRECTIONAL CENTERS

MULTIPHASIC DIAGNOSTIC CENTERS

APPENDIX 2

SUMMARY OF HEALTH SERVICES CAPABILITY IN MAJOR INSTITUTIONS

INSTITUTION	HEALTH SPACE AVAILABLE (sq. ft.)	NO. OF INPATIENT BEDS	SERVICES PROVIDED									LABORATORY PROCEDURE PERFORMED						MAJOR HEALTH SERVICES EQUIPMENT					REMARKS
			SURGERY	GEN MEDICAL	PSYCHIATRY	PSYCHOLOGY	DENTAL	OPTOMETRY	PHARMACY	X RAY	EKG	SEROLOGY	URINALYSIS	CULTURE & SENSITIVITY	HEMATOLOGY	CHEMICAL	ELECTROLITES	SURGERY	DENTAL	LABORATORY	X-RAY	OTHER	
ACI	3,351	9		X	X	X	X	X cntrct.	X cnsult.	X			X		X				Complete Operatories-3	Microscope, Unimeter 300	Profex-ray 100 MA stationary	EKG Machine	Tallahassee Memorial Hosp. & Jackson Memorial Hosp. used for medical emergencies, Thompson Clinic & State Health Dept. for Lab. use.
APCI	4,125	20		X	X	X	X	X cntrct.	X cnsult.	X ltd.	X		X	X		X			Complete Operatories-2	Unimeter 300, Micro Hematocrit Centrifuge, Microscope, Scale, Incubater, Refrigerator	x-ray, 100 MA basic		Walker Memorial Hosp. (Avon Park), Highlands Hosp. (Sebring), & Hardee Memorial (Wauchula) used for medical emergencies, Epilepsy Research Lab. & State Health Dept. for Lab. use.
BCI	3,728	9		X		X	X	X cntrct.	X cnsult.			NONE							Complete Operatories-2	NONE			Jess Parrish Hosp. for emergencies & Wreathoff Hosp. for (neuro) emergencies, Patterson Coleman Lab. (Tampa) for Lab. use.
CCCI	4,000 (Est.)	9		X		X		X (RMC)	X cnsult.			NONE REFERRED TO RMC											RMC for emergency and elective surgical.
DACI	4,000 (Est.)	9		X		X	X	X cntrct.	X cnsult.			X							Complete Operatories-2				James Archer Smith Hosp. Hosp. (Homestead) for emergencies, Roche Lab. (Miami) for Lab. use.
DCI	4,452	9		X	X	X	X	X cnsult	X cnsult.		X		X		X	X			Complete Operatories-2	Unimotor 250, Microscope, Centrifuge, Refrigerator, Micro Centrifuge, Drying oven, Microcap. reader.		EKG, Optometry Chair	DeSoto Memorial Hosp. for x-ray and emergencies, Patterson & Coleman (Tampa) & State Health Dept. for Lab. use, Punta Gorda for ENT, Opthmology, Orthopedic.
FCI	10,675	20		X	X	X	X	X cntrct	X	X	X		X		X				Complete Operatories-1	Unimeter 300, Microscope, Hematocrit, Frigidaire, Centrifuge, Autoclave.	Duncan Videx profex	Operating Table	Munroe Memorial Hosp. (Ocala) for emergencies & Dr. Goulard (Ocala) for radiology/x-ray, Chehy Lab. for Lab. use.
FSP	7,981	19		X		X	X	X (UCI)	X cnsult.	X	X	PROVIDED BY UCI (SEE REMARKS)							Complete Operatories-3	Microscope, Centrifuge, Blood Shaker.		EKG, Whirlpool, Resuscitation Hyfreactor.	UCI, RMC, Shands Teaching Hospital for emergencies, specialized surgical clinics and laboratory services.
GCI	2,460	9		X	X	X	X	X	X cnsult.	X		X			X				Complete Operatories-2	Centrifuge, Microscope.	Universal Duncan Videx, 30 MA.		Glades General Hosp. (Belle Glade) for emergencies and x-ray, Offices in West Palm Beach for orthopedic, cardiology, ENT, Patterson Coleman (Tampa) for Lab. use.

INSTITUTION	HEALTH SPACE AVAILABLE (sq. ft.)	NO. OF INPATIENT BEDS	SERVICES PROVIDED									LABORATORY PROCEDURE PERFORMED							MAJOR HEALTH SERVICES EQUIPMENT					REMARKS
			SURGERY	GEN MEDICAL	PSYCHIATRY	PSYCHOLOGY	DENTAL	OPTOMETRY	PHARMACY	X RAY	EKG	SEROLOGY	URINALYSIS	CULTURES	SENSITIVITY	HEMATOLOGY	CHEMICAL	ELECTROLITES	SURGERY	DENTAL	LABORATORY	X-RAY	OTHER	
IRCI	3,500 (Est.)	6		X		X ltd.	X emer only	X cntrct	X consult.			NONE												Indian River Memorial Hosp. for emergencies, Vero Beach for orthopedic and optometrics Patterson Coleman (Tampa) for Lab. use. *Opened in July 1976
LCI	1,893	6		X		X (SCI Provides Services)	X cntrct	X cntrct	X consult.			Utilizes SCI									Clinistix			SCI and SouthLake Memorial Hosp. (Clermont) for emergencies and Lab. use, Lake Community Hosp. for cranal and heart, Dr. Foust (Leesburg) for optometrics. *Personnel, services and resources of SCI utilized.
LWCI	200	3		X		X Remarks	X	X cntrct				Provided by A. G. Holley												A. G. Holley Hosp. for emergencies and Lab. use, also x-ray and dental; J. F. Kennedy Hosp. (Lake Worth) for emergencies also. *Located in proximity of A. G. Holley.
LWCI	SEE Remarks																							Not yet operative, undergoing expansion; 9 bed clinic projected with gen. medical svcs. provided. To use UCI, RMC, FSP, Shands.
MCI	3,000 (Est.)	6		X	X Remark			X cntrct	X SEE Remarks	X	X	Provided by FCI SEE Remarks								Complete Operatories-1				Munroe Memorial Hosp. (Ocala) for emergencies, Chehy Lab. for Lab. use. *FCI facilities used including personnel as needed, i.e. Pharmacist, Psychiatric.
RMC	60,500	150	X	X Remarks	X	X	X	X	X	X	X	X	X	X	X	X	X	X	Equipped to perform major surgery	Complete Operatories-8	Spectrophotometer, hematocrit reader, microscope, centrifuge, refrigerator.	300 Profex-ray with image intensifer.	ENT, Orthopedic, Plastic, Opthalmology provided wkly. from Shands. Radiologist & Urologist svcs. wkly. and Neurologist svcs. mnthly. from private sources.	Shands Teaching Hosp. for medical needs beyond capability, G. Werner, Automated Medical, Linden Lab for Lab. use, also Epilepsy Research Foundation.
RJCI	623	0		X			X Remarks	X cntrct	X SEE Remarks (ACI)	X	X	Provided by ACI												Florida State Hosp. for emergencies and dental. *Located in proximity of Florida State Hosp. Supportive medical svcs. provided by ACI.

STITUTION	HEALTH SPACE AVAILABLE (sq. ft.)	NO. OF INPATIENT BEDS	SERVICES PROVIDED									LABORATORY PROCEDURE PERFORMED						MAJOR HEALTH SERVICES EQUIPMENT					REMARKS
			SURGERY	GEN MEDICAL	PSYCHIATRY	PSYCHOLOGY	DENTAL	OPTOMETRY	PHARMACY	X RAY	EKG	SEROLOGY	URINALYSIS	CULTURE & SENSITIVITY	HEMATOLOGY	CHEMICAL	ELECTROLITES	SURGERY	DENTAL	LABORATORY	X-RAY	OTHER	
KCI	2,495	9		X	X	X	X	X corrct.	X cnsult.	X	X		X	X	X	X			Complete Operateries-2	Unimeter 300 Microscope, Incubator	Profex-ray 150 KV, 300 MA	EKG Burdick EK III Optometry Chair, Operating table, anesthesia machine with basin, dermatone, operating lights, Hemorhoid surgical tray.	Lake Community Hosp. (Leesburg) for emergencies, Chehy Lab. for Lab. use. *Also service LCI. No surgery performed due to expense to equip.
TCI	16,985	37 Remarks	X SEE	X Remarks	X	X	X	X	X	X	X	X	X	X	X	X	X	Equipped to perform major surgery.	Complete Operatories-3	Spectrophometer, Hemophometer, Microscope, Incubator, Centrifuge	GE Console DX-D325 with table and fluro. tabe, GE portable model 90-11 film dryer pass box, developing tanks, 3 film processor, image intensifer.	Chair, Opth. exam & RX, Opthmascope binoculars, keratometer, projector chart, ultramatic RX master, EKG Burdick EK 5, EKG Burdick EK/SAS cardial console with 5" cardioscope module, autoclave, steam cyclomatic, sterilizer.	RMC, Shands Teaching Hosp. for emergencies and individual evaluation and consultation, United Medical Lab. for Lab. use. *21 medical and 16 psychiatric beds projected to increase to total of 74 beds. Services of RMC & Shands utilized for specialized clinics, consultation, and surgery beyond capability.

