

Department of Corrections



“A Balanced Approach”



PROFESSIONAL RELATIONSHIPS

2008 Appropriations
Act Chapter 879 Item 387—B
“Assisted Living Facilities for Geriatric Inmates”

Gene M. Johnson, Director

ITEM 387- B EXECUTIVE SUMMARY

In accordance with the 2008 Appropriations Act, Item 387-B the Department of Corrections and the Virginia Parole Board have analyzed the comparative costs and benefits of state operation compared to contracting for privately operated assisted living or nursing facilities for geriatric offenders. The report first reviewed how to define the “geriatric” inmate. Second, the geriatric release mechanisms for older inmates were explored. Finally, the comparative costs and benefits of state operation compared to private operation of geriatric facilities were considered.

Geriatric release application in Virginia is limited to offenders who have not been convicted of Class 1 felonies and either (1) are at least 60 years old and have served at least 10 years of their sentence, or (2) are at least 65 years old and have served at least 5 years of their sentence. The Parole Board reviews all geriatric release applications. However, relatively few apply. Truth-in-Sentencing offenders who are not normally parole eligible, have to petition the Parole Board to be considered for geriatric release. Since there will be increasing numbers of such offenders eligible in the future, an automatic review of these cases might result in more geriatric releases. The nature of the offenses committed by geriatric inmates and concerns for public safety are the most common reasons stated by the Parole Board for not releasing those that apply for geriatric release. Even if released, reentry for these offenders is difficult. Without families or nursing facilities willing to take these offenders due to their offenses, placement in the community is a problem. It is recommended that legislation to form a joint committee to study the issue of reentry for geriatric offenders be enacted.

A comparative cost assessment of Richmond area private nursing homes versus Deerfield Correctional Center, as the Department’s representative example of a geriatric/special needs facility, revealed that the Department is the least cost care provider. In general, health care costs for geriatric inmates are higher than for the younger inmate. This is true whether provided in the Department or in the Community; the main difference being the source of revenue used to support such care. In the Department, general funds are used and in the community, the federal tax dollars that support Medicare and Medicaid would be used. The average 2006 nursing home costs of \$56,940 to \$66,430, do not include hospital care, and is twice the per capita cost of housing an inmate at Deerfield (\$25,395), which does include hospital care. Contracting for privately operated assisted living or nursing facilities for lower risk geriatric offenders is difficult. There are limited public facilities for geriatrics in the community. Many of these for profit facilities have long waiting lists and many do not accept offenders. Since the Parole Board is not likely to release many offenders on geriatric release because of the nature of their offense, and many geriatric offenders have no family or outside support to go home to, it is more likely that the Department is and will be the place of last resort for many geriatric inmates.

The Department is able to provide diagnostic and disease prevention/care less expensively than the private sector and therefore has recommended to the General Assembly a statewide correctional medical center. The Department is providing geriatric inmates with the services needed in a much more cost effective manner than private nursing home care would cost, even if it could be secured.

ITEM 387-B
VIRGINIA DEPARTMENT OF CORRECTIONS AND PAROLE BOARD
REPORT ON GERIATRIC OFFENDERS

Introduction: Item 387-B from the 2008 General Assembly required that the:

“Department of Corrections and the Virginia Parole Board shall analyze the comparative costs and benefits of state operation compared to contracting for privately operated minimum security assisted living or nursing facilities, or other appropriate facilities or programs for lower risk geriatric offenders. Copies of the analysis shall be provided to the Chairmen of the Senate Finance and House Appropriations Committees by September 1, 2008.”

How to Define Geriatric Offender by Age: The term geriatric can be defined in various ways. Traditional measures have frequently been tied to ages when people become eligible for geriatric benefits, such as retirement or social security. However, other definitions may examine the physiological age of a group or statutory definitions. When looking at the offender population all of these definitions need to be considered in order to plan for the physical needs of the offenders as well as to determine what types of benefits might be available to assist in taking care of these needs.