NOTES: If distance and time is not a factor, patients are transferred to RMC Hospital for hospital and post-surgical care; medical cases (Hepatitis, TB, Cardiac, Diabetes, etc.) that are able to travel and all elective surgery. All clinics refer to RMC cases of a non-emergency nature and for consultative services. Departmental optometrist provide these services for FSP, UCI, CCCI, and RMC. All institutions equipped to perform limited laboratory procedures.

APPENDIX 3

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

- DIVISION OF CORRECTIONS -

INMATE PHYSICAL GRADE GUIDELINES

Physical Grade 1

This grade is suitable for heavy duty work. It is defined as no physical or mental problems noted from initial physical examination. Individual is of such age and stamina that no restrictions are placed upon duties that are assigned to him. Such a person would be under the age of fifty with no physical defects evident at the time of his physical examination, with no medical referrals required. The inmate may be assigned to an institution that does not engage the services of a resident physician. The visual acuity may be 20/40 or better bilaterally for suitability for physical grade #1. No inmate over the age of fifty should be assigned grade #1.

Physical Grade 2

This grade is suitable for moderate duty assignments. It is defined to include individuals having certain defects discovered on physical examination such as a visual acuity of unilateral blindness; loss of hearing in one ear; a person with old fractures with perhaps some degree of malunion; an individual with missing limbs or digits but such that he could still be moderately functional. Also, cases where the inmate might have small hernia where the physician would recommend that reparative surgery is not mandatory. This type of individual may be classified to an institution without a physician in residence. However, this individual would not normally be suitable for a road prison assignment. Individuals between the ages of forty and fifty without evidence of physical impairment would normally be classified as a physical grade #2; however, in cases of extremely good health could be classified to grade #1.

Physical Grade 3

This grade is suitable for light duty assignments only. Such a classification would be required for an individual with, for instance a heart condition, asthma, bronchitis, diabetes, epilepsy, or a history of mental illness. Such an inmate would normally only be suitable for placement at an institution that, engages the services of a full-time physician. Any exceptions to placing a physical grade #3 inmate at an institution without full-time physician services must be approved by the Division of Corrections Medical and Surgical Director.

Physical Grade 4

Generally this classification is designated to individuals who, due to their physical disability, or perhaps advancing age, are unsuitable for any type of work assignment. Individuals who fall into this category are hospitalized or nursing home patients, generally inmates over the age of seventy, men with a

cardiac condition, an advanced chest condition or general physical deterioration. Non-ambulatory patients, paraphlegics or legally blind patients would also warrant physical grade four classification. Occasionally, when at the specific request of the particular physical grade #4 inmate and only when sanctioned by the institution's physician, a moderate work assignment is sought, such can be approved under the appropriate conditions and with the opportunity of medical supervision. Such individuals would often feel far less inadequate given the opportunity to use certain acquired skills which would not cause a great deal of physical stress.

All physical grade #4 individuals must be assigned to an institution which has full-time authorized physician positions.

General Remarks

At the time of the initial physical examination at the Reception and Medical Center, when a physician designates other than a physical grade #1 classification, he will list the specific reason for same on the physical sheet under "Remarks and Recommendation".

Those defects noted on the physical examination that are correctable by surgery or treatment may be assigned a temporary medical grade and will be placed on a medical hold pending respective treatment. Those individuals may be upgraded more permanently after completion of their treatment program.

SUMMARY OF AUTHORIZED HEALTH POSITIONS

POSITION TITLE	ACI	APCI	BCI	CCCI	DACI	DCI	FCI	FSP	GCI	IRCI	LCI	LNCI	LWCI	MCI	RMC	RJCI	SCI	UCI	ZEPHYR-HILLS*	HILLS-BOROUGH	BROWARD*	TOTAL
Medical & Surgical Director															1							1
Surgeon															2		1	2				5
Physician III		1				1																2
Physician II			1	1	1		1	1	1			1		1	5	1	1	2			1	18
Physician I													1									1
Psychiatrist II	1	1				1	1	2	1						5		1	1				14
Psychiatrist I																		1				1
Clinical Psychologist								1	1						1			2				5
Psychologist	2	2	1	1		3	4	3	1	1			1		3	1	3	2		1		29
Psychologist Technician			3															5				8
Optometrist																		1				1
Pharmacist III															1							1
Pharmacist II		1					1											1				3
Pharmacist I															1							1
Nursing Director I															1							1
Assistant Nursing Director I															4							4
Registered Nurse III						1	1								17			1				20
Registered Nurse II			1	1	1	2	6			1	1	1	1		26	1	2	9	1	1		55
Registered Nurse I		1					3								7			1			1	13
Nurse Anethetist															2			1				3
Medical Tech. Supervisor II															5			1				6
Medical Tech. Supervisor I	1	1		1		1		1	1		1		1	1	1	1	1		1			13
Medical Technician	8	9	7	4	5	7	4	10	6	5	4	5	4	1	41	4	8	41	4	5	5	187
Physical Therapist															1							1
Dietician I															1							1
X-Ray Technician III															1							1

POSITION TITLE																						
X-Ray Technician II		1													1			1				3
Laboratory Technologist II		1				1																2
Medical Technologist II							1		1						2			1				5
Medical Technologist I															1							1
Hospital Administrator															1			1				2
Social Service Worker								2							1			3				6
Clinical Social Svcs. Director															1							1
Clinical Social Svcs. Worker I															5							5
Medical Transcriber II												1			2							3
Medical Transcriber I								1							5			4				10
Medical Records Librarian II															1			1				2
Medical Records Librarian I															1							1
Medical Surgical Buyer															1							1
Secretary III															1							1
Secretary II			1		1	1								1	3			3				10
Clerk Typist III																		1				1
Clerk Typist II	2	2		1		1	2	3	1						5		3	1			1	22
Vocational Instructor III															1							1
Correctional Officer II							2															2
Correctional Officer I															2							2
Dentist II								1							1			1				3
Dentist I	1	1				1	1		1					1	1		1					8
Dental Intern	1	1						1							4			1				8
Dental Hygienist															1							1
Dental Assistant II								1							1		1	1				4
Dental Assistant I	1	1						1							4		1	1				9
Clerk III	1	1																1				3
TOTAL	18	24	14	9	8	20	27	28	14	7	6	8	8	5	172	8	23	92	6	7	8	512

APPENDIX 5

HEALTH POSITION VACANCIES BY INSTITUTION

LOCATION	CLASS TITLE	VACANT 6 MONTHS OR MORE	NEVER FILLED
APALACHEE CORRECTIONAL INSTITUTION	Psychiatrist		√
	Psychologist	√	
	Dental Intern	√	
AVON PARK CORRECTIONAL INSTITUTION	Medical Technician	√	
	Dental Intern		√
	X-Ray Technician II		√
DESOTO CORRECTIONAL INSTITUTION	Registered Nurse II		√
	Registered Nurse II		√
FLORIDA STATE PRISON	Psychologist	√	
RECEPTION & MEDICAL CENTER	Nurse Anesthetist	√	
	Dental Intern	√	
	Physical Therapist		√
	Registered Nurse II	√	
	Registered Nurse II	√	
SUMTER CORRECTIONAL INSTITUTION	Dental Assistant II	√	
UNION CORRECTIONAL INSTITUTION	Nurse Anesthetist		√
	Registered Nurse II	√	
	Registered Nurse II	√	
	Medical Technician	√	

DEPARTMENT OF OFFENDER REHABILITATION
STATUS OF HEALTH POSITIONS
REQUIRING STATE LICENSES

Position	No. of Positions Authorized	No. of Vacancies	No. of Persons with State License	
Medical & Surgical Director	1	-	1	
Surgeons	5	1	3	
Physicians I, II, III	21	-	12	
Psychiatrists	15	1	11	
Clinical Psychologists	5	0	0	PhD Req. for Licensing
Optometrist	1	-	1	
Dentist I, II	11	-	7	
Dental Intern	8	3	5	Permit Req. Only
Dental Hygienist	2	-	2	
Pharmacist I, II, III	5	-	5	
Registered Nurses (Include Nurse Director & Assistant Director)	93	6	85	
Nurse Anesthetist	3	2	1	
Physical Therapist	1	1	0	
Medical Technologist I, II	6	2	4	

Note: Florida Statutes provide for exception from State licensing for several of these positions when employed in public institutional settings, e.g. Physicians, Dentists w/permit, Psychologists.