- **50 Years and Older:** In the corrections field an inmate age 50 and older is typically regarded as ‘geriatric’ because their previous lifestyles have tended to make these offenders age faster than non-inmates (Morton, 1992). An inmate that is chronologically age 50 may be physiologically equivalent to a non-offender who is 10 to 15 years older. Lifestyle reasons that contribute to offenders being physically older than their stated age include a history of alcohol and drug use and abuse, limited health care prior to incarceration and the stressors of prison life (Madden, Rossiter, & Klock, 2003). On June 2, 2008, 4,678, or 12.2%, of the confined Virginia Department of Corrections (VA DOC) prison population was 50 years and older. Over the last 18 years, the 50 or older confined population increased almost six-fold from 715 to 4,678. Over the same period of time, almost 8% of those sentenced and committed to DOC were age 50 or older. New Court Commitments (NCC) have increased by more than four-fold from 223 (3.6%) in 1990 to 1,028 (7.8%) in 2007. As of June 2008, 4,956, or 8.4%, of the approximately 59,005 offenders on community probation and parole (P&P), were age 50 or older at the time of their release from prison.
- **60 Years and Older:** Under *Code of Virginia Section 53.1-40.01*, inmate ages are tied to the term “geriatric” for purposes of conditional releases. Inmates must apply for geriatric release as no automatic review occurs for this population. Offenders who were convicted of a Class 1 felony are not eligible for geriatric release. To apply for geriatric release, an inmate must **be at least 60 years of age and have served at least 10 years or at least 65 and served at least 5 years.**

From CY 1999 to CY 2007, there has been a 59% increase in the number of inmates eligible for geriatric release (201 to 489). Only 52 of the 489 eligible inmates applied for geriatric release in CY 2007 and only two were granted. Most inmates were denied due to the seriousness of their crime. Reasons for not applying for geriatric release include annual discretionary parole review and inmates not wanting to be released (Virginia Parole Board Policy Manual, 1996). While the 'geriatric release' mechanism might have been originally enacted to help offset the increasing numbers of elderly offenders confined, few offenders in Virginia have been released under 'geriatric release' since it was enacted in 1994. The Virginia Parole Board (VPB) continues to state that the likelihood is slim that many inmates will be released under the geriatric clause because of the serious nature of their crime and risk to the community.

- **65 Years and Older:** The Social Security Act, initially signed into law by President Franklin Roosevelt in 1935, refers to the federal Old-Age, Survivors, and Disability Insurance (OASDI) program (Social Security Administration, 2007a). Within these social insurance programs are two that would help geriatric inmates. While inmates are incarcerated, they are not eligible to receive benefits from the Health Insurance for Aged and Disabled (Medicare) and Grants to States for Medical Assistance Programs (Medicaid). While social security disability benefits could start at an earlier age than 65, generally the anticipated age for Medicare benefits is **65 years** of age (Social Security Administration, 2007b). It should also be mentioned that while an individual is not eligible based just on his age, Social Security has strict disability rules that adults must qualify under including a physical or mental impairment (or combination of impairments) that prevents him from working, and that has lasted or can be expected to last for at least one year or to result in death. Social Security pays only for total disability. No benefits are payable for partial disability or for short-term disability. (Social Security Administration, May 2007a.)

While it may be worth investigating to see if the law can be changed, currently, as long as inmates are confined in the VA DOC facilities, they are not eligible for Social Security or full Veteran benefits. If they were in the community, they potentially would be eligible, if they met eligibility requirements. However, if inmates were to be released to the community with the intention of seeking Social Security disability benefits, the releasee must meet strict government qualifications and certifications.