SALARY SCHEDULE FOR HEALTH SERVICES POSITIONS

JOB CLASSIFICATION	PAY GRADE	ANNUAL SALARY
Medical And Surgical Director	36	$33,700.32 - $46,938.24
Surgeon	35	$31,591.44 - $44,015.04
Physician III	33	$27,770.40 - $38,711.52
Physician II	31	$24,429.60 - $34,034.40
Physician I	31	$24,429.60 - $34,034.40
Psychiatrist II	34	$29,628.72 - $41,279.76
Psychiatrist I	33	$27,770.40 - $38.711.52
Clinical Psychologist	23	$14,699.52 - $20,337.12
Psychologist	19	$11,609.28 - $15,889.68
Psychology Technician	14	$8,832.24 - $11,901.60
Optometrist	23	$14,699.52 - $20,337.12
Pharmacist III	26	$17,706.24 - $24,680.16
Pharmacist II	23	$14,699.52 - $20,337.12
Pharmacist I	22	$13,822.56 - $19,084.32
Nursing Director I	21	$13,029.12 - $17,935.92
Asst. Nursing Director I	19	$11,609.28 - $15,889.68
Registered Nurse III	17	$10,377.36 - $14,114.88
Registered Nurse II	15	$ 9,312.48 - $12,590.64
Registered Nurse I	14	$ 8,832.24 - $11,901.60
Nurse Anesthetist	21	$13,029.12 - $17,935.92
Medical Technician Supervisor II	14	$ 8,832.24 - $11,901.60
Medical Technician Supervisor I	13	$ 8,393.76 - $11,275.20
Medical Technician	12	$ 7,976.16 - $10,690.56
Physical Therapist	16	$ 9,834.48 - $13,321.44
Dictician I	16	$ 9,834.48 - $13,321.44

JOB CLASSIFICATION	PAY GRADE	ANNUAL SALARY
X- Ray Technician III	13	$ 8,393.76 - $11,275.20
X-Ray Technician II	11	$ 7,579.44 - $10,126.80
Laboratory Technologist II	14	$ 8,832.24 - $11,901.60
Medical Technologist II	16	$ 9,834.48 - $13,321.44
Medical Technologist I	15	$ 9,312.48 - $12,590.64
Hospital Administrator	19	$11,609.28 - $15,889.68
Social Service Worker	14	$ 8,832.24 - $11,901.60
Clinical Social Services Director	21	$13,029.12 - $17,935.92
Clinical Social Worker I	16	$ 9,834.48 - $13,321.44
Medical Transcriber II	08	$ 6,577.20 - $ 8,686.08
Medical Transcriber I	06	$ 5,992,56 - $ 7,516.80
Medical Records Librarian II	16	$ 9,834.48 - $13,321.44
Medical Records Librarian I	14	$ 8,832.24 - $11,901.60
Medical Surgical Buyer	12	$ 7,976.16 - $10,690.56
Dentist II	28	$20,128,32 - $28,062.72
Dentist I	26	$17,706.24 - $24,680.16
Dental Intern	19	$11,609.28 - $15,889.68
Dental Hygienist	13	$ 8,393.76 - $11,275.20
Dental Assistant II	09	$ 6,890.40 - $9,124.56
Dental Assistant I	07	$6,284.88 - $ 8,268.48

APPENDIX 8

ANALYSIS OF HEALTH SERVICES EXPENDITURES
FOR FY 1975-76

INSTITUTION	SALARIES	OPS	EXPENSES	OCO	TOTAL	AVERAGE INMATES	HOSPITAL BEDS AVAILABLE	ANNUAL COST PER INMATE
APALACHEE CORR. INST.								
Medical Services	115,488.13	5,342.96	31,229.90	89.50	152,150.49	1,076	9	141.40
Dental Services	38,730.04	--	7,856.47	1,150.54	47,737.05	1,076		44.36
Total	154,218.17	5,342.96	39,086.37	1,240.04	199,887.54	1,076		185.76
AVON PARK CORR. INST.								
Medical Services	172,441.04	1,800.00	94,607.48	285.88	269,134.40	755	20	356.46
Dental Services	31,015.23	--	7,177.38	--	38,192.61	755		50.58
Total	203,456.27	1,800.00	101,784.86	285.88	307,327.01	755		407.04
FLORIDA CORR. INST.								
Medical Services	340,364.87	--	223,079.67	1,871.75	565,316.29	929	26	608.52
Dental Services	23,587.30	--	5,176.87	--	28,764.17	929		30.96
Total	363,952.17	--	228,256.54	1,871.75	594,080.46	929		639.48
FLORIDA STATE PRISON								
Medical Services	294,149.04	--	111,455.42	1,968.84	407,573.30	1,463	19	278.58
Dental Services	46,788.40	--	10,637.75	1,128.00	58,554.15	1,463		40.02
Total	340,937.44	--	122,093.17	3,096.84	466,127.45	1,463		318.60
GLADES CORR. INST.								
Medical Services	147,721.27	3,172.50	49,171.71	113.50	200,178.98	745	8	268.69
Dental Services	21,986.50	--	10,211.85	219.25	32,417.60	745		43.52
Total	169,707.77	3,172.50	59,383.56	332.75	232,596.58	745		312.21
SUMTER CORR. INST.								
Medical Services	238,292.84	427.20	54,637.35	1,184.73	294,542.12	959	9	307.13
Dental Services	27,214.44	--	10,343.84	1,091.75	38,650.03	959		40.30
Total	265,507.28	427.20	64,981.19	2,276.48	333,192.15	959		347.43
DESOTO CORR. INST.								
Medical Services	213,493.69	4,640.76	25,521.23	1,430.48	245,086.16	643	9	381.16
Dental Services	17,382.84	--	4,973.77	--	22,356.61	643		34.76
Total	230,876.53	4,640.76	30,495.00	1,430.48	267,442.77	643		415.92
RECEPTION & MED. CTR.								
Medical Services	1,451,507.81	74.54	547,654.39	2,045.11	2,001,281.85	2,209	150	905.96
Dental Services	126,575.95	--	22,388.63	2,689.00	151,653.58	2,591		58.53
Total	1,578,083.76	74.54	570,043.02	4,734.11	2,152,935.43	2,591		964.49

ANALYSIS OF HEALTH SERVICE EXPENDITURES
FOR FY 1975-76
(Page Two)

INSTITUTION	SALARIES	OPS	EXPENSES	OCO	TOTAL	AVERAGE INMATES	HOSPITAL BEDS AVAILABLE	ANNUAL COST PER INMATE
LAKE CORR. INST.								
Medical Services	57,803.12	5,028.06	17,821.54	8.95	80,661.67	387	9	208.42
Dental Services	--	6,147.36	1,847.00	562.80	8,557.16	387		22.11
Total	57,803.12	11,175.42	19,668.54	571.75	89,218.83	387		230.53
UNION CORR. INST.								
Medical Services	893,052.38	--	327,511.59	2,953.22	1,223,517.19	2,302	60	531.50
Dental Services	50,327.98	--	16,380.66	3,023.76	69,732.40	2,302		30.29
Total	943,380.36	--	343,892.25	5,976.98	1,293,249.59	2,302		561.79
CROSS CITY CORR. INST.								
Medical Services	101,179.16	2,550.00	10,578.29	231.90	114,539.35	382	6	299.84
Dental Services	--	--	--	--	--			--
Total	101,179.16	2,550.00	10,578.29	231.90	114,539.35	382		299.84
BREVARD CORR. INST.								
Medical Services	45,364.71	1,314.00	14,135.22	--	60,813.93	198	9	307.14
Dental Services	--	3,729.33	2,632.05	450.00	6,811.38	198		34.40
Total	45,364.71	5,043.33	16,767.27	450.00	67,625.31	198		341.54
RIVER JUNCTION CORR. INST.								
Medical Services	88,377.66	2,620.00	27,983.64	1,951.55	120,932.85	402	0	300.82
Dental Services	--	--	69.00	--	69.00	402		--
Total	88,377.66	2,620.00	28,052.64	1,951.55	121,001.85	402		300.82
LANTANA CORR. INST.								
Medical Services	--	6,609.00	20,046.18	--	26,655.18	232	0	114.89
Dental Services	--	3,369.93	2,044.36	--	5,414.29	232		23.33
Total	--	9,978.93	22,090.54	--	32,069.47	232		138.22
DADE CORR. INST.								
Medical Services	7,132.66	--	--	--	7,132.66	6	--	1,188.66
Dental Services	--	--	--	--	--			--
Total	7,132.66	--	--	--	7,132.66	6		1,188.66
TOTAL MAJOR INSTITUTIONS								
Medical Services	4,166,368.38	33,579.02	1,555,433.61	14,135.41	5,769,516.42			454.73
Dental Services	383,608.68	13,246.62	101,739.63	10,315.10	508,910.03			40.10
Total	4,549,977.06	46,825.64	1,657,173.24	24,450.51	6,278,426.45	12,688	--	494.83