Services/Resources Required: There is **no one age** that defines a geriatric offender. Geriatric medicine focuses on health care of the elderly. Such health care aims to promote an individual's health, preventing and treating diseases and disabilities that are more common to older adults. In the August 2008 issue of "Corrections Today," Sterns, et. al., clarify that there is "**no set age**" at which adults need geriatric services; rather this is determined by a profile of the typical problems including immobility, instability, incontinence and impaired intellect and memory (Sterns, et. al., 2008). The most common health issues in older adults are arthritis, hypertension, and heart disease. Other serious health issues include cancer, stroke, lung disease, depression, and memory loss (National Institute on Aging, 2007).

While there are varying definitions regarding the age which defines a 'geriatric' offender, the DOC is legislatively obligated to meet the needs of all of its population. This includes providing needed health care for medical, dental and mental health services consistent with community standards. Older inmates are not targeted for specialized service on the basis of their age, but

rather, on the basis of their need. All offenders are assessed and given an appropriate level of care and treatment according to their needs. They can have problems with mobility, medical conditions, hearing, vision, and diet creating special needs in providing for their housing and care. They can have special security needs; they could easily be victimized by younger inmates or need extra vigilant supervision to ensure that officer's instructions are heard, understood and obeyed. The older inmate has special programming and treatment needs. Discharge planning normally presents challenges which must accommodate their special housing and medical conditions.

The same August 2008 "Corrections Today" article reported that a 'crisis is building in U.S. corrections that can be averted only by deliberately modifying existing facilities, personnel training and programming to support and house frail older inmates.'" In their survey, they questioned the number of facilities dedicated to the management of older prisoners. They received responses from 41 states. Some states indicated they had "dedicated units" for older prisoners inside prisons, some had "dedicated prisons", some had "dedicated secure medical" facilities, or "secure nursing home" facilities and some states had "dedicated hospice" facilities. The reported survey capacity dedicated to the management of older prisoners, a total capacity of less than 10,000, is in sharp contrast to the 117,337 male prisoners of 50 years and older in the survey count and 7,541 females 50 years and older.

Special Needs Facility-Deerfield: Older prisoners in Virginia are housed in a number of institutions throughout the Department. If not housed at Deerfield Correctional Center (DCC), the geriatric inmate is more likely to be confined at other DOC facilities that have the ability to care for the more acute medical needs of the geriatric inmate. Greensville and Powhatan Correctional Centers, along with Marion Correctional Treatment Center, have appropriate facilities. Currently inmates that have medical needs beyond DOC's on-site abilities are transported to off-site medical facilities. However, since 1998 Deerfield has been devoted to housing male inmates with special health care needs and the older inmate. In 2005, the Assisted Living Unit increased from 40 to 56 beds. By December 2006, just 8 years after opening, DOC expanded DCC from 497 to 1,059 beds to provide additional housing for geriatric inmates and inmates needing assisted living services. When it expanded, it required an additional 194 employees for this 600 bed expansion. A new 18 bed medical infirmary was also part of this expansion. The medical infirmary provides a skilled nursing level of health care. In addition, four of six units at DCC are equipped with a nurse's station for easy access to nursing care. For the purposes of providing comparative data for Item 387-B, DCC is used as DOC's representative geriatric facility since it houses more of Virginia's older prisoners than any other VA DOC facility.

Deerfield is a one-story and completely handicap accessible institution that addresses the mobility needs of its inmates. Among other special health care equipment, additional handicap accessible vans are available to transport the population. While the 18 bed medical infirmary, added during the recent expansion, is sufficient for the Department's immediate needs, the Agency anticipates needing to expand this infirmary over time as more Deerfield housing units and pods need to be converted to assisted living. Such expansion is to be integrated with the Agency's plan for a future statewide correctional medical center which would include surgery, radiology, medical oncology, dialysis, and physical rehabilitation services.