Cross City's dental work is being handled at RMC. *

River Junction's dental work is being handled at Florida State Hospital.
Some of River Junction's medical service needs are handled by Apalachee Correctional Institution.

Lantana is being serviced by A. G. Holley Hospital Staff, the department picks up some of the expenses.

Lake Correctional Institution's medical services are supplemented by Sumter Correction Institution.

The funding breakdown by institution is not avialable for FY 1976-77.
In total however, the appropriation for major institutions are as follows:

Salaries	OPS	EXPENSES	OCO	TOTAL	BUDGETED POPULATION	AVERAGE MEDICAL COST PER INMATE
6,414,141	128,815	2,332,433	71,850	8,947,239	16,221	551.58

Senate Appropriations Committee
Jay Tiedeberg
October 25, 1976

DEPARTMENT OF OFFENDER REHABILITATION

CONTRACTUAL HEALTH SERVICES
1975-76

EXTERNAL CONTRACTUAL SERVICES AND SUPPLIES

INSTITUTION	HOSPITALS	PHYSICIANS	OTHER SERVICES AND SUPPLIES	DENTAL	TOTAL
APALACHEE CORRECTIONAL INSTITUTION	7,840.63	2,257.00	3,767.42		13,865.05
AVON PARK CORRECTIONAL INSTITUTION	43,797.00	15,085.00	4,363.00		63,245.00
DESOTO CORRECTIONAL INSTITUTION	5,420.00	2,715.00	3,998.00		12,133.00
FLORIDA CORRECTIONAL INSTITUTION	97,379.79	64,774.67	9,361.70		171,516.16
FLORIDA STATE PRISON (Expended $61,662.98 To Shands Teaching Hospital For Services Out Of This Total Expense)	45,140.40	16,791.58	3,073.46		65,005.44
LANTANA CORRECTIONAL INSTITUTION (Reimbursed Holley State Hospital $10,505 Out Of This Total Expense)	4,434.16	6,609.00		3,369.93	14,413.09
RIVER JUNCTION CORRECTIONAL INSTITUTION (Reimbursed Florida State Hospital $2,549 Out Of This Total Expense)	143.00	1,334.00	769.00	3,917.00	6,163.00
LAKE CORRECTIONAL INSTITUTION	6,744.05	18.00	188.75	9,611.00	16,561.80
SUMTER CORRECTIONAL INSTITUTION (Expended $14,555.01 To Shands Teaching Hospital For Services Out Of This Total Expense)	91,944.83	11,199.50	4,627.95		107,772.28
UNION CORRECTIONAL INSTITUTION (Expended $112,527 To Shands Teaching Hospital For Services Out Of This Total Expense)	82,736.00	51,702.00	21,837.00		156,275.00

EXTERNAL CONTRACTUAL SERVICES AND SUPPLIES

INSTITUTION	HOSPITALS	PHYSICIANS	OTHER SERVICES AND SUPPLIES	DENTAL	TOTAL
GLADES CORRECTIONAL INSTITUTION			43,742.68		43,742.68
CROSS CITY CORRECTIONAL INSTITUTION			1,749.26		1,749.26
BREVARD CORRECTIONAL INSTITUTION		70.50	2,200.81	377.00	2,648.31
RECEPTION & MEDICAL CENTER (Expended $308,662.88 To Shands Teaching Hospital For Services Out Of This Total Expense)	308,662.98	21,700.00			330,362.98
COMMUNITY CORRECTIONAL CENTERS (All Health Services Are Contractual)			68,414.06	5,059.50	73,473.56
ROAD PRISONS (All Health Services Are Contractual)			55,101.33	15,886.00	70,987.33
TOTALS	$694,242.84	$194,256.25	$223,194.42	$38,220.43	$1,149,913.94

FOOTNOTE: (1) Indian River and Dade Correctional Institutions did not become operational until after July 1, 1976. Marion Correctional Institution Health Expenses are included in Florida Correctional Institution.

(2) Total amount expended to Shands Teaching Hospital for above institutions $505,960.02.

DEPARTMENT OF OFFENDER REHABILITATION

LOUIE L. WAINWRIGHT, SECRETARY

Planning Document

HEALTH CARE COSTS STATE SURVEY

Bureau of Planning, Research and Statistics

JULY 21, 1976

HEALTH CARE COSTS

STATE SURVEY

INTRODUCTION

Recent concern over the cost of prison inmate health care in Florida prompted a survey of these costs in the other 49 states. As Florida's inmate population continues to grow at an unprecedented rate, the demand for inmat health care likewise continues. Although considerable effort has been expended by the Florida Department of Offender Rehabilitation (DOR) to monitor and evaluate health care expenditures within the state, this effort has not been extended to the national level for comparative assessments. Therefore, in order to develop comprehensive health care cost information and to propose national standards for prison health care, this survey was undertaken.

METHODS

A letter and questionnaire requesting information regarding size of the inmate population and the annual budget, the number of health care personnel and hospital beds, the cost of any health care facility contruction or remodeling, and number of individual health care contracts were sent to the correctional agencies of the 49 other states on February 13, 1976. Responses from 31 state correctional agencies were received prior to May 14, 1976; at this time a second letter and questionnaire were sent to those states not yet responding.

A total of 34 state correctional agencies responded to the health care cost questionnaire. Data from these questionnaires and from Florida DOR records were comparatively analyzed. The findings were displayed in tabular form to prevent loss of vital data. In addition, simple statistical techniques were utilized to summarize the information on health care costs in the 35 states included in the study. Such a comparative study can provide Florida not only with standards for

measuring current efficiency, but with valuable information which can be utilized in the department's overall planning process.

ANALYSIS

Table 1 presents the average inmate population of the states responding to the survey for the past three fiscal years. It is clear in this table that Florida represents one of the largest correctional systems in the study, only California, Texas, and Wisconsin report higher inmate populations. Florida's average inmate population is also considerably above the average inmate population in each of the other states reporting.

TABLE Ia

AVERAGE INMATE POPULATION FOR THREE FISCAL YEARS BY STATE

STATE	FY 73-74	FY 74-75	FY 75-76
ARIZONA	2,010.	2,438.	3,039.
ARKANSAS	1,792.	2,085.	2,249.
CALIFORNIA	22,765.	24,480.	25,015.
COLORADO	1,954.	1,934.	1,954.
DIST. OF COLUMBIA	2,827.	2,725.	3,250.
FLORIDA	10,646.	12,192.	16,026.
HAWAII	250.	250.	260.
IDAHO	437.	524.	580.
ILLINOIS	N/A	7,500.	8,500.
INDIANA	4,849.	4,505.	4,775.
KENTUCKY	2,927.	3,049.	3,377.
MARYLAND	2,893.	6,415.	6,896.
MASSACHUSETTS	N/A	N/A	3,000.
MICHIGAN	8,053.	8,860.	10,603.
MINNESOTA	1,707.	1,493.	1,868.
MISSOURI	3,433.	3,778.	4,500.
MONTANA	N/A	N/A	379.
NEVADA	755.	867.	925.
NEW HAMPSHIRE	264.	239.	261.
NEW JERSEY	6,049.	5,843.	6,105.
NEW MEXICO	801.	1,013.	1,179.
NORTH DAKOTA	145.	134.	132.
OHIO	7,800.	10,000.	11,779.
OKLAHOMA	3,787.	3,200.	3,800.
OREGON	1,501.	1,676.	2,159.
PENNSYLVANIA	5,705.	5,886.	6,975.
SOUTH CAROLINA	3,540.	4,616.	6,196.
SOUTH DAKOTA	239.	273.	687.
TENNESSEE	3,495.	3,786.	4,415.
TEXAS	16,479.	17,099.	19,200.
VERMONT	371.	417.	390.
VIRGINIA	6,953.	6,456.	6,652.
WASHINGTON	2,492.	2,531.	3,100.
WISCONSIN	16,955.	19,084.	20,800.
WYOMING	278.	289.	425.

Table Ib presents a comparison of the descriptive statistics for all the states represented in Table Ia and the average inmate population of Florida. The greater size of the Florida correctional system as compared to the average of all the state correctional agencies studied is evident.

TABLE Ib

AVERAGE INMATE POPULATION FOR THREE FISCAL YEARS - STATISTICS

DESCRIPTORS	FY 73-74	FY 74-75	FY 75-76
FLORIDA AVERAGE	10,646.	12,192.	16,026.
OVERALL AVERAGE	4,404.	4,795.	5,159.
OVERALL MEDIAN (MIDPOINT)	2,827.	2,729.	3,100.
MINIMUM	145.	134.	132.
MAXIMUM	22,765.	24,480.	25,015.
STATES NOT REPORTING	3.	2.	0.

Table II presents the total agency operating expenditures for all states in the study over three fiscal years. Again the size of the Florida system is reflected in the summary statistics. Florida's yearly expenditures in FY 1975-1976 of $76,812,911 were only exceeded by California ($180,638,314) and Illinois ($103,000,000) and exceed the average expenditures by more than $50 million dollars.

TABLE II

CORRECTIONAL AGENCY OPERATING EXPENDITURES
FOR THREE FISCAL YEARS BY STATE

STATE	DOLLARS SPENT FY 73-74	DOLLARS SPENT FY 74-75	DOLLARS SPENT FY 75-76
ARIZONA	15,397,200.	18,606,000.	20,892,600.
ARKANSAS	6,112,137.	8,332,129.	1,034,451.
CALIFORNIA	150,509,779.	175,387,177.	180,638,314.
COLORADO	10,110,718.	12,481,807.	14,168,350.
DIST. OF COLUMBIA	34,590,400.	37,671,600.	45,387,500.
HAWAII	2,541,000.	2,671,000.	328,000.
IDAHO	137,115.	144,781.	137,097.
ILLINOIS	N/A	93,412,000.	103,000,000.
INDIANA	816,460.	966,024.	1,023,985.
KENTUCKY	450,000.	480,000.	920,000.
MARYLAND	29,482,158.	31,321,598.	34,487,691.
MASSACHUSETTS	N/A	N/A	38,100,000.
MICHIGAN	48,700,000.	58,600,000.	69,500,000.
MINNESOTA	1,102,795.	1,237,486.	1,529,322.
MISSOURI	1,529,974.	19,113,536.	20,849,468.
MONTANA	N/A	N/A	4,072,299.
NEVADA	950,290.	1,286,890.	1,441,943.
NEW HAMPSHIRE	1,575,928.	2,137,643.	2,530,025.
NEW JERSEY	40,214,351.	45,476,371.	52,862,079.
NEW MEXICO	33,620.	39,610.	13,890.
NORTH DAKOTA	1,810,134.	1,841,902.	1,721,537.
OHIO	44,341,234.	48,679,900.	52,414,314.
OKLAHOMA	8,179,774.	16,805,899.	20,000,000.
OREGON	10,686,125.	11,360,393.	14,066,339.
PENNSYLVANIA	49,530,143.	59,938,866.	61,752,357.
SOUTH CAROLINA	13,129,476.	18,983,477.	22,732,370.
SOUTH DAKOTA	1,612,257.	1,848,491.	2,000,000.
TENNESSEE	14,722,971.	16,513,134.	20,344,100.
TEXAS	31,355,277.	36,864,330.	49,192,680.
VERMONT	1,541,300.	1,966,900.	2,340,800.
VIRGINIA	N/A	61,495,676.	72,750,000.
WASHINGTON	23,939,000.	24,680,000.	30,701,000.
WISCONSIN	44,683,348.	51,569,206.	55,625,400.
WYOMING	144,498.	1,472,965.	2,180,687.
FLORIDA	52,139,382.	60,899,643.	76,812,911.
MEAN	19,660,000.	26,300,000.	25,100,000.
MEDIAN	8,183,466.	16,600,000.	20,600,000.
MINIMUM	137,115.	144,781.	137,097.
MAXIMUM	150,500,000.	175,378,277.	180,638,314.
NOT REPORTING	4	2	0

Table III displays a comparison between the average number of patients seen on an in-patient and out-patient basis in other states and in Florida for the past three fiscal years. As would be expected in Florida's large system, the number of patient visits per year was higher than the average.

TABLE III

NUMBER OF HEALTH CARE VISISTS PER FISCAL YEAR

a. IN-PATIENT VISITS

DESCRIPTORS	FY 73-74	FY 74-75	FY 75-76
FLORIDA	8,275.	8,310.	5,496.
OVERALL AVERAGE	2,555.	2,471.	2,679.
OVERALL MEDIAN	371.	351.	351.
OVERALL MINIMUM	10.	20.	17.
OVERALL MAXIMUM	19,468.	18,700.	21,300.
STATES NOT REPORTING	18.	15.	14.

b. OUT-PATIENT VISITS

DESCRIPTORS	FY 73-74	FY 74-75	FY 75-76
FLORIDA	405,055.	416,081.	454,062.
OVERALL AVERAGE	39,435.	93,948.	86,076.
OVERALL MEDIAN	22,987.	32,273.	30,015.
OVERALL MINIMUM	150.	180.	180.
OVERALL MAXIMUM	136,246.	483,965.	575,918.
STATES NOT REPORTING	17.	15.	12.

Table IV presents statistics on health care personnel. As might be expected, the increase average inmate population is reflected in the increased number of medical personnel. Again the size of the Florida system is reflected by the larger number of health care personnel in each category for Florida as compared to the average of the states reporting.

TABLE IV

HEALTH CARE PERSONNEL STATISTICS

HEALTH PERSONNEL		CENTRAL TENDENCY AVERAGE	MEDIAN	MODE	RANGE MINIMUM	MAXIMUM	FLORIDA	STATES NOT REPORTING
PSYCHIATRISTS	FY 74-75	7.8	2.5	1	1	87		8
	FY 75-76	5.3	3.3	1	1	25	14	7
OTHER MEDICAL DOCTORS	FY 74-75	8.3	4.5	1	1	48	3.5	2
	FY 75-76	9.3	5.8	1	1	51	11	1
DENTISTS	FY 74-75	6.3	3.0	2	1	51	2.5	4
	FY 75-76	6.4	3.4	1	1	51	18	3
NURSES	FY 74-75	17.1	8.5	1	1	80	35	6
	FY 75-76	19.2	9.3	1	1	80	60	3
MEDICAL TECHNICIANS	FY 74-75	24.6	11.8	2	1	243	40	11
	FY 75-76	24.4	9.3	1	1	250	139	9
DENTAL TECHNICIANS	FY 74-75	1.9	1.3	1	1	6	2	15
	FY 75-76	1.9	1.3	1	1	6		15
OTHER	FY 74-75	17.7	7.3	2	1	114	0	9
	FY 75-76	17.5	9.5	2	1	91		8
TOTAL	FY 74-75	66.0	31.5	11	1	487	375.5	2
	FY 75-76	71.6	46.3	12	1	510		1

Table V presents the Health Care Costs Per Inmate. This figure was computed by dividing the health care budget for each fiscal year by the average inmate population reported for the year. Florida falls very close to the average health care cost per inmate for each fiscal year reported.

TABLE V

HEALTH CARE COST PER INMATE PER FISCAL YEAR

DESCRIPTORS	FY 73-74	FY 74-75	FY 75-76
FLORIDA COST	$ 376.73	$ 443.83	$ 390.04
OVERALL AVERAGE COST	$ 424.29	$ 391.02	$ 355.96
OVERALL MEDIAN COST	$ 268.87	$ 277.15	$ 279.08
MINIMUM COST	$ 46.75	$ 6.46	$ 14.79
MAXIMUM COST	$2149.89	$2596.16	$1074.44
STATES NOT REPORTING	7.	4.	3.