Currently the Department offers the following geriatric treatment programs at Deerfield: horticulture, library with large print books, board games and assisted living services including reality orientation to check for dementia, Alzheimer's' Disease and cognitive abilities. There is peer tutoring, a computer program for the blind, and a cooperative effort with the Virginia Beach library to assist with material for the blind and visually challenged. Activities such as arts and crafts, music and games are used to keep the inmates physically active and mentally alert. The activities are designed to encourage independent living skills and good health. In addition, other substance abuse, sex offender treatment, educational services and recreational services, including special exercise equipment and machines are available that not only provide activity for the geriatric inmate but also helps keep them as healthy as possible, thus, reducing medical and rehabilitation costs. These latter services are also offered to geriatric inmates who are at other prisons throughout the state. There are programs like productive citizenship, anger management, and sex offender treatment, plus, pre-release services that are also offered. Because of the special needs of the geriatric offenders, employment may not be an option so placement and assistance are planned for some of the inmates' release. While all sex offenders are difficult to return to the community, geriatric sex offenders are a special challenge. Families may no longer know the inmates who have been incarcerated for a long period of time or may not be willing to take them in due to the nature of the crime. Similarly, nursing homes and assisted living facilities may reject them due to the nature of their violent offenses.

Approximately 90 inmates at Deerfield are confined to a wheelchair. Currently 65% of the Deerfield population is 50 and older. The average age of the Deerfield inmate is 54 years old and has a projected length of stay of almost 18 years. The single, most common, primary offense is rape/sexual assault (29%). Over 75% of Deerfield's population is incarcerated for violent offenses (including rape/sexual assault, homicide, abduction, robbery and other assaults) making placement of these offenders in the community extremely difficult (Virginia Department of Corrections, 2008a).

Deerfield's FY2008 operating per capita was \$25,395 compared to \$24,870 for other DOC major institutions. Medical costs are becoming a bigger part of total expenditures. In FY 2003 the medical per capita was \$3,037 or 11.4% of total DOC operating expenditures. In FY 2007, it increased to \$4,059 or 12.9% of DOC operating expenditures (VA DOC, 2008b.) Medical expenditure data, within the DOC, is not available currently by age. However, a large portion of the total medical expenses is the off-site which is available by age. Off-site medical expenses are greatly impacted by an aging population and are reflective of the increased costs associated with an older group. Off-site costs are almost 23% of the total medical expenditures and are referenced here to reflect a trend. In FY 2005, the average inmate under the age of 50 has had annual off-site medical costs of \$512 while the average inmate age 50 and older has had annual off-site medical costs of \$2,490. These average age group expenses, however, have risen substantially in FY 2007. The average inmate under the age of 50 has had annual off-site medical costs increase to \$790 while the average inmate age 50 and older has had annual off-site medical costs increase to \$3,350.

While DCC's operating per capita is not the exact cost to house and care for a geriatric inmate, it is the facility chosen to more closely resemble what VA DOC believes is representative of such in-prison custodial care, treatment and overall costs. The cost cited for DCC includes not only housing but also security, medical and mental health treatment costs. DOC does not run

Deerfield to make a profit as outside private facilities are likely to need to do to operate. The equivalent health care is expensive not only because of the nature of the medical treatment needed, but because of the profit motive included providing care, food, board and supervision. For inmates who might be located to private facilities, when the treatment needs exceed the general nursing care available, the need to transport the inmate and potential security cost involved with needed off-site health care can also add to the expense.

Service and Cost Comparisons: The components of medical costs (i.e. supplies, medical equipment and space) are the same regardless of whether an inmate is housed in a DOC facility or in the community. The difference is where the money comes from to pay for the costs which would be either VA DOC general funds or federal tax dollars such as Medicare and Medicaid.

The average nursing home costs in 2006 in Richmond for a semi-private room is \$156/day and a private room is \$182 (Virginia Health Information, 2008). These estimates do not include hospital costs; only room, board and nursing care. The National semiprivate average is \$186 and private is \$206 (AARP, 2008). While it is suggested that the costs could be increased by 5% per year to arrive at 2008 costs, even using the 2006 costs, one can recognize that ($\$156 \times 365 = \$56,940$ and $\$182 \times 365 = \$66,430$ without inflation) is at least twice the per capita cost of \$25,395, which includes hospital costs, for housing an inmate at Deerfield. Contracting for privately operated assisted living or nursing facilities for lower risk geriatric offenders is difficult with long waiting lists for many such facilities. Moreover, many do not want to take offenders.