Table VI presents the Health Care Cost Per Inmate Visit. This figure was computed by dividing the health care budget reported for each fiscal year by the number of patient visits reported for that fiscal year. It was noted that Florida is well below both the average and the median costs per inmate visit.

TABLE VI

HEALTH CARE COST PER INMATE VISIT

DESCRIPTORS	FY 73-74	FY 74-75	FY 75-76
FLORIDA COST	$ 9.90	$ 13.01	$ 13.76
OVERALL AVERAGE COST	$ 355.55	$ 331.76	$ 356.66
OVERALL MEDIAN COST	$ 27.54	$ 25.76	$ 20.08
MINIMUM COST	$ 5.71	$ 4.53	$ 4.75
MAXIMUM COST	$2,365.81	$2,481.67	$3,054.76
STATES NOT REPORTING	21.	19.	16.

Table VII presents various categories of health care expenditures for the three fiscal years reported. Again as in several of the earlier tables the size of the Florida system is reflected in the expenditures in Florida which are greater than the average of the other states reporting.

TABLE VII

HEALTH CARE EXPENDITURE STATISTICS BY FISCAL YEAR

COST CATEGORY		AVERAGE DOLLARS SPENT	MEDIAN DOLLARS SPENT	DOLLARS SPENT IN FLORIDA	STATES NOT REPORTING
PERSONNEL COSTS	FY 73-74	1,116,392.78	443,822.00	2,803,476.	11
	FY 74-75	1,251,752.70	669,162.00	3,715,516.	7
	FY 75-76	1,326,694.62	729,451.00	4,719,364.	5
OPERATING EXPENSES	FY 73-74	562,735.40	109,506.00	1,102,338.	9
	FY 74-75	716,899.41	268,670.00	1,528,238.	5
	FY 75-76	802,511.48	168,170.00	1,454,178.	3
EQUIPMENT	FY 73-74	15,891.00	7,566.00	104,894.	17
	FY 74-75	15,489.60	6,806.50	167,514.	14
	FY 75-76	32,625.29	8,135.00	77,376.	10
TOTAL	FY 73-74	1,695,019.09	560,894.00	4,010,708.	8
	FY 74-75	1,984,141.71	974,638.50	5,411,628.	4
	FY 75-76	2,161,831.39	905,756.00	6,250,918.	4

Table VIII presents statistics on renovation and construction expenditures in the three fiscal years reported. As is noted in the row "STATES NOT REPORTING" most of the states had no health care renovation or construction costs. The statistics reported are on only those states that reported some renovation or construction expenditures. These costs varied from minor refurbishing to major construction.

TABLE VIII

HEALTH CARE RENOVATION AND CONSTRUCTION

COST PER FISCAL YEAR

DESCRIPTORS	FY 73-74	FY 74-75	FY 75-76
FLORIDA COSTS	0.0	0.0	312,420.
OVERALL AVERAGE COSTS	$ 51,000.	$297,116.	$140,978.
OVERALL MEDIAN COSTS	$ 51,000.	$ 2,829.	$150,000.
MINIMUM COSTS	$ 2,000.	$ 341.	$ 8.
MAXIMUM COSTS	$100,000.	$834,260.	$290,000.
STATES NOT REPORTING	32.	30.	29.

CONCLUSION

This survey was undertaken in order to provide a frame of reference regarding inmate health care costs. The results of this study could be particularly useful in future administrative and planning decisions relevant to the health and welfare of Florida's inmate population.

The inmate population in Florida represents one of the country's largest in comparison with the other states responding to this survey. Consequently, health care programs, personnel, budget, and inmate visits to health care facilities in Florida's prisons also represent some of the largest items in each of the respective categories. Still, Florida's overall health care cost per inmate and cost per inmate visit are either near or below the average cost reported by other states.

The findings of this survey suggest that Florida's inmate health care costs are quite close to the national average. The information generated by this study, can now be utilized to devise comparative cost standards for health and medical care within the Department of Offender Rehabilitation. It is expected that these standards will be utilized in the future evaluation of the inmate health care system.

SURVEY OF OPTOMETRIST SERVICES IN MAJOR INSTITUTIONS FOR 1975 - 76

	EXAMINATIONS			GLASSES				
INSTITUTION	NUMBER PROVIDED	COST PER EACH	TOTAL COST	NUMBER PROVIDED	COST PER UNIT	TOTAL COST	TOTAL EXPENDITURE	PROVIDER/VENDOR
ACI	106	68 @$15 38 @$17	$1666	90	$23.00	$2079	$3745	Dr. M. B. Davis Merritt Peninsula, Jacksonville
APCI	149	$12	1,788	207	14.35	2,966	4,764	Dr. R. O. Sevigny
DCI	89	62 @$12 27 @$15	1,149	80	12.75	1,020	2,169	Dr. R. O. Sevigny Dr. D. D. Richardson Superior, St. Pete Peninsula, Jacksonville
FCI/MCI	414	$10	4,140	388	28.20	7,537	11,677	Dr. John Williams Dispenser Optical Svcs.
FSP	1,696 Exams provided for FSP/UCI Combined by DOR Optometrist			150	15.00	2,250	2,250	
GCI	246	Exams & Glasses Cost Combined		212	45.75		11,245	Dr. Lane
RMC	Provided by DOR Optometrist			714	13.56	9,682	9,682	
RJCI	130	$15	1,950	60	25.00	1,500	3,450	Dr. M. B. Davis
SCI	184	$15	2,760	120	13.85	1,658	4,418	Dr. D. Appelquist Dynoptic Corp, St. Pete
UCI	See FSP			321	15.00	4,817	4,817	
TOTALS	$3,015	$14 Avg. (Range:$10-$17)	$13,453	2,342	$17.87 Avg (Range: $12.75-$28.20)	$33,509	$58,217	

NOTES:

1. Optometrist Services For CCCI Provided By RMC.
2. Figures Not Available For LCI and LNCI.
3. BCI, DACI, IRCI, LWCI Not Included.

SOURCE: Institutions Reports

APPENDIX 12

J. HILLIS MILLER HEALTH CENTER • UNIVERSITY OF FLORIDA
COLLEGE OF MEDICINE
Office of the Dean

September 21, 1976

MEMORANDUM

TO: James P. McLean
Associate Dean for Administration

FROM: Pat Cockrell

SUBJECT: U. of F. College of Medicine Medical Training Programs

A. Types of Programs

1. Medical Education - M.D. degree
2. Post-graduate Clinical Education
3. Technician Training Programs

B. Number of students in each Program

1. Medical Education - M.D. degree

First year	87
Second year	120
Third year	112
Fourth year	111
TOTAL	430

2. Post-graduate Clinical Education

Anesthesiology	28
CHFM	18
Medicine	77
Neurology	8
Ob-Gyn	16
Ophthalmology	19
Orthopaedic Surgery	15
Pathology	13
Pediatrics	43
Psychiatry	22
Radiology	21
Surgery	63
TOTAL	343

3. Technician Training Programs

*Physicians Assistants	62
Nurse Anesthesia	6
*Respiratory Therapy	40

3. Technician Training Programs Cont'd

EEG Technician	8
OR Technician	10
Oxygenator Technician	1
*Cardiovascular Technician	60
*Radiologic Technician	32
*Nuclear Medicine Technician	20
Orthoptic Technician & Ophthalmic Technician	9
Histology Technician	1
TOTAL	249

*Programs offered in conjunction with Sante Fe Community College

C. Personnel employed and their areas of specialization for each program:

The College of Medicine Faculty consists of approximately 250 full-time faculty, instructor and above, in twelve clinical departments and approximately 60 full-time faculty in basic science departments. Included in the 250 full-time clinical department faculty are approximately 210 clinicans with practice privileges within the Shands Teaching Hospital; the remaining faculty members in clinical departments and the basic science faculty are generally Ph.D.'s in their specialty area. Additionally, there are 15 part-time faculty members, instructor and above, and 75 support faculty (Associate In and Assistant In). Part-time faculty includes both clinicans and Ph.D's; support faculty primarily include individuals with master's degrees in particular specialities and Physician's Assistants.

The department of appointment (and area of specialization) for the full-time faculty is as follows:

Clinical Departments:

Anesthesiology	13
Community Health & Family Med.	12
Medicine	43
Neurology	6
Obstetrics-Gynecology	17
Pathology	25
Ophthalmology	21
Orthopaedic Surgery	7
Pediatrics	32
Psychiatry	28
Radiology	18
Surgery (Includes all clinicians)	27
	249

Basic Science Departments:

Anatomy	11
Biochemistry	11
Microbiology	6
Neuroscience	12
Pharmacology	11
Physiology	8
	59

The Teaching Faculty (full-time and part-time) provide instruction for the above listed Medical Training Programs. The following is a profile of the present effort of the faculty devoted to each of the programs (the balance of faculty effort is of course devoted to other activities such as research, patient care, non-medical training, and administration):

Program	Basic Sciences	Clinical Sciences	College Total
Medical Education-M.D. degree	9.8%	17.9%	16.4%
Post-graduate Clinical Education	1.0%	25.0%	20.7%
Technician Training	-	2.2%	1.8%
Total Effort to Medical Training Programs	10.8%	45.1%	38.9%

The Support Faculty also provides instruction for these medical training programs. The following provides a summary of the percent effort devoted to each of the programs:

Program	College Total
Medical Education - M.D. degree	1.2%
Post-graduate Clinical Education	4.1%
Technician Training	4.3%
Total effort to Medical Training Programs	9.6%

Instruction for those Technician Training Programs designated as offered in conjunction with Sante Fe Community College (is provided by College of Medicine faculty as identified above & also by Santa Fe Community College personnel)..

D. Clinical Experience in Training Programs

1. Medical Education - M.D. degree

The four years of training for the M.D. degree are divided into phases: Phase A occupies the entire first year with the fall quarter devoted to basic science studies and the second and third to interdisciplinary, interdepartmental, basic and clinical science studies; electives are available in physical therapy, occupational therapy, laboratory medicine and other areas. Phase B occupies the second year and approximately half of the third with course work consisting of Systemic Pathology, Physical Diagnosis and Laboratory Diagnosis and clinical pharmacology; the major portion of Phase B is devoted to clinical clerkships in which groups of students rotate among the major clinical services receiving direct patient contact. Phase C occupies the remainder of the third year and the fourth year, consisting of elective experiences; the student devotes one-third of his time to significant basic science study and one-third to clinical study and the remaining one-third to either basic science or clinical assignments.

Phase B clinical clerkship specialty areas include: Medicine, psychiatry, surgery, obstetrics-gynecology, and pediatrics. This clinical experience is gained at Shands Teaching Hospital, Gainesville Veterans Administration Hospital, and various other locations such as Lake City Veterans Hospital and outlying clinics.

Phase C clinical specialty areas include: Medicine, psychiatry,

surgery, radiology, obstetrics-gynecology, and pediatrics. This clinical experience is also gained at Shands Teaching Hospital, Gainesville and Lake City VA Hospitals, Jacksonville Hospitals Education Program, and various other locations.

2. Post-graduate Clinical Education

Straight internships, each twelve months in duration, are offered annually, beginning July 1, in the services of medicine, pathology, pediatrics, and surgery. Residencies vary in length with each of the services (between two and four years). Formal residencies are offered in anesthesiology, medicine (internal medicine), neurology, obstetrics and gynecology, ophthalmology, orthopaedic surgery, pathology, pediatrics, psychiatry, radiology and its subspecialities, and surgery (general, plastic, thoracic, neurosurgery, otolaryngology, and urology). Clinical experience is performed at Shands Teaching Hospital, VA Hospitals in Gainesville and Lake City, outlying clinics, Jacksonville Hospitals Education Program, and various other locations.

The following summary characterizes the location of clinical experience for the current housestaff:

Specialty	Shands	VAH	Other
Anesthesiology	20	7	1
CHFM	5	1	12
Medicine	42	34	1
Neurology	4	4	-
Ob-Gyn	15	1	-
Ophthalmology	14	3	2
Orthopaedic Surgery	9	4	2
Pathology	9.5	3.5	-
Pediatrics	39	-	4
Psychiatry	11	5	6
Radiology	13	7	1
Surgery	41	18	4
Totals	222.5	87.5	33

3. Technician Training Programs

These programs provide diverse clinical experience in terms of the type of experience, the length of experience and the location. The following is a summary of the clinical experience provided:

3. TECHNICIAN TRAINING PROGRAMS (Cont'd)

Program Name	Duration	Clinical or Practical Experience	Location of Experience
Physician Assistants	2 yrs.	Final 15 months areas: pediatrics, family practice internal medicine, general surgery, orthopaedics and various subspecialities. Final 12 weeks in program includes two 6-week preceptorships with practicing physicians in internal medicine, pediatrics, or in family practice in the State of Florida	Shands, Gainesville VA Hospital, Clinics such Gainesville & Jacksonville Family Care Centers, outlying services such as Mayo, Trenton, and Dowling Park
Nurse Anesthesia	2 yrs.	40 hours/week	Shands & VA Hospital OR
Respiratory Therapy	2 yrs.	8 hours/week	Shands, VA, North Florida, Alachua General
EEG Technician	1 yr.	3 hours/week	Shands, VA
Operating Room Technician	1 yr.	8 hours/week last 9 months	Shands, Major Surgery
Oxygenator Technician	2 yrs.	40 hours/week	Shands and VA, major surgery
Cardiovascular Technician	1½ yrs.	First 9 months - 1 hour/week; Second 9 months - 40 hours/week	Shands Shands, VA, North Florida, various other hospitals in Florida
Radiologic Technician	2 yrs.	25 hours/week	Shands, Radiology
Nuclear Medicine Technician	2 yrs.	15 hours/week	Shands, Eye Clinic
Histology Technician	1 yr.	37 hours/week	Shands, Histopathology Labs

I. Medical Training Programs - HRP

A. PROGRAM	B. NO. OF STUDENTS	C. PERSONNEL EMPLOYED	AREA OF SPECIALIZATION	D. CLINICAL EXPERIENCE 1. TYPE	2. LENGTH	3. WHERE
Clinical and Community Dietetics	33	Ann P. Emerson	Clinical Research and Nutrition Education	SEE ATTACHMENT A		
		Ruth Anne Browning	Clinical Dietetics			
		Julia F. Paulk	Community Dietetics			
		Helen W. Lane	Nutrition and Biochemistry			
		Martha Sue Dale	Food Systems Management			
Clinical Psychology	105	C. D. Belar	Clinical Psychology	SEE ATTACHMENT B		
		L. D. Cohen	Clinical Psychology			
		H. C. Davis	Clinical Psychology			
		J. R. Goldman	Clinical Psychology			
		B. McMahon	Clinical Psychology			
		M. H. McCaulley	Clinical Psychology			
		N. W. Perry	Clinical Psychology			
		W. C. Rasbury	Clinical Psychology			
		P. Satz	Clinical Psychology			
		S. J. Taffel	Clinical Psychology			
		V. D. VanDeReit	Clinical Psychology			
Communicative Disorders	60	K. R. Bzoch	Speech Pathology and Audiology	Diagnostic Therapeutic Supervised Clinical Practicum	360 hours during Graduate Training One year post-graduate for certificate.	Department of Communicative Disorders' Clinics, ENT Clinic, Shands Teaching Hospital Oral-Facial Clinic
		L. C. Hammer	Speech Pathology and Audiology			
		E. Scroggie	Speech Pathology and Audiology			
		Judy Callan	Speech Pathology and Audiology			
		Linda Byrnes	Clinical Speech and Language Therapist			
		Barbara Redfearn	Clinical Speech and Language Therapist			
Bachelor of Health Science Program	37	Dr. B. Scott	Allied Health	None	None	None
		R. Winkler	Allied Health			
		F. West	Allied Health			