There are several reasons why the DOC may be the best provider of services for these offenders: (1) DOC can provide elder care more economically than the private sector; (2) the VPB is not likely to release these offenders, and (3) these offenders are very difficult to place in public facilities and (4) many have no family or outside support. Furthermore, VA DOC has been doing a good job of providing services to geriatrics. Since VA DOC is likely to be the last resort for many geriatric offenders, the question of how can VA DOC provide for the geriatric inmate more economically is addressed with several suggestions.

How to Minimize VA DOC Costs: VA DOC is able to provide diagnostic and disease prevention/care less expensively than the private sector and therefore has recommended to the General Assembly a statewide correctional medical center. By having such a facility, DOC also avoids the security/transportation costs and complexity of transporting and treating offenders offsite. Many older inmates have problems with medical conditions, endurance, hearing and vision. A DOC statewide correctional medical center that would include surgery, radiology, medical oncology, dialysis, and physical rehabilitation is a future option. Such a statewide correctional medical center would provide needed services for geriatric inmates. To accommodate the special physical and mobility requirements that many older inmates have, special measures are needed. Housing needs to be wheelchair accessible with single level bed dorms. Geriatric inmates require special equipment and more assistance. Geriatric chairs (shower and wheel chairs and higher legged chairs), beds, walkers and special bathroom facilities should be provided. They may also require a special, more costly diet.

There are additional Measures DOC Must Take: According to the DOC Reentry Services Manager, a major obstacle to the reentry of the geriatric inmate is the lack of available beds in nursing homes/assisted living facilities. Placement is further complicated by the refusal of the

administration of these private facilities to consider anyone with a criminal history. Additional nursing homes or assisted living facilities run by the state, community-based or non-profit organizations may be a solution. Until such time that there is place for geriatric inmates to go once released, efforts to assist with their release from prisons, will remain difficult. Legislation establishing a joint subcommittee to study this issue is recommended.

Estimated Future Geriatric Correctional Population: Based on the Secretary of Public Safety's (SPS) Official State Responsible New Court Commitment Forecast, the total number of inmates expected to be sentenced to DOC from FY2008 through FY2011 is 13,230, 13,766, 14,176, and 14,573. It is estimated that for these same four years there will be respectively 1,032, 1,071, 1,103 and 1,134 geriatric offenders sentenced to DOC.

The state responsible (SR) population of 50 and older for June 30, 2008 was 12.2%, or 4,737, of the confined population. Based on this percentage the SR population of 50 and older is estimated to be 4,811 inmates at the end of FY 2009. The SR population is projected to be 4,939 in FY 2010 and 5,057 in FY 2011.

The Probation and Parole (P&P) caseload at the end of FY 2008 was 59,005. Current projected P&P caseload growth indicates that there will be 61,365 and 63,820 under supervision by the end of FY 2009 and FY 2010 respectively. Since currently 8.4% of the P&P population are 50 and older, it is assumed that a minimum of 8.4% of the future P&P population will be 50 and older. That would equate to a geriatric population of at least 4,956 at the end of FY 2008. The geriatric population would increase to 5,155 at the end of FY 2009 and to 5,361 at the end of FY 2010. Since the total number of age 50 and over released from prison in FY 2008 was 1,507 (direct discharges and those under supervision) this previously used estimate may be low and deserves close monitoring. P&P Officers and Supervisors will likely need additional training in what resources are available to assist the geriatric client and training in how to recognize and identify mental, physical and social challenges of the older offender now under community supervision.

VA DOC is Monitoring the Geriatric Population: The VA DOC is keenly aware of its growing geriatric and special needs population. Geriatric reports have been produced and updated for the past three years. The Executive staff monitors and reviews these reports. In addition, The Board of Corrections has requested a special presentation be given at its September meeting concerning the aging inmate population in prison and in the community.

The Master Plan for Healthcare Services completed in June 2007 addressed a General Assembly directive to the VA DOC. Item 387 #3c of the 2006 Acts of Assembly states:

“The Department of Corrections shall provide a planning report on alternative for developing additional medical, mental health, and geriatric facilities. The report shall consider the potential for cost savings through the expansion or replacement of the medical unit at Powhatan Correctional Center, the optimum mix of services and facilities at other facilities, the use of contract services, requirements for mental health services, requirements for geriatric services for older inmates, and financial options....”

The master plan addressed the needs primarily of male inmates. Female offenders are thought to have adequate medical and mental health capacity at Fluvanna Correctional Center for Women,

which includes a 46 infirmary/medical beds, 46 acute mental health beds and 144 residential mental health beds for a total of 236 healthcare beds. To address the future healthcare needs, the Masterplan includes recommendations to fund the following:

- Powhatan Correctional Center to add a 150 bed medical, surgical, infirmary beds and a comprehensive outpatient unit; \$171,000,000.
- Deerfield Correctional Center to add an 80 bed skilled nursing unit; an 89 bed assisted living unit; and a 42 bed Alzheimer's' unit; \$24,000,000.
- Greensville Correctional Center to add a 42 Axis II unit; \$13,000,000.
- Marion Correctional Treatment Center to add a 28 bed acute unit; 81 bed residential unit; and a 42 bed transitional unit; \$35,000,000.

The DOC just completed in 2007 the Deerfield Correctional Center expansion and is proposing a statewide correctional medical center which would assist in the health care of a number of geriatric inmates.

Improved coordination between the DOC and the Parole Board concerning the 'geriatric release' may help to assure that new law cases are heard. Currently, since geriatric inmates must apply to the Parole Board for geriatric release, new law offenders will not be considered unless they apply. Old law offenders who are parole eligible will be heard at their annual review without the need to apply. There have only been seven geriatric releases granted between 2003 and 2007, mainly because of the nature of the offenses of those that applied. As more new law sentenced inmates age and serve enough time, the pool of new law offenders eligible for geriatric release will increase and having automatic hearings may result in more utilization of this release option. In FY 2007, there were 14 new law inmates that were at least 60 years old and had served 10 years or more (all violent offenders). Of those inmates, two applied for geriatric release. In addition, there were 53 new law inmates that were at least 65 years old and had served 5 years or more. Only two of those offenders were incarcerated for non-violent (1) or drug (1) offenses, the remainder were violent. Of that group, 21 applied for geriatric release, eight of them applied twice and two applied three times. One of the offenders that applied for a third time (in FY 2007) was granted release. Of 67 new law offenders (14 + 53), only 23 (2 + 21), or 34%, applied for geriatric release and 66% did not. Out of the total new law inmates, 65 were incarcerated for violent offenses; only 2 were not. If there were automatic review, then these additional 44 cases, or 66%, would have been considered. However, even with a larger number being referred for geriatric release, because of their violent offenses, it is likely they would not be granted.

Summary: Geriatric inmates present special challenges in their housing, security, medical, general care and reentry needs. The majority of these offenders are incarcerated for violent offenses. Many do not have families willing to take them due to the nature of their crimes. Similarly, private nursing homes/assisted living facilities are also reluctant to accept them due to their criminal records. To comply with the directive of this report, three elements were considered. First, defining who geriatric inmates are was addressed. Second, release mechanisms for geriatric inmates were explored. Finally, the comparative costs and benefits of state operation compared to private operation of geriatric facilities were considered.

There are several possible definitions of geriatric age that are commonly used, depending on the situation. In literature that addresses the general population, often times the age of 65 is

associated with the term geriatric because of its historical association with retirement benefits. However, when looking at the offender population, lifestyles prior to incarceration and the stressors of imprisonment are believed to result in inmates being physiologically older than their non-offender counterparts. In correctional literature, offenders age 50 and older are often referred to as geriatric inmates. According to Virginia statute, the minimum age for consideration for geriatric release is age 60.