I. Medical Training Programs (Cont.) Page Two

A. PROGRAM	B. NO. OF STUDENTS	C. PERSONNEL EMPLOYED	AREA OF SPECIALIZATION	D. CLINICAL EXPERIENCE 1. TYPE	2. LENGTH	3. WHERE
Medical Technology	49	M. Britt	Bacteriology, Immunology, Virology, Laboratory Supervision	Bacteriology Parasitology Mycology Immunology & Serology Blood Donor Processing Immunohematology Hematology Hemostasis Clinical Chemistry Toxicology Clinical Microscopy	28 weeks of clinical experience in hospital medical laboratories following several months of course work in medical technology teaching laboratories.	Shands Teaching Hospital, Alachua General Hospital, VA Hospital, North Florida Regional Hospital and Civitan Regional Blood Center.
		J. Rodeheaver	Blood Banking, Clinical Microsopy			
		V. Jordan	Clinical Chemistry			
		F. Fisher	Microbiology, Mycology, Hemostasis			
		L. Pursley	Hematology			
		J. Hornsby	Immunohematology, Serology			
		J. Brouillette	Clinical Instrumentation, Chemistry			
		D. Price	Microbiology, Inventory Control			
Physical Therapy	77	F. M. Rutan	Therapeutic Procedures, Modalities, Prosthetics, and orthotics, etc.	Rehabilitation Centers, public health, general hospitals, private practice, childrens' hospital, cerebral palsy center and will be initiating affiliations with a public school system.	600+ hours.	SEE ATTACHMENT C
		M. C. Wroe	Therapeutic Exercise, Neurology.			
		C. Finley	Anatomy, Orthopedics			
		T. M. Holmes	Community Health			
		N. P. Fisher	Kinesiology, Clinical Practicum Coordinator			
		L. Morgenstern	Pediatrics, Therapeutic Exercise and Orthotics.			
Occupational Therapy	60	L. A. Llorens	Pediatrics, Psychiatry	Physical Dysfunction Psychiatric Pediatric Geriatric	Six months	SEE ATTACHMENT D
		C. J. Slaymaker	Psychiatry, Geriatrics			
		K. W. Sieg	Pediatrics, Physical Dysfunction			
		L. A. Maduro	Physical Dysfunction, Psychiatry			
		A. A. Gill	Physical Dysfunction			
		G.L. McCormack	Physical Dysfunction, Psychiatry			
		F. A. Menks	Psychiatry, Pediatrics			
		S. P. Adams	Pediatrics, Physical Dysfunction			
		N. A. Marmo	Physical Dysfunction, Pediatrics			

I. Medical Training Programs (Cont.) Page Three

A. PROGRAM	B. NO. OF STUDENTS	C. PERSONNEL EMPLOYED	AREA OF SPECIALIZATION	D. CLINICAL EXPERIENCE 1. TYPE	2. LENGTH	3. WHERE
Rehabilitation Counseling	60	Dr. J. Bozarth Dr. J. Joiner Dr. J. Muthard Dr. J. Saxon	Rehabilitation Counseling Rehabilitation Counseling Rehabilitation Counseling Rehabilitation Counseling	Practicum Clinical Experience	Ten Hours per Quarter	Community Mental Health Center, Office of Vocational Rehabilitation, Prison System, Crisis Center, Corner Drug Store, CETA, Santa Fe Vocational Evaluation Program, Rehabilitation Centers.
				Internship	One Quarter of full time clinical experience.	Same as above.

SENATE
CORRECTIONS, PROBATION & PAROLE COMMITTEE
The Capitol, Tallahassee, Fla. 32304

September 10, 1976

Mr. Louie Wainwright, Secretary
Department of Offender Rehabilitation
1309 Winewood Boulevard
Tallahassee, Florida 32303

Dear Secretary Wainwright:

As you may know, the Senate Committees on Corrections, Probation and Parole, Health and Rehabilitative Services, Judiciary-Civil and Appropriations are involved in an interim study of the health services provided to inmates in Florida. Accordingly, we would appreciate receiving information regarding the Department's medical facilities, personnel, services and the procedures involved in obtaining those services for each major institution, community correctional center and road prison.

In particular, the following information, by institution, is requested:

1. An inventory of the existing facilities, equipment and supplies used in providing health care to inmates. This should include medical, surgical, psychiatric, dental, pharmaceutical, laboratory, rehabilitation, emergency, mortuary, medical records and such other facilities, equipment and supplies in each institution. Please indicate whether the facilities are in use; whether the equipment is functioning; and if functioning, whether or not it is used.

2. Job descriptions for all administrative direction and support staff and direct care positions in the institutions.

3. For all personnel involved in health care delivery, including administrative direction and support staff and those providing direct patient care, the number of positions and the classification of each position by institution; fulltime, parttime, OPS status; current salaries, whether the position is currently vacant and if vacant, the date it became vacant; and the qualifications of the employee occupying each position including whether or not the employee is licensed to practice in this state.

4. Whether inmate personnel are used, and if so, the duties they perform, the training provided, and what their wages are.

5. Staffing patterns in effect.

6. Are volunteers used and, if so, how many and what are their duties?

7. A summary of health services available in each institution including the specific medical, surgical, psychiatric, psychological, rehabilitative, dental, optometrical, obstetrical, gynecological, pharmaceutical, laboratory, radiological, rehabilitative, inpatient, outpatient, emergency and burial services.

8. Who provides each service?

9. If not available in the institution, how is the service obtained?

10. Utilization rates by service provided.

11. The procedures established in each institution for obtaining those services.

12. The procedures necessary for an inmate in administrative or disciplinary confinement to obtain services.

13. The procedures involved in classification of prisoners to include:

a. A description of the intake physical examination.

b. The difference between classification procedures performed at the Reception and Medical Center and those performed at County Jails.

c. Method of screening for mental illness, mental retardation, drug and alcohol addiction.

14. A description of sick call procedures including what the examinations consist of, which personnel are involved, where sick call is held, how frequently it is held, how an inmate obtains access to sick call, how the determination is made to refuse access to sick call, who has the authority to refuse access to a physician, whether the inmate's medical record is available for referral at the time of sick call and whether attendance and the outcome of the visit is recorded in the inmate's record. What are the sick call procedures for inmates in administrative or disciplinary confinement?

15. The procedures for handling emergencies including the availability of emergency treatment, how access to emergency treatment is obtained, who has the authority to allow or deny access to emergency treatment, and what posted regulations, written guidelines or standing orders are provided for handling emergencies. If emergency treatment is not provided at the institution, who can authorize a transfer, where are inmates transferred to, what is the travel time involved, what type of vehicle is used in transporting inmates, what are the vehicles equipped with and what personnel are in attendance during transportation?

16. How are inmates referred to specialists? Who may authorize referral to a specialist, in what areas of specialization is consultation provided, is there a practice of accumulating a minimum number of inmates needing referral before referral is made or a specialist consulted?

17. If an inmate requires a transfer for diagnosis and treatment, where is he transferred to? If transfers are made to community facilities, what is the established relationship with that facility for handling all aspects of the transfer and treatment? What type of vehicle is used to transport non-emergency cases? What is the procedure for transferring medical records?

18. A description of any preventive care provided in each institution including physical and dental examinations, screening for specific diseases, basic health education and immunizations. If provided, is participation mandatory?

19. How frequently and to whom in the female inmate population are Pap tests and examinations for venereal disease made?

20. What contraceptives are generally available to inmates prior to furlough or release and how do inmates secure them?

21. What services are provided to pregnant inmates and what provisions are made for the care of the baby after delivery?

22. What non-prescription medications are readily available to the inmate population and how does an inmate obtain them?

23. Does the Department have a drug formulary used by all institutions or does each institution have its own formulary? Please provide copies of all formularies and any instructions concerning their use.

24. What are the drug purchasing procedures?

25. What are the written procedures or established routines for controlling drugs in general use?

26. What are the procedures for inspecting stored medications?

27. What are the utilization rates for the various prescription medications?

28. What appliances or prosthetic devices are provided inmates and how are they paid for? How are they secured and what are the procedures for maintenance and repair?

29. Indicate the availability of special diets, the types available, who plans them, who prepares them, and who prescribes them?

30. Describe the medical records system. Please include copies of any standard forms in use.

31. What is the procedure for handling cases of contagious illnesses?

32. What are the special arrangements made for the aged, physically handicapped and victims of homosexual assault?

33. What are the special facilities provided for their care?

34. How many deaths have occurred in the past three years and what were the causes of death? What reports concerning deaths are made and to whom are they sent?

35. Under what circumstances are autopsies performed, who is responsible for ordering an autopsy and by whom and where are they performed?

36. What are the policies and practices regarding medical experimentation? If inmates are participating in experiments, please list the types of experiments and the number of inmates participating, and what type of authorization or consent is obtained? What authorization or consent is obtained of mentally ill or mentally retarded inmates? What benefits do participating inmates receive?

I would appreciate your providing us with this information no later than Friday, October 1, 1976. While I realize that this is a substantial amount of information, I understand that much of it is already available at the institutional level.

I would appreciate the opportunity to meet with your staff as soon as possible to discuss this request and its timely completion.

Sincerely,

Raymond S. Wilson
Staff Director

RSW/CME/dk

cc: Mr. Cody Thames