Geriatric release application in Virginia is limited to offenders who have no convictions for Class 1 felonies and either (1) are at least 60 years old and have served at least 10 years of their sentence, or (2) are at least 65 years old and have served at least 5 years of their sentence. The Parole Board reviews all geriatric release applications. However, relatively few apply. For those who are parole eligible, they will have their cases reviewed annually even without geriatric release (VPB will not review on both grounds in one year). For those convicted under truth-in-sentencing (TIS), their cases will not be reviewed unless the offender applies. Since TIS offenders will be increasing in the future, an automatic review of these cases might result in more geriatric releases. The nature of the offenses committed by geriatric inmates and concerns for public safety are the most common reasons stated by VPB for not releasing those that apply for geriatric release. Even if released, reentry for these offenders is difficult. Without families or nursing facilities willing to take these offenders due to their offenses, placement in the community is a problem. It is recommended that legislation to form a joint committee to study the issue of reentry for geriatric offenders be enacted.

A comparative assessment of private nursing home costs versus DOC costs revealed that the DOC is the least cost care provider. Medical costs are substantially higher for older inmates. These are fixed costs (in VA DOC or in the Community) with the main difference being the source of revenue used to support such care. In VA DOC, general funds are used and in the community, the federal tax dollars that support Medicare and Medicaid would be used. The average 2006 nursing home costs of \$56,940 to \$66,430, do not include hospital care, is twice the per capita cost of housing an inmate at Deerfield (\$25,395), which does include hospital care. Contracting for privately operated assisted living or nursing facilities for lower risk geriatric offenders is difficult. There are limited public facilities for geriatrics in the community. Many of these facilities have long waiting lists and many do not accept violent offenders. Since the VPB is not likely to release many offenders on geriatric release because of the nature of their offense, and many geriatric offenders have no family or outside support to go home to, it is more likely that VA DOC is and will be the place of last resort for many geriatric inmates.

The geriatric population in prison and in the community is projected to increase over the next six-year forecast horizon. As the geriatric population increases so will the costs and activities to provide the appropriate types of institutional and community care and services required by law. DOC is providing geriatric inmates with the services needed in a much more cost effective manner than private nursing home care would cost, even if it could be secured.

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- DOC and VPB Participants involved in completing Item 378-B Geriatric Study: The report was coordinated by the Research, Evaluation and Forecast Unit, Research & Management Services.

Dr. James E. Arndt	Shirley Hughes
Gary Bass	Dr. Robin Hulbert
Russ Boraas	John Jabe
John T. Britton	Gene Johnson
Dr. Lou Cei	Rudolph C. McCollum, Jr.
Dr. Tama Celi	Walter Pulliam
Richard Crossen	Scott Richeson
Christine Eacho	William F. Robinson
Louis Eacho	Fred Schilling
Helen Fahey	Kim Scifres
Lois E. Fegan	Cookie Scott
Helen S. Hinshaw	Mary O. Worrell

Correction Noted: This version has had page 8 of the original report corrected. The report originally said: “The state responsible (SR) population of 50 and older for June 2, 2008 was 12.2%, or 4,678, of the confined population. Based on this percentage the SR population of 50 and older is estimated to be 5,047 inmates at the end of FY 2009. The SR population is projected to be 5,182 in FY 2010 and 5,306 in FY 2011.” The corrected copy of this paragraph, which appears in it’s entirety in the narrative, on page 8, now says: “The state responsible (SR) population of 50 and older for June 30, 2008 was 12.2%, or 4,737, of the confined population. Based on this percentage the SR population of 50 and older is estimated to be 4,811 inmates at the end of FY 2009. The SR population is projected to be 4,939 in FY 2010 and 5,057 in FY 2011